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Intimate Partner Violence and HIV/STD Risk Among Lesbian, Gay, Bisexual, and Transgender Individuals

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To date, there has been little research examining HIV/STD risk among lesbian, gay, bisexual, and transgender (LGBT) individuals who are in abusive relationships. This article uses data collected from a community-based organization that provides counseling for LGBT victims of intimate partner violence (IPV). A total of 58 clients completed the survey, which inquired as to sexual violence and difficulties negotiating safer sex with their abusive partners. A large percentage of participants reported being forced by their partners to have sex (41%). Many stated that they felt unsafe to ask their abusive partners to use safer sex protection or that they feared their partners' response to safer sex (28%). In addition, many participants experienced sexual (19%), physical (21%), and/or verbal abuse (32%) as a direct consequence of asking their partner to use safer sex protection. Training counselors on issues of sexuality and safer sex will benefit victims of IPV.

Keywords: *intimate partner violence; domestic violence; sexual negotiation; safer sex; rape; sexual assault; LGBT; HIV/AIDS; STDs*

There has been growing attention to the problem of intimate partner violence (IPV) within same-sex relationships (Renzetti, 1992; Renzetti & Miley, 1996; Stall et al., 2003; Tjaden, Thoennes, & Allison, 1999). Incidence rates are estimated to be equal to or greater than that of heterosexual women (Greenwood et al., 2002; Tjaden & Thoennes, 2000). However, to date, there has been little research examining HIV and/or sexually transmitted disease (STD) risk among lesbian, gay, bisexual and transgender (LGBT) individuals who are in abusive relationships. Intimate partner violence (IPV) is a pattern of controlling abusive behavior (including physical, emotional,

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verbal, and sexual) in an intimate relationship (Renzetti & Miley, 1996). HIV/STD risk is an important consideration for those experiencing abuse, as transmission can occur directly through forced unprotected sex with a partner or indirectly by impairing the victim's ability to negotiate safer sex.

LGBT individuals may experience difficulty in successfully negotiating safer sex for a variety of reasons, including a decreased perception of control over sex, fear of violence, and unequal power distributions (financial and social) within the relationship. Those experiencing IPV live in a context where their abusive partners control multiple aspects of their lives. Many find it difficult to assert their needs and wants. The pattern of abuse is such that individuals may concentrate on protecting themselves from physical and emotional harm before thinking about safer sex. Furthermore, LGBT individuals experience intimate partner abuse within a context of homophobia, transphobia, and other biases, which may further compound the effect of abuse on safer sex negotiation (Allen & Leventhal, 1999; Greenwood et al., 2002).

Power in Relationships

Although power imbalances are evident in LGBT relationships where abuse is present (Greenwood et al., 2002), to date research on LGBT IPV has not focused on the difficulties of people who are abused to negotiate safer sex. Perceived or actual lack of power in an intimate relationship is likely to negatively affect safer sex negotiations. The majority of research on IPV and safer sex negotiation has focused on heterosexual relationships (Amaro, 1995; Amaro, Fried, Cabral, & Zuckerman, 1990; Beadnell, Baker, Morrison, & Knox, 2000; Koenig & Moore, 2000; Wingood & DiClemente, 1997; Wyatt et al., 2002). Several researchers have theorized the importance of power in heterosexual relationships stating that unequal power relations between men and women evident in society at large are often epitomized in interpersonal relationships between men and women (Amaro, 1995; Gomez

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& Marin, 1996; McCormick, 1994; Perper & Weis, 1987; Williams, Gardos, Ortiz-Torres, Tross, & Ehrhardt, 2001; Wingood & DiClemente, 1997). Research has demonstrated that women in heterosexual relationships who are abused report lower perceptions of control over safer sex than women who are nonabused (Beadnell et al., 2000; Mendez, 1996); many fear violence when negotiating safer sex (Kalichman, Williams, Cherry, Belcher, & Nachimson, 1998) and are more likely to incur abuse as a result of requesting a partner wear a condom (Wingood & DiClemente, 1997).

While gender is an important consideration for IPV, it is not the only manifestation of unequal power in relationships. In fact, some theorists have critiqued the prevalence of gender-based theories of domination in domestic violence (DV; see, e.g., Renzetti, 1992) for its inability to incorporate same-sex DV concerns and for its failure in integrating simultaneous systems of oppression that may underlie interpersonal power relations including homophobia and racism. Other theorists argued for a gender-neutral approach and have pointed out that gender is, in fact, not the crucial motivator of IPV, instead positing that the batterer's personality and behavioral characteristics are more important for understanding IPV (Island & Letellier, 1991).

