EXPERIENCES OF SCOTTISH MEN WHO HAVE BEEN SUBJECT TO INTIMATE PARTNER VIOLENCE IN SAME-SEX RELATIONSHIPS

RESEARCH REPORT SUMMARY 2022

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1. INTRODUCTION AND METHODS

1.1 INTRODUCTION

The World Health Organisation (WHO) (2021) defines intimate partner violence (IPV) as behaviour by an intimate partner or ex-partner that causes physical, sexual, social, and mental health harm, including violence, sexual coercion, psychological abuse and controlling behaviours. IPV may be more prevalent in male same-sex relationships than in heterosexual relationships (Rollè et al, 2018), with prevalence studies estimating that 34-45% of men in same-sex relationships ever experience IPV (Bacchus et al, 2017; Duncan et al, 2018; Miltz et al, 2019; Stults et al, 2015). Men who experience IPV from same-sex partners have increased risks of mental ill health, substance misuse and transmission of sexually transmitted infections (Bacchus et al, 2017; Miltz et al, 2019; Stults et al, 2015; Duncan et al, 2018; Stults et al, 2019). Identifying and providing accessible support to men who experience abuse from same intimate partners is therefore important in minimising biopsychosocial harm. Some evidence indicates social discourses of masculinity and gay stereotypes prevents men from acknowledging the abuse they experience from partners, or from accessing services (Ristock and Timbang, 2005; Baker et al, 2013). Where men access services, their experience are often not recognised as IPV (Rohrbaugh, 2006) and some experience discrimination (Rollè et al, 2018). There is some evidence that examines IPV among gay and bisexual men (GBM), but these studies are predominantly undertaken from a heteronormative perspective. Such positionality limits the possibility of the evidence base understanding same-sex IPV from the perspective of the person's lived experiences, silencing these voices within the policy and practice context. This limits the effectiveness of policy and practice to provide fully adapted, effective and inclusive support for this high-risk population. This study will address this substantive evidence gap through providing a socio-culturally situated exploration of the lived experiences of men who are subject to same-sex IPV within Scotland. The aim was to understand how men who self-identify as having been subject to IPV within a same-sex relationship dynamic conceptualise and understand their experiences. The objectives were:

1. To identify the relationship factors that influences men's experiences of being subject to IPV within a same-sex dynamic.
2. To identify and describe the types and forms of IPV that men have been subject to within consensually influenced same-sex relationships.
3. To identify and describe the biopsychosocial impact of IPV on men who have been subject to within a same-sex relationship.
4. To identify the perceptions and experiences that influenced men's disclosure and engagement with health, social care and law enforcement services following their same-sex IPV subjection.

1.2 METHODS

Study design

A qualitative narrative approach enabled us to explore participants' experiences through the stories they told in loosely structured interviews. Narrative is the most common way in which people represent their experiences to themselves and to others (Reissman 1993; Gee 1985). Eliciting narratives is supported using loosely structured interviews where the participant is invited to tell their story in relation to the phenomenon being investigated and the interview uses probing questions to invite deeper exploration of the participant's story (Greenhalgh, Russell and Swingelhurst 2005). In this way, the stories that are told are led by the participant rather than the interviewer. Enabling the participant to take the lead in this form of interview supports ethical engagement as the they can manage the topics covered. Where a follow up question asks them to go deeper into something that they would prefer not to, they are more able to say no than in more structured interviews. This study was on a sensitive topic and the design is underpinned by relational ethics and need to ensure ethical engagement through the whole processes.

Participants

10 GBM were recruited via a digital poster on multiple Scottish based GBM charities social media and three advert on a GBM geo-social networking website/apps (Recon, Scruff and Grindr). Men contacted the research team via an email address on the digital poster. Participants were eligible if: 1. Were 18 years old and over, 2. Residing in the Scotland, 3. Self-identified as previously having experienced abuse from an intimate male partner, 4. Believed they would not be at any risk of harm from the perpetrator by taking part in the study, and 5. Felt safe and secure in their wellbeing to discuss their IPV experiences.

Data collection

Between June-July 2022 we conducted single virtual in-depth narrative interviews with 10 GBM. Loosely structured narrative interviews were used to elicit stories from participants who perceived they have been subject to same-sex IPV. Narrative interviews enabled participants to tell their story in their own language, starting where they wanted, and structuring it in a way that made sense to them (Stenhouse, 2013). The interviews began with a broad statement inviting the participant to tell their story in a way that felt comfortable for them. This meant that participants had control of the agenda and presented issues that were relevant to them. As the participants had control of the agenda, the loosely structured interviews enabled them to maintain boundaries around areas that they do not wish to talk about, thus safeguarding against over disclosure (Stenhouse, 2013). This approach more effectively protected participants wellbeing by enabling them to close lines of discussion that they found uncomfortable. SM conducted all the interviewed all the participants via Zoom or telephone. To promote confidentiality, participants were advised to be

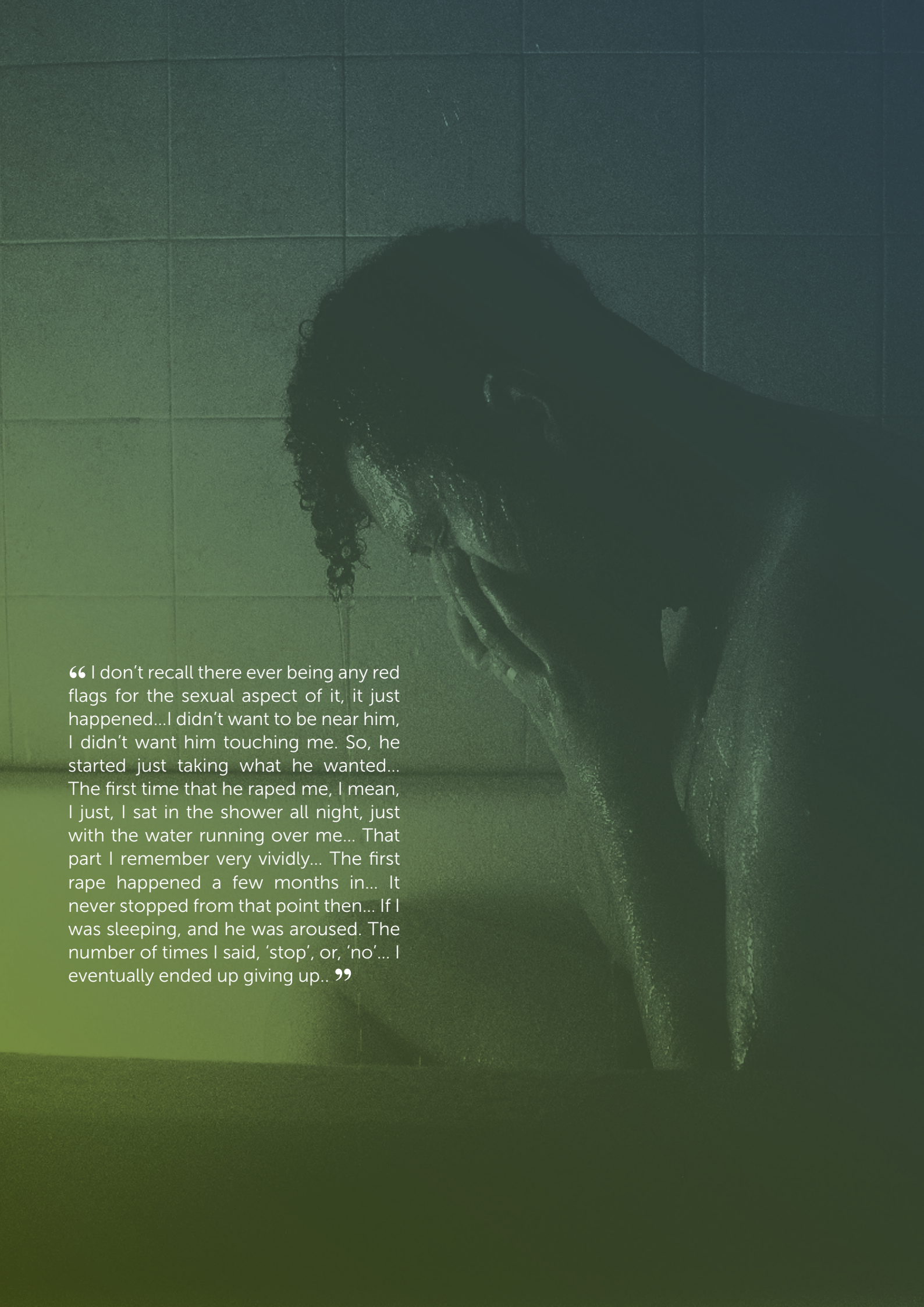
alone in a private enclosed space. Topics discussed during interview were unique relationship factors, types of abuse, impact on wellbeing and barriers/facilitators for attending services. Average interview time was 75 minutes. All interviews were audio recorded and transcribed verbatim by a professional transcription company (1st Class Secretarial).