While there is dissent among theorists about the root cause and explanation for DV, research demonstrates that it affects LGBT individuals and heterosexual women in similar ways. Individuals experiencing IPV in a same-sex relationship may experience many of the same issues relating to power and negotiation of safer sex observed by researchers in heterosexual women who are abused. For example, researchers have found that men who have sex with men (MSM) and who have been victims of partner violence are more likely than MSM who are nonabused to have lower incomes, be unemployed, experience depression, and to abuse substances (Stall et al., 2003). Although causation between IPV and HIV is difficult to establish, the inability to negotiate safer sex may lead to a higher incidence of HIV infections among MSM who have been abused. Studies demonstrate that men who experience IPV within a same-sex relationship are between 50% and 60% more likely to be HIV positive than those who had not experienced any type of abuse (Greenwood et al., 2002; Stall et al., 2003).

Examining same-sex DV and HIV/STD risk including safer sex negotiation is important to increase awareness of IPV among LGBT communities (McLaughlin & Rozee, 2001) and to extend safer sex counseling services for LGBT victims of DV. This article reports on data collected at The New York City Gay and Lesbian Anti-Violence Project, an agency servicing LGBT clients seeking services for DV. The agency is a grassroots, nonprofit, community-based organization that has served the LGBT community in New York City since 1980. It provides counseling for victims of sexual

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assault, police brutality, hate crimes, and DV. These data provide a unique opportunity to examine the effects of intimate partner abuse on HIV risk among LGBT individuals who are currently in an abusive relationship or who have recently been in an abusive relationship.

Method

This study analyzed data collected by a research project that began as part of the Sexuality Training and Research (STAR) program at the HIV Center for Clinical and Behavioral Studies at the New York State Psychiatric Institute and Columbia University. The purpose of the STAR program was to develop and guide sexuality research in community-based organizations (CBOs; O'Sullivan & Parker, 2003). Members of CBOs who were interested in conducting research on issues of sexuality were asked to write a research proposal as part of the application process for the STAR program. CBO members attended a weeklong training designed to cover basic research methodology specific to sexuality. A second session was designed to train participants on the basics of evaluating research data. A researcher from the HIV Center partnered with each participant to help further develop the research proposal and to serve as a guide and resource for the research project. It is important to note that the "mentoring" process between academic researchers and CBOs is one of mutual learning and functions as a research partnership.

Study Procedures

Study recruitment began in May of 2002 and concluded in June 2003. Data were collected from the Manhattan office of the agency. As LGBT individuals and as victims of DV, participants represent a uniquely vulnerable population. Services at the agency focus on safety, support, and empowerment for individuals who have been victimized and who are dealing with the trauma of IPV. Some clients receive a one-time consultation with a counselor; however, most are given ongoing counseling for DV that includes safety planning for staying physically safe. Because of safety and clinical concerns, only clients who came to the agency offices (as opposed to those who telephoned the agency) were asked to participate in the survey. To help ensure clients' emotional well-being, free and confidential counseling services were available after the interview. No client availed himself or herself of counseling specifically related to the questions in the survey; however, many continued on to receive ongoing counseling from the agency staff. The

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study was designed to assess services needed for the agency and, as such, did not require Institutional Review Board approval. In keeping with the spirit of the organization, the current study did undergo extensive internal review by directors, counselors, and mentors at STAR.

As part of agency procedure, those requesting counseling or advocacy related to DV were interviewed for an initial assessment of their case before being assigned a counselor to work with at a later date. After completing this initial interview with a counselor, clients were asked by the counselor if they would like to participate in a study inquiring about safer sex behaviors. Counselors informed clients that they were under no obligation to complete the survey and that their services would not be affected in any way if they declined to participate. If the client agreed to participate, the same counselor who conducted the initial assessment delivered the survey instrument. Participants were not compensated for taking part in the survey.

The research study utilized the counselors to administer the survey for several reasons. First, the survey itself was brief and quick to administer. Counselors were, therefore, in an ideal location to administer this survey. Many clients would hesitate to schedule another appointment to complete a survey. Second and most important, counselors are uniquely trained to deal with the issues of this population. The agency's staff is composed of LGBT individuals who have years of experience speaking about sexual assault and DV with LGBT victims. Hiring outside researchers would not allow us to utilize the unique skills of these advocates who have had a great deal of contact with this community. Finally, the agency did not have monetary resources to hire additional staff for any portion of the current study.