Data analysis

RO completed all the primary data coding and developed a thematic analysis. The approach was taken to identify themes looking at the data 'vertically' (the whole of each interview) and 'horizontally' (across sub-groups of participants and the overall data). There were five stages in developing the analysis which included 1) Familiarization with data 2) Development of a coding framework based on a combination of a priori ideas and themes grounded in the data; 3) Coding of all data; 4) Thematic mapping, to identify patterns, commonalities, contradictions, and silences within the data set as a whole; and 5) Writing, development, and refinement of an interpretative narrative account. The coding framework was reviewed by all authors at the early stages of data analysis. At the final stage RS and SM independently reviewed the representation of the findings. MAXQDA 22 was used for data management.

Ethics

The study gained ethical approval from Glasgow Caledonian University. The research was designed in a way to support ethical engagement with participants at each stage through involvement of workers from S-X on the advisory committee, consultation through S-X with a person with experience of GBM IPV when considering the research design. The use of loosely structured narrative interviews was intended to level the power imbalance between researcher and participant and was an important aspect in supporting participants to maintain boundaries in the telling of their narratives. Participation was voluntary and informed consent was recorded at the beginning of each interview. Participants were able to withdraw at any time or close any line of enquiry in the interviews. To maintain the anonymity and confidentiality of participants, each has been assigned a pseudonym and features of their stories which might render them easily identifiable, including reference to places and people, have been removed.



“I don’t recall there ever being any red flags for the sexual aspect of it, it just happened…I didn’t want to be near him, I didn’t want him touching me. So, he started just taking what he wanted… The first time that he raped me, I mean, I just, I sat in the shower all night, just with the water running over me… That part I remember very vividly… The first rape happened a few months in… It never stopped from that point then… If I was sleeping, and he was aroused. The number of times I said, ‘stop’, or, ‘no’… I eventually ended up giving up.. ”

2. SUMMARY OF MAIN FINDINGS

The 10 participants were GBM aged over 18 living in Scotland who had previously experienced IPV from an intimate male partner and felt safe to discuss their experiences. Participants had a median age of 32 ranging from 26-47 years (IQR 27-42).

Forms of male same-sex intimate partner violence

1. Most participants described being subjected to multiple forms of IPV, including coercive control and verbal, physical, sexual, and financial abuse. 'Gaslighting' was a very commonly used term in the type of abuse all the men had experienced.
2. Some forms of IPV were perceived to be easier to identify than others. However, early warning signs ("red flags"), patterns of behaviour, and escalation, only appeared obvious to most men in hindsight.
3. Much of what many participants described appears consistent with people's experiences of IPV in heterosexual relationships. However, some experiences relayed unique relationship factors for male victims of IPV in same-sex relationships.
4. Male-on-male IPV assault was perceived societally to be a 'normal' way for men to enact masculinity. Meaning that physical abuse that occurred in public was sometimes ignored and some reports to the police were trivialized.
5. Some participants with big muscular bodies worried that appearing 'acceptably' masculine might make others doubt that they were victims of IPV. Several minimized the seriousness of physical assaults to perform the key practice of 'masculinity'; that of appearing strong and avoiding outward signs of physical weakness.
6. The absence of a rape narrative for men in same-sex relationships made it difficult for some participants to recognise when they had been sexually assaulted. The identified need for awareness raising about what rape looks like when meeting other men, in both causal/longer-term relationships, including same-sex marriage.

> "There is a similar common theme through all types of IPV. It's the possession, the controlling, the feeling of being a dominant person, the feeling of being able to control somebody - is what was present throughout. When your partner becomes controlling, possessive and at times physical, whether that was through just intentional physical harm, but also violence through the relationship, through sex, through intimacy, and just through everyday communications."

7. Those men who recognised they had been raped had been helped by agencies, such as Police Scotland and Rape Crisis, which was to process and define precisely what had happened to them.
8. All participants who experienced financial abuse were the main providers in their relationships. Some worried that it might be assumed, that this meant they had greater power in their relationships. These concerns were linked to a heteronormative construction of the male breadwinner/stay-at-home female partner dynamic.

The impact of IPV on wellbeing

1. IPV impacted the mental health of most participants both during, and after the relationships had ended. During relationships, anxiety/panic disorders, eating disorders, self-harm, and a worsening of pre-existing conditions such as obsessive-compulsive disorder were experienced.
2. After relationships ended many participants reported experiencing short-term impacts on mental health, including constant thought rumination and sleep disturbances. Some men out of the relationships for a few years reported longer-term impacts such as PTSD, depression, and suicidal thinking.

> “One-minute things were nice and then horrible, then nice, then it was horrible. It really wore me down physically. It wore me down mentally. I was seeing the doctor a lot more and more. I was gaining weight, comfort eating, and self-harming.”