If the client agreed to participate in the research study, the counselor asked the client to sign a consent form. The counselor read aloud the questionnaire and recorded the participant's responses. Consent form and completed survey were given to project personnel who filed the consent form securely and separately from the survey. The survey did not contain any identifying information.

Participants

All participants were clients of the agency, and a total of 65 participants completed the survey. Six clients refused to participate in the survey. After completion of the survey, counselors identified three participants as likely batterers and two as suffering from severe mental illness. In addition, one survey was incorrectly completed and disregarded, and another survey was delivered to a male who was seeking services as a victim of DV in a heterosexual relationship. To ensure that the current study findings are relevant to

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LGBT individuals who experience IPV as victims, these seven cases were dropped from the study.

A total of 58 completed surveys were analyzed. Most study participants (72%, $n = 42$) were MSM. All but two of these men identified as gay, one identified as bisexual, and another declined to provide a sexual identity category. Eleven participants (19%) were women who have sex with women (WSW); all identified as lesbians. Four participants identified as transgender women (male-to-female) and identified as heterosexual. One participant identified as a transgender man (female-to-male) who declined to state his sexual orientation.

The average age of the participants was 33.5 years with a range of 18 to 50 years ($SD = 7$). On average, WSW were 2 years older than the MSM and the transgender individuals. The largest ethnic group was Latino/a (35%, $n = 20$). A little over one fourth of all participants were African American, and another one fourth of the participants consisted of individuals who identified as White. The remainder of participants (16%, $n = 9$) identified as multiethnic, Asian and/or Pacific Islander, Arab, or Native-American individuals.

Almost all participants (98%, $n = 57$) had experienced verbal abuse by their current or recent partner. A large portion of participants had experienced physical violence (71%, $n = 41$), and a smaller portion had experienced partner assault with a weapon such as a knife or a bat (26%, $n = 15$).

Instruments

The survey consisted of 13 questions that took approximately 5 minutes to administer. All questions addressed characteristics and partner interactions within the abusive relationship, which in all cases was either a current abusive relationship or a recent abusive relationship. We drafted the survey, which was based on standardized instruments from the literature on DV and negotiation of safer sex. Because an important goal of this research was the integration of research with the services of CBOs, the counselors were consulted as to the structure of the survey and its relevance to their clients. Part of the goal of this research was to utilize the experiences and ideas of people who work directly with LGBT clients and victims of violence and to gain from their experience and insight. The following describes the measures used for this analysis.

Demographic information. As part of the initial interview with the counselor (and as part of the regular agency procedure), participants were asked to provide their age, ethnicity, gender identity, and sexual orientation. In addition, participants were asked about the extent of the abuse and extent of inju-

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ries incurred as a result of their abusive partner. Participants were also asked their history of abuse with their partner, including past sexual abuses and past assault with a weapon, framed as yes or no questions.

Sexual violence. Participants were asked if they had ever been forced to have anal or vaginal penetrative sex with their abusive partner and if so if their partner used a condom. Because counselors reported that many clients had described being forced by their partner to have sex with others, we also asked participants, in a separate question, if their partner had ever forced them to have anal or vaginal penetrative sex with others, and if condoms were used when this occurred. Responses to all these questions were yes, no, or not sure.

Frequency of safer sex. Participants were asked how frequently they used condoms or other protection during sex (currently). They had the option of replying always, some of the time, or never.

Changes in frequency of condom use. As use of safer sex protection may change over the course of a relationship, one question in the survey asked participants to describe their use of safer sex protection with their partner over time. Participants were asked if in "their relationship they used (a) more protection over time, (b) less protection over time, or (c) no change over time."

Decreased use of safer sex protection. Participants who reported a decrease in protection over time were asked to explain why the decrease in condom usage had occurred. Participants could provide their own answer and/or they could choose among four choices: (a) "My partner refused to use protection, even though I wanted to use it;" (b) "My partner became violent with me;" (c) "I was frightened to bring it up;" (d) "We agreed to not use protection." Participants could choose as many of these options as were relevant to them.

Safer sex negotiation. There were five questions that inquired into clients' safer sex negotiations with their partners: (a) participants were asked "did you ever not use safer sex because you wanted to avoid problems with your partner?" (b) in a separate question, participants were asked if they did not use safer sex because they "feared their partners' response" to a safer sex request; in three separate questions, participants were asked if they had ever experienced (c) verbal, (d) sexual, or (e) physical violence as a result of requesting safer sex; and finally, (f) participants were asked if they felt "safe

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negotiating safer sex" with their partners. For all these questions, participants replied either yes, no, or not sure.

Deceptive condom use. Counselors noted that many of their clients reported that their partner had told them they were using a condom only to discover that they were not. For this reason, participants were asked "have you ever been told that your partner was using a condom when in fact he or she was not?" Participants could answer either yes, no, or not sure.

Data Analyses

LGBT is a broad category made up of four distinct groups. Because the agency serves the LGBT community in New York, we provided data for the group as a whole and as separate information for MSM, WSW, and transgender people. Descriptive statistics were used to examine the prevalence sexual violence, frequency of safer sex, decline in the couple's use of safer sex protection, violence as a result of requesting a partner to use protection, and deceptive condom use.

We wanted to understand if the presence of sexual violence in the relationship further affected safer sex negotiation. Does sexual violence make it more likely for participants to state that they fear their partner's response to safer sex? Thus, logistic regression analyses were used to assess the impact of being forced to have sex with your partner (or by your partner with others) on safer sex negotiation. The dependent variable was one variable that asked participants if they feared their partner's response to safer sex. The explanatory variables were (a) being forced by your partner to have sex and (b) being forced by your partner to have sex with others. Each explanatory variable was entered individually into the regression model. We conducted two separate logistic regression analyses for each explanatory variable and hypothesized for each that participants who had been forced to have sex with their partners (or with others) would be more likely to report that they fear their partner's response to safer sex.

Results

Sexual Violence

As shown in Table 1, rates of sexual violence were high in this sample of LGBT people who were abused. Almost one half of all participants had been forced to have sex with their abusive partner at some point during the relationship. One half of those who had been raped by their partners reported that

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Table 1
Percentage (Number) of LGBT Victims of Intimate Partner Violence and STD/HIV Risks

	% Total (n = 58)	% MSM (n = 42)	% WSW (n = 11)	% Transgender (n = 5)
Sexual violence				
Forced sex with partner	41 (24)	45 (19)	27 (3)	40 (2)
Partner forced participant to have sex with others	10 (6)	12 (5)	—	20 (1)
Unprotected forced sex with partner[a]	58 (14)	53 (10)	100 (3)	50 (1)
Unprotected forced sex with others[b]	83 (5)	80 (4)	—	100 (1)
Frequency of safer sex				
Engage in safer sex with abusive partner				
Never	31 (18)	19 (8)	64 (7)	60 (3)
Some of the time	47 (27)	57 (24)	27 (3)	—
Always	22 (13)	24 (10)	9 (1)	40 (2)
Use of safer sex in the relationship over time				
Safer sex decreased over time	58 (34)	67 (28)	27 (3)	60 (3)
No change in safer sex use over time	41 (24)	29 (12)	73 (8)	40 (2)
Safer sex increased over time	4 (2)	5 (2)	—	—
Reasons for decrease in condom use over time				
Partner refused to continue practicing safer sex[c]	31 (10)	32 (9)	—	33 (1)
Partner became violent with regard to safer sex[c]	16 (5)	18 (5)	—	—
Frightened to bring it up with partner[c]	19 (6)	14 (4)	—	67 (2)
Agreed with partner not to engage in safer sex[c]	40 (13)	36 (10)	100 (3)	—
Safer sex negotiation				
Not using protection to avoid problems	32 (18)	36 (15)	9 (1)	40 (2)
Not safe to negotiate because fear partner's response	28 (16)	26 (11)	27 (3)	40 (2)
Abuse as a result of requesting safer sex				
Verbal abuse	32 (18)	33 (14)	18 (2)	40 (2)
Sexual violence	19 (11)	21 (9)	9 (1)	20 (1)
Physical violence	21 (12)	21 (9)	18 (2)	20 (1)

(continued)

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Table 1 (continued)

	% Total (n = 58)	% MSM (n = 42)	% WSW (n = 11)	% Transgender (n = 5)
Partner misinformed participant they were using protection when they were not	17 (10)	24 (10)	—	—

Note: MSM = men who have sex with men; WSW = women who have sex with women; LGBT = lesbian, gay, bisexual, and transgender; STD = sexually transmitted disease.
a. Among those who reported being forced by partner to have sex, n = 24 for all.
b. Among those who reported being forced by partner to have sex with others, n = 6 for all.
c. Among those who reported a decline in safer sex practices within their relationship, n = 32 for all. Participants could choose all categories that applied.

their partners used safer sex protection. In addition, among the small number of participants who had been forced by their partner to have sex with others, only one reported that condoms were used.