3. Police involvement which required them to recount what had happened and having court cases ‘hanging over them’ appeared to exacerbate stress, which had both mental and physical health impacts.
4. Participants who had been physically injured by their partners had to engage in a lot of recovery work, which continued to impact their lives long after relationships ended. Some men’s masculine identity was negatively impacted due to scarring and other bodily changes. These were triggering emotionally and transported them back to the traumatic incident.
5. Men who had previously perceived themselves ‘careful’ with their sexual health reported that they began to engage in sexual risk-taking after the relationships ended. Some participants explained these behaviours were possible acts of self-harm, which reproduced the lack of regard partners showed for their health.
6. Several participants said that experiencing IPV had an impact on them forming other intimate same-sex relationships. Some men coped by entirely avoiding intimacy, whilst others only formed relationships with clear boundaries.

> “I didn’t want to have sex. I didn’t want to be touched. I didn’t want anybody near me. But at the same time, I wanted to be normal, I wanted all of that. So, it was a very confusing time. Only through doing work with my therapist have I been able to get to a point where I can have a normal relationship, but it’s taken years.”

7. Most participants had to wait a long time for NHS mental health support and were offered little emotional support by the police or agencies they were referred to. A few participants had been offered or sought out support to help come to terms with rape and sexual trauma.

Relationship factors within IPV experiences

1. Most participants said they found it difficult to identify what was and was not 'normal' behaviour in a same-sex relationship.
2. Several participants said they lacked friendships with other gay men and LGBTQ role models to guide them on what healthy same-sex relationships looked like. This meant they lacked opportunities to compare notes with peers about how to successfully navigate their first and subsequent relationships.
3. Loneliness appeared to be a common experience for most participants who described difficulties negotiating life as gay or bisexual man in a heteronormative and often homophobic societal context.

> "Like you'll put up with a lot more for a lot less in return. I don't know whether that's to do with you worth. The threshold for straight people that they'll put up with is a lot higher than what you'll put up with in the homosexual. Like if a guy doesn't text a girl back my friends will just block the number whereas because it's so difficult to find someone as a homosexual. I was just grateful that I had someone. I didn't really care how they treated me...I'm going to put up with this until it no longer becomes palatable."

4. In the context of participants partnership development their experience of loneliness appeared to intensify new intimate relationship. "Red flags" or warning signs were sometimes ignored early in the relationship to preserve sought-after intimacy.
5. Some participants thought that early warning signs of IPV abuse and how it may manifest in LGBTQ relationships needed to be taught to the wider community and services.

> "I'd spotted a red flag. I think I spotted it quickly, but I didn't want to listen to it, because I just wanted to be loved, I just wanted to be wanted. I just wanted to be normal. And so, I didn't listen to the red flag. And so, I just let it go on and on."

6. Objectification, dehumanization, and rough treatment of male bodies during sex was viewed by some participants as a common dynamic between men in intimate same-sex relationships. These roles sometimes 'split over' into everyday interactions between partners who performed 'submissive' and 'dominant' roles.
7. Some participants thought that their own vulnerabilities including pre-existing physical, mental and health problems may have made them more susceptible to abuse.
8. Some perceived abusive partners as being vulnerable which led to them to conclude that they might be more worthy of victim status than them. The latter led to some participants tolerating or excusing IPV.
9. Some participants described that their partner's heavy drinking and/or drug-taking was a "red flag" or a possible risk factor for IPV. Substance use was presented as having a role in either fuelling or damping down IPV.

Barriers/facilitators for IPV disclosure about implications for services

1. Most participants spoke about a general lack of socio-cultural recognition that 'men' could be victims of IPV which made it difficult for them to recognize and disclose to services what was happening to them.
2. Some participants described that documented and shared 'stories' about same-sex IPV experiences was an important step towards improving recognition and helping more male victims to disclose.
3. Most participants described that the public narratives of IPV was perceived to be only a heteronormative dynamic which rendered the IPV experiences of men in same-sex relationships invisible.
4. For some participants LGBTQ experiences of IPV were felt to be entirely absent from the standard 'script' used and services, making it difficult for them to disclose what was happening.

> "The police did not treat or regard it as serious. I think it was a complete lack of training. They didn't know how to treat it because it was man-on-man. The police just do not take it seriously...There's just a complete lack of empathy or understanding from the police about same-sex relationships."

5. Many participants believed that developing training which improves staff awareness of same-sex IPV in services that GBM were most likely to have contact with would be beneficial.
6. Some participants perceived that sexual health services were more LGBTQ friendly and accepting which made them a perfect environment to attach specialised IPV support hubs.

> "It's on and off, on and off, it's nice to know that they (sexual health services) do ask and it's nice to see that obviously they do ask about it and see whether if you are okay. Are you in danger? Do you need help or support? But it's so irregular. It's not part of the process."