Frequency of Safer Sex

Almost one third of the sample had never engaged in safer sex with their abusive partner. While about one fifth of the sample reported "always" using safer sex, almost one half reported engaging in safer sex "some of the time" with their abusive partners.

More than one half of all LGBT people who were abused reported that their use of safer sex protection had declined from the beginning to the current point in the relationship. The two reasons most cited by participants for explaining the decrease in safer sex over time were they had "agreed with their partner not to engage in safer sex" and that their partner had refused to practice safer sex.

Safer Sex Negotiation

A large proportion of participants reported that they had not engaged in safer sex because they wanted to avoid problems with their partner at some point during their relationship. Many also reported that they felt unsafe to ask for safer sex or that they feared their partners' response to a safer sex request and reported experiencing sexual, physical, and/or verbal abuse as the direct result of requesting safer sex from their abusive partners.

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Deceptive Condom Use

Even when negotiation may have appeared successful, some MSM were deceived by their partners with regard to safer sex. Among MSM, one in four reported being deceived by their partner—that is that they thought a condom was being used by their partner, when in fact it was not.

Effects of Sexual Abuse on Negotiation

Using logistic regression, individuals who reported that they had been forced to have sex with their partner were 10.3 times more likely than those who had not to report not using protection because they feared their partner's response to safer sex (not shown: 95% Confidence Interval [CI] = 2.40 to 44.29, p = .002). Among those participants who had been forced by their partner to have sex with others, the results were insignificant (odds ratio [OR] = 4.12, 95% CI = .69, 24.75, p = 122). Thus our hypothesis that participants who had been forced to have sex with their partners were more likely to fear their partner's response to safer sex was supported by the regression analyses; however, among those who had been forced by their partners to have sex with others, our hypothesis was not supported.

Discussion

This article supports previous findings that there is a significant risk of HIV/STD transmission among victims of DV among LGBT people (Greenwood et al., 2002; Stall et al., 2003). These results also highlight that sexual assault is a major concern for LGBT people who are in abusive relationships. More attention by researchers and CBOs needs to be given to the topic of LGBT victims of IPV to decrease risk of HIV/STD transmission.

Where participants reported being raped without protection by their abusive partner, the link between HIV/STD risk and abuse was clear. However, sexual assault is a direct and indirect risk factor for HIV/STD infection. In the logistic regression analyses, participants who had been raped by their partner (with or without a condom) were more likely to fear their partners' response to safer sex. The psychological effects of sexual assault within an intimate relationship may have long-term consequences with regard to negotiating safer sex. Those experiencing IPV are often forced to appease their batterers at the expense of their own needs, wants, and safety (Renzetti & Miley, 1996). Many in this sample may accommodate their batterers' wishes to use less safe sex protection at the expense of their own health; likewise

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many live in a climate of fear where their own wishes are often not known or realized.

Although negotiation of safer sex is an important consideration for victims of IPV, it has not been the focus of the few studies that have examined DV in LGBT populations. These findings expand on current research about LGBT IPV by examining the ways that negotiation of safer sex affects this community. In total, 78% of participants reported that they never used safer sex with their abusive partners or used it sporadically. LGBT victims of DV experience many of the same difficulties negotiating safer sex that have been previously reported in samples of heterosexual women in abusive relationships (Amaro, 1995; Wingood & DiClemente, 1997). Given the prevalence of fear and real violence surrounding safer sex negotiation among this sample of LGBT victims of IPV, it is crucial that steps be taken to protect them from HIV/STD. Safe and effective methods of staying safe not only from physical and sexual violence but also from HIV/STDs need to be discussed with LGBT victims of IPV.

Although the current study extends the research on IPV among LGBT people, there are a number of limitations. The current study was small and based on a convenience sample. Even though the current study included some transgender participants, more research needs to be conducted to examine the special characteristics and types of abuse specific to them. In addition, because the instrument was delivered by counselors who also took the initial assessment of each client, there may have been a bias in the responses.