7. Some participants believed that psychotherapy was an important recovery step. They described that IPV had resulted in them becoming disconnected from their feelings as they focused solely on their partner's needs. Unravelling the full extent of IPV took months and in some cases years with a skilled therapist.
8. Most participants who received psychological therapy paid privately which was related to gaining quicker access and/or exercising choice over the therapist. They were more comfortable with an LGBTQ therapist who had better insight into same-sex lived experiences and provided role modelling for healthy relationships.

3. DISCUSSION

3.1 KEY DISCUSSION POINTS

There were multiple findings of interest, but key discussion areas were:

Identifying IPV

The forms of abuse participants experienced were similar to that in heterosexual based IPV evidence. However, this study was partially informed by an understanding that there are low numbers of GBM reporting or seeking help following IPV. Whilst there might be a range of barriers 'downstream' it might also be that there was an 'upstream' issue relating to how GBM interpreted what was happening in their relationships in relation to the widely available governmental definitions of IPV (Scottish Government 2018; United Kingdom (UK) Government 2018). All the participants experienced difficulties in naming behaviours that they experienced as uncomfortable, or possibly 'wrong', as IPV. Many of the participants felt unsure of what was 'normal' within a GBM relationship. This left them unsure as to whether the initial controlling or sexual behaviours that they did not feel entirely comfortable with were a normal part of GBM relationships. Messinger (2017) identifies a lack of media portrayals of GBM relationships leading to a lack of cultural understanding of what a healthy relationship looks like. In addition, participants tolerated a range of abusive behaviours which was driven by loneliness and isolation when not in a relationship. This driver may be based in minority stress (Meyer, 2003) as being part of a minority community, i.e. LGBT.

Difficulties in identifying IPV may arise from the dominant social discourses which position IPV as primarily an act of abuse perpetrated by men on women (Scottish Government 2018; NHS Health Scotland 2019; Stewart, Macmillan, and Kimber 2020; WHO 2012; Messinger 2017). The WHO identifies that IPV is primarily experienced by women (WHO 2012). Although Stewart et al (2020) highlight that most of the epidemiological data on IPV only comes from a WHO study of women's health and domestic violence, thus the data is from a perspective that has only recognised females as potential victims of IPV. A similarly very gendered perspective is found in the Scottish policies and strategies around IPV and domestic abuse (Scottish Government 2018; NHS Health Scotland 2019). There are instances of public information on IPV or domestic abuse which avoid identifying the gender of victims or perpetrators (United Nations 2020; UK Government 2018). However, these do not take the positive step of stating that men within same-sex relationships experience IPV. Messinger (2017) identifies a need to raise the profile of IPV within LGBTQ communities and start to provide narratives that will enable GBM to identify their experiences. We suggest that spaces need to be made for the voices of GBM who experience IPV which are heard by policy makers and service providers so that they start to influence the development of health policy and practice.

Accessing support

The dominant discourses around IPV also impact the knowledge and understanding of health and social care professionals who support people who experience IPV. For many participants a fear of judgement by professionals either in relation to their masculinity or their sexuality prevented them from accessing support. Such fears were often based on previous experience where their needs for support were either ignored, or actively dismissed. The interpersonal response of those professionals who made the first contact with GBM who were experiencing IPV was associated with the participant's future actions or intentions around seeking support. In some cases, it was the system, most often criminal justice system, which created the most distress.

> "I feel like they're (the police) used to speaking to women all day, all the time, that have been harmed by men. And I feel like when I've come in with my case, I feel I'm potentially this random anomaly that they'd have to deal with. I feel like I'm quite embarrassed to tell them that I was in a relationship with a man, that I was getting beaten up by him, sort of thing."

Health professionals are a key resource in identifying signs of IPV and providing opportunities for people to disclose (NHS Health Scotland 2019). For some participants, interactions with health or social care professionals provided them with a name for what was happening to them, enabling them to recognise the IPV that was occurring. However, where there are opportunities for services to initiate conversations relating to GBM's relationships during routine contact, for example in sexual health services, few participants had experienced an approach to questioning that facilitated disclosure. The importance of health and social care professionals recognising that IPV occurs within GBM relationships is therefore crucial in providing this support. Wei et al. (2020) affirmed that the foundation of support system for victims of same-sex IPV is family and friends. However, many of the study participants were socially and psychologically isolated from friends and family, limiting the support they might receive. Hence, highlighting a potential need for developing professionals understanding of same-sex IPV and enquiry process.

> "To be a man and even admit that you were in an IPV relationship, I mean, it knocks your confidence, it knocks your self-esteem, and self-worth... The hatred for yourself. The hatred for allowing it... There's a huge stigma around men coming out as domestic abuse victims, because we're men, we should be able to deal with it, we should be able to fight back."