The researchers were unfortunately unable to ask participants about their HIV status because of the policies of the nonprofit agency at which the current study took place. The agency had legal and client-related concerns about asking clients their HIV status. While it is likely that the HIV status of clients affected some of their safer sex practices, there are three factors that help to mitigate this gap in information. The first is that in explaining why or how participants had changed their safer sex practices they had the opportunity to add their own explanation, at which point clients have had the opportunity to state if HIV status played into their practice. Second, individuals who were HIV positive still benefit from practicing safer sex to avoid coinfection of more aggressive or drug-resistant strains of HIV and to avoid the transmissions of other STDs for which they are at greater risk. Third, this research was focused on the direct impact of IPV on safer sex practices. While the impact of HIV status on such practices is an important concern, it was not the focus of the current study. While some may not have practiced safer sex because of their HIV status, our focus is on the number who had their sexual practices affected by violence in the relationship.

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Accessing LGBT victims of IPV is no easy task. Mainstream DV services rarely service LGBT clients, and most LGBT agencies rarely deal with issues of violence in relationships. This research was made possible only because the agency has earned a reputable reputation of servicing LGBT individuals with issues relating to violence. The agency itself operates with few resources; and, thus, although the sample size was small, it is also unique and the largest and most diverse possible given the social and economic context of both the population and the research.

Clinical Implications

These data lead to a number of recommendations that can be enacted by service agencies assisting victims of IPV or doing work in the field of HIV/AIDS. This study was unique because it examined the HIV/STD risks of LGBT people seeking assistance for dealing with IPV. These data provide evidence that screening for safer sex and safer sex negotiation is crucial for the health and safety of those experiencing IPV.

Many DV service providers deal with issues of safety with their clients. Often counselors will develop safety plans to assist their client to leave a relationship or to help a client find a way to minimize (wherever possible) the violence he or she experiences. Yet most DV agencies rarely discuss safer sex. Given that 21% of participants experienced physical abuse and 19% experienced sexual violence as a direct consequence of asking their partner to use safer sex protection, how can DV service providers explicitly address the risks that many victims are experiencing related to HIV/STDs?

First, screening needs to be more comprehensive. Counselors dealing with IPV (among all populations) need to inquire about safer sex within the relationship. Many of the counselors from the agency were initially hesitant to discuss sexual matters with their clients. However, after training they became more comfortable asking about sexual matters with their clients and were surprised to discover that many clients had not been disclosing some severe experiences of abuse. This survey served as an opportunity for counselors and for the organization to discover a gap in their assistance to their clients. The survey also contributed to a context in which clients were able to discuss sexual violence and receive adequate counseling and advocacy related to it. By asking clients if they engage in safer sex with their partners and if they are forced to engage in sex with their partners or with others, service providers will, at last, address the crucial and common nexus between IPV and STD risk in a way that gives voice to the victims. This will allow a

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more accurate, effective and safe plan for reducing the risk of violence and STD transmission that is shaped by the clients.

Second, DV service organizations, and other organizations that deal with victims of IPV, need to develop safer sex safety plans with their clients. While the primary focus of counseling must remain on keeping victims safe from physical harm, counselors should also state that the risk for HIV/STD is a real concern and that steps should be taken to reduce this risk. Counselors need to discuss with their clients the importance of safer sex and to discuss the possible risks that come from requesting safer sex. Victims of DV should learn techniques for for staying physically safe and sexually safe. They should be given concrete guidelines for having a safer sex discussion with their partner including deciding beforehand where and when to request safer sex (making sure it happens before engaging in foreplay). Such negotiation will necessarily differ from individual to individual, much as general DV safety plans do. Such tailoring is an appropriate way to give a victim voice and agency and to utilize his or her own assessment of what is safe to talk about. Domestic violence services are perhaps best suited to administer safety planning for safer sex negotiation to their clients who are in abusive relationships. However, HIV/STD service providers should also find ways to address issues of DV and safety for those clients they serve who are involved in abusive relationships. Otherwise they face the danger of encouraging clients to have "safer sex" with tactics that may, in fact, lead to those clients being further battered by their partners.

Conclusions

The current study makes clear that individuals who have experienced IPV are at increased risk for HIV/STD infection. It is essential, therefore, that all DV service providers screen and provide assistance for issues relating to safer sex. Similarly, all HIV/STD service providers should screen for DV and discuss safety within the context of abusive relationships when making safer sex plans with their clients. Research is clear that violence within same-sex relationships is prevalent. As demonstrated in this article, it is likewise clear that the effects of IPV can lead to an increased risk for HIV/STDs.

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