Impact of IPV

The findings of this study clearly demonstrate the extensive psychological, physical, and relational consequences of IPV both during and after the relationship. The psychological consequences had implications for the participants' financial security through impact on employment; family relationships; and ability to form future intimate relationships. These findings are long supported by Woodyatt and Stephenson (2016) who identified

the long lasting impact of emotional abuse on a victim's identity including self-belief and efficacy. Therefore, there are considerable psychological, physical, and financial costs to the individual and their social support network on both a short- and long-term basis. Arguably this cost is increased where IPV is not identified, and support not accessed. Hence, it is imperative that further work is undertaken to develop resources (cultural, informational, practical) that enable individuals and professionals to identify IPV in GBM relationships. In tandem, there is a need for inclusively acceptable and wellbeing support for those who experience IPV within GBM relationships.

IPV in GBM relationships is not the same as gender-based violence

The heteronormative context of IPV differs from the context in GBM relationships through the impact of lack of social role differentiations. In this study there was no stereotypical gender role associated with men in same-sex intimate relationships when compared with heterosexual relationships where there are clear social roles related to power expectations. According to Goldenberg et al. (2016), the lack of clear-cut roles in same-sex male relationships creates conflict where there is no clear power hierarchy. Dominance in same-sex male relationships can be attributed to psycho-social inequalities creating a power imbalance between partners. Within the relationship, these inequalities can be leveraged as a tool to achieve hegemonic masculinity (e.g., making decisions, emotional strength) and therefore dominance in the relationship (Finneran and Stephenson, 2014).

> “When you look at domestic violence (physical) you always stereotype the victim, you don't mean to, but you do. You don't look at a big guy as a victim at all. You just…it's just the way people are. You always sort of stereotype who's going to be the victim. Yes, I didn't fit that victim profile in my mind, and I'm sure in the police's mind as well… I allowed it, I thought…He was (perpetrator) younger and a lot smaller than me. ”

Within this study there is evidence that participants held ideas of the characteristics associated with hegemonic masculinity and dominance – being older, having a muscular body – which were incongruous with being seen or seeing themselves as a 'victim'. This incongruity and linked fear of how others would judge them in relation to their masculinity, made it difficult for those who were being abused by younger and/or smaller men, to seek help.

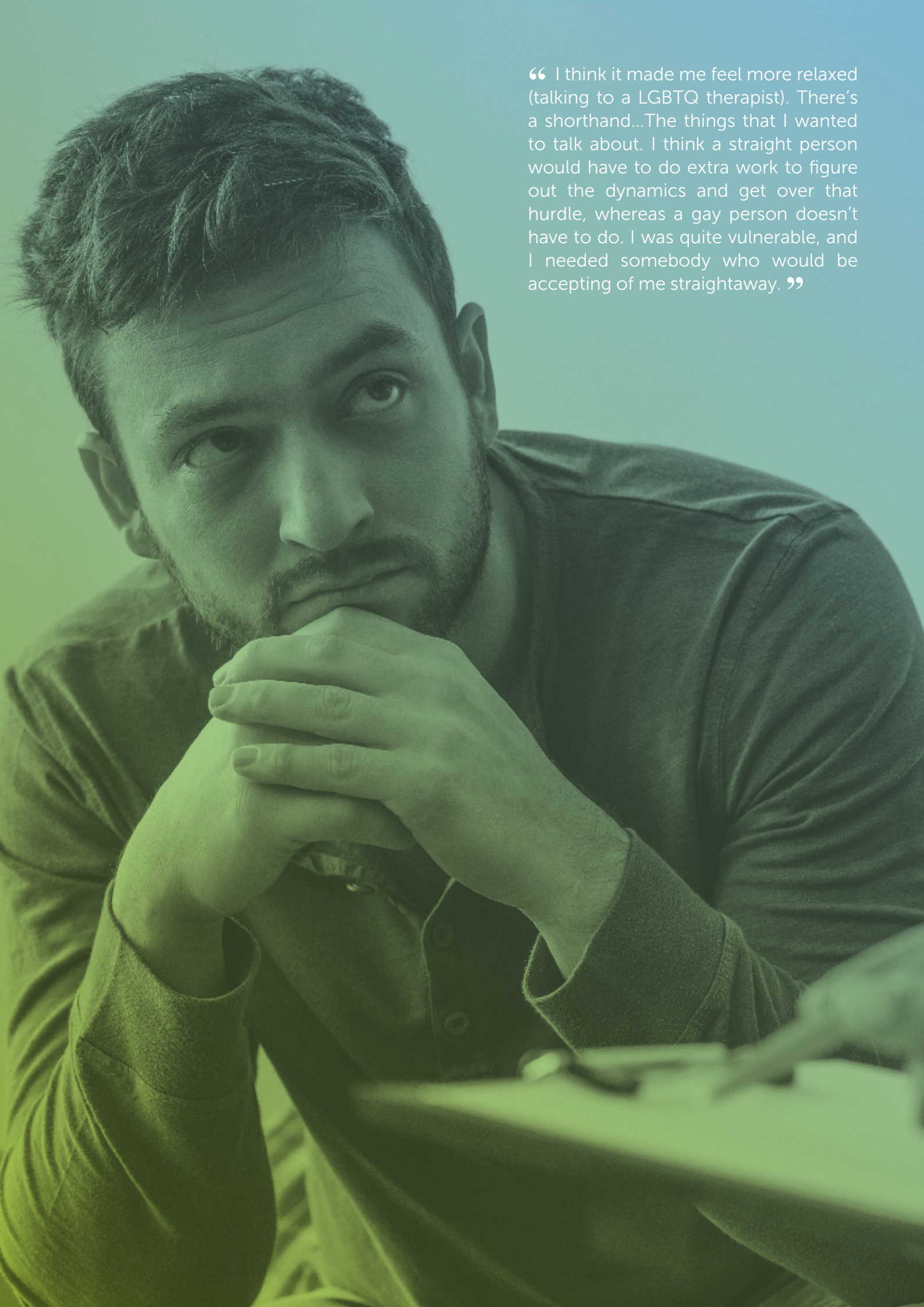
3.2 STRENGTHS AND LIMITATIONS

This is a small narrative study of the experiences within a minority group of men. The narrative approach is a study strength, enabling the gathering of rich data focused on a sensitive topic. Such data, enables a deep understanding of the complex and traumatic experiences of participants which can inform policy and practice. This study was designed in collaboration with an advisory group and service users to ensure that the design was responsive to the sensitivity of the topic. That relational ethics was a central aspect of the research.

Recruitment was undertaken using a range of GBM social media for participants from one nation within the UK. These avenues for recruitment and the limit to residence in a single nation mean that there will be groups of GBM whose voices are not represented. However, qualitative research whilst attempting to capture a range of voices does not aim for representativeness. Findings from this study provide a snapshot of the experiences of a range of men that can sensitise practitioners and policy makers to same-sex IPV experiences.

3.3 CONCLUSION

This study set out to better understand GBM's experience of IPV. Through the analysis of the narratives gathered from participants it is evident that whilst IPV might take a similar form to that identified in heterosexual relationships, the situation of GBM within a marginalised LGBTQ discourse impacts their ability to recognise and name their experiences of IPV. Thus, there is a need to consider GBM's experiences of IPV separately from those of either men or women in a heterosexual relationship. This has implications for policy makers, and for those who design and deliver evidence-based services that support GBM. In addition, there is a role for educators and those providing relationship education to young GBM which enables them to explore healthy same-sex relationships. Further research is required within Scotland and UK to better understand GBM and wider LGBTQ IPV experiences. Additionally, research that explores statutory services understanding of same-sex IPV would enable the development of more effective and inclusive person-centred interventions.



“ I think it made me feel more relaxed (talking to a LGBTQ therapist). There’s a shorthand…The things that I wanted to talk about. I think a straight person would have to do extra work to figure out the dynamics and get over that hurdle, whereas a gay person doesn’t have to do. I was quite vulnerable, and I needed somebody who would be accepting of me straightaway. ”

3.4. KEY FINDINGS AND RECOMMENDATIONS

Study knowledge exchange methodology

A core approach for the study design was using an active participatory approach with key stakeholders including GBM with lived IPV experience. To enhance any meaningful impact from the study a two-stage stakeholder knowledge exchange (KE) process was completed.

Stage 1: A half day KE event with partners from key GBM third sector providers, Scottish Government and two NHS boards (public health policy leads and sexual health clinicians). Lay members of the GBM community who were engaged with Waverley Care were invited but on the day were unable to attend. This led to the decision to undertake the stage 2 KE activity described below. The purpose of the event was to enable the stakeholders to identify key findings, prioritise action areas and inform recommendations for research, policy, and practice. The findings were presented by the study team and a short version of the report was provided. Following the presentations, facilitated round-table discussions focused on prioritising the findings and the development of recommendations. The outcome of these discussions was recorded by discussion facilitators.

Stage 2: An online consultation with GBM community members which forms part of NHS Lothian's patient and public consultation process. This involved an online qualitative feedback questionnaire administered to self-identifying GBM lay community members residing in Scotland who were provided a copy of the research report and associated summary. The purpose of this aspect of the KE was to gain an understanding of the key findings and priority areas for action that had meaning and potential impact from the perspective of those whom they are aimed to support.

Following completion of the two stages the lead researcher (SM) undertook a thematic analysis process using data from the events to form the following key findings and recommendations.

Key findings

The following findings emerged from the engagement events as key areas which enable further insights into GBM IPV lived experience and priority areas that underpin the recommendations. However, understanding the full lived IPV experience is set within the wider study findings of which these key areas form a part of the narrative journey. Whilst forms of GBM IPV abuse and its health impact bore similarities to those found in a heterosexual dynamic, there were distinct same-sex relationship influences, risk factors, wellbeing effect and disclosure/support factors which marked the IPV experience of GBM as different to that of heterosexual people.

Key male same-sex factors were:

1. The power and control function were formed within a homo-intimacy dynamic in which male sexual roles could influence wider day to day controlling and coercive abusive behaviours.
2. GBM subject to IPV may have tolerance for maintaining an abusive relationship due to a fear of being lonely which was influenced by perceiving it was more challenging to find a long-term partner than heterosexual people.
3. GBM subject to IPV had a lack of recognition of being victims as they perceived IPV through societal norms as a heterosexual phenomenon and experienced the need to maintain a strong masculine role identity which is interwoven with stigma avoidance of effeminate 'gay' masculinity.
4. Service providers either did not recognise GBM as IPV victims, or dismissed their experiences, as they perceived the phenomena through a heterosexual dynamic in which masculinity is only related with the perpetrator role
5. The lack of an available rape narrative within the LGBTQ discourse made it difficult for GBM subject to IPV to interpret the non-consensual sexual acts that were perpetrated on them as rape.
6. GBM subject to IPV experienced short and long-term effects on their mental wellbeing which manifested in varied forms including generalised anxiety disorder, depression, PTSD, and suicidality.
7. LGBTQ allied services provided a safe non-judgemental space for GBM to discuss their experiences and LGBTQ identified therapists provided a peer related person-centred insight approach to discuss the modelling of same-sex healthy relationships.

Recommendations

The following recommendations for GBM IPV are categorised into three areas: **1. Research:** where there are currently knowledge deficits and further insight is required, **2. Policy:** where there are current deficits within national/local policy and improvements for inclusion can be made and, **3. Practice:** where there is a need to enhance the provision of person-centred practice and community wellbeing. The recommendations are focused on GBM IPV experiences although it was highlighted within the knowledge exchange process that there is further work required for the wider diverse LGBTQ community of which GBM is a component.

Research

1. To conduct a mapped evidence synthesis of high-income countries LGBTQ IPV research literature that is published in peer reviewed journals.
2. Utilise current data or develop new quantitative research that examines the prevalence level of LGBTQ IPV, associated demographics, key risk behaviours and wellbeing impact.
3. Develop and implement a larger scale qualitative study that further explores the diverse LGBTQ IPV experiences including perpetrators experiences, survivor journey and service providers views.
4. Develop and implement qualitative research that explores the wellbeing impact of IPV on GBM victims and interventions that enhance person-centred disclosure and support.

Community engagement and policy

1. To commission a Scottish wide desktop and rapid level assessment of need and mapping for GBM and wider LGBTQ IPV.
2. To prioritise a level of funding that supports the implementation of policy, workforce development, services pathways that adopts GBM inclusive person-centred practice.
3. Develop safe and inclusive consultation spaces for LGBTQ IPV survivors to engage in meaningful policy and service development.
4. Expand the Scottish Equally Safe policy to be inclusive with explicit identification of GBM/wider LGBTQ IPV experiences which has appropriate targeted outcomes.
5. To implement revised national inclusive policy at a local level which stakeholders can take direct action to develop LGBTQ diversified and inclusive actions.
6. Local joint board Violence for Women and Girls networks could be expanded to include more diverse groups, or a similar robust system is required to be inclusive.
7. Local GBM stakeholders to implement local level policy which identifies them as a high-risk group, increases community awareness, and promotes person-centred services.

Practice

1. Increase community awareness on the issue of diverse range of LGBTQ IPV, and promotion of role modelling for diverse healthier relationships.
2. Ensure sexual and gender cultural diversification is represented in all generic awareness campaigns about IPV and domestic violence.
3. Inclusion of LGBTQ IPV content that supports disclosure within adult safeguarding LGBTQ education that is mandatory for health practitioners and law enforcement.
4. Development of specialist same-sex IPV education that supports disclosure and person-centred pathways for practitioners that provide LGBTQ services.

5. Provision of peer centred lead services which provide disclosure and therapeutic support to LGBTQ who are and who were subject to IPV.
6. Development of tailored LGBTQ IPV resources which provides accessible digital and non-digital safe spaces to access help and person-centred information.
7. Continue to ensure RSHP materials are inclusive by including sexual and gender culturally diverse IPV relationship content.
8. To increase the impact from awareness/educational interventions it is beneficial to use creative mechanisms that tell the narrative stories of LGBTQ IPV experiences.

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