

Intimate Partner Violence in the LGBTQ + Community

Experiences, Outcomes, and Implications for Primary Care

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KEYWORDS

- Abuse • Domestic violence • Gender minority • LGBT • Sexual minority • Transgender

KEY POINTS

- Lesbian, gay, bisexual, transgender, queer, and other sexual and gender (LGBTQ+) minorities are vulnerable to intimate partner violence (IPV) in their relationships.
- IPV in LGBTQ+ individuals' relationships can result in detrimental physical and mental health outcomes.
- Providers are in a unique position to detect IPV and provide resources for LGBTQ+ survivors, but efforts might be hindered by inaccurate stereotypes and assumptions about LGBTQ+ relationships and IPV.
- Providers should screen for IPV, regardless of a patient's sexual orientation and gender identity.
- Providers should be aware of the diversity within the LGBTQ+ population and the impact of discrimination on LGBTQ+ people's experiences.

BACKGROUND

Prevalence

Lesbian, gay, bisexual, transgender, queer, and other sexual and gender (LGBTQ+) minorities appear to experience heightened rates of intimate partner violence (IPV) compared with heterosexual^{1,2} and cisgender³ individuals. IPV is at least as common in same-gender as different-gender relationships, with bisexual individuals at

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particular risk.^{4–6} Lesbian and bisexual women are more likely than heterosexual women to experience rape, violence, stalking, and psychological and controlling abuse by a partner.¹ Gay men and bisexual men also are more likely to experience IPV than men exclusively partnered with women.⁷ Likewise, trans and nonbinary individuals appear to be at elevated risk for IPV, even compared with cisgender LGBTQ+ people.^{3,8,9} Although there are some cases where a trans person is an abuser, research consistently recognizes the epidemic of cisgender perpetrators abusing trans and nonbinary people.^{10,11} LGBTQ+ people of color also appear to experience heightened rates of IPV victimization compared with their white counterparts.^{9,12}

Considerations

Minority stress often plays a role in understanding IPV in LGBTQ+ relationships.¹³ Minority stress theorists argue that LGBTQ+ people face unique stressors related to their identity, such as discrimination, violence, and/or a dislike of one's sexual orientation or gender identity (ie, internalized homophobia, biphobia, and/or transphobia).¹⁴ Although the presence of minority stressors might be related to IPV itself,¹³ providers also should be aware of how histories of minority stress can prevent survivors from reporting IPV. In some cases, survivors may encounter (and internalize) various harmful notions, including that IPV cannot exist between same-gender partners (eg, "lesbian utopia"),¹⁵ the need to protect a stigmatized community from being pathologized,^{15,16} a lack of recognition of IPV in LGBTQ+ relationships,^{16,17} and/or a fear of interacting with potentially hostile law enforcement^{16,18,19}—the last might be especially relevant to trans survivors,^{20,21} who experience heightened rates of police mistreatment and assault.²² Knowledge about the contexts in which IPV occurs is critical for providers to understand why patients might be hesitant to disclose abuse. To identify IPV properly, providers must be aware of the unique ways that LGBTQ+ survivors experience IPV.

Those who work in clinical settings should be advised that, in addition to what IPV survivors experience generally,¹ LGBTQ+ survivors also may experience controlling behaviors related to their sexual orientation²³ and gender identity.¹⁰ One LGBTQ+ form of abuse is threatening to "out" a partner's sexual orientation or gender identity to friends, family, coworkers, or community.^{10,23,24} Another tactic is forcing a partner to hide their sexual identity or gender expression.²⁵ Abusers may use derogatory slurs toward the survivor or question their LGBTQ+ identity.²³

Bisexual individuals are especially vulnerable to IPV^{1,2} yet often are overlooked when considering IPV survivors.²⁶ Bisexual survivors may experience unique forms of abuse. For example, they may be sexually coerced because an abuser argues they have few to no sexual boundaries or an abuser may objectify the survivor's same-gender attraction. If a survivor is a parent in a different-gender relationship, their abuser might threaten to sue for custody, arguing that the survivor is not as good of a parent based on their sexual orientation.²⁷

Trans survivors also experience trans-specific tactics, such as being purposely misgendered, being denied access to gender-affirming resources (eg, clothes and hormones), being touched in areas that cause feelings of dysphoria (eg, breasts and genitals), or having those areas sexually fetishized by a cisgender partner.^{10,28} A trans survivor also might have a partner who questions their gender identity, says no one will love them, or calls them "it."^{10,28,29} Trans individuals with cisgender partners appear to be the most vulnerable to IPV during social and physical transitions.³⁰ It is critical for providers to understand that, just as general power and control tactics have negative health outcomes, so too do LGBTQ+ -specific controlling behaviors.^{28,31}

CLINICAL RELEVANCE

Survivors of IPV have reported significant short-term and long-term physical and mental health concerns.³² To date, most research on the mental and physical health effects of IPV are focused on (assumed) heterosexual and cisgender survivors.³³ This discrepancy perhaps is due to the false belief that IPV in same-gender relationships is less severe than cisgender male-to-female perpetrated violence¹¹ or by categorizing bisexual individuals in different-gender relationships as being heterosexual.²⁶ LGBTQ+ survivors in both same-gender and different-gender partnerships, however, experience negative physical (eg, injury) and mental (eg, posttraumatic stress disorder [PTSD] and continued fearfulness) health outcomes that can result in needing health care.¹

Physical violence may result in injuries, such as bruises, cuts, scrapes, swelling, and burns,³⁴ and survivors may suffer from chronic pain.^{35,36} Strangulation, a common precursor to intimate partner homicide in (assumed) heterosexual individuals' relationships, does not always leave visible bruising.³⁷ Instead, strangulation victims may exhibit signs of subconjunctival hemorrhages (ie, broken blood vessels) in the eyes or have a hoarse voice.³⁸ Compared with heterosexual women, bisexual women, who often are partnered with a male abuser,¹ are more likely to experience IPV that causes injury and requires medical attention.¹¹ Somen partnered with women, however, also are vulnerable to fatal or life-threatening injury.³⁹ Importantly, between 16% and 42% of trans victims of IPV experience physical injuries.¹¹ Sexual IPV also can lead to physical injuries in and around survivors' genital areas, and they may be at increased risk of sexually transmitted infections and painful intercourse.³⁵ Moreover, LGBTQ+ IPV victims are at significant risk of human immunodeficiency virus/sexually transmitted infections transmission within abusive relationships.^{1,40} Due to abuse and fear, LGBTQ+ survivors may be less able to negotiate condom use and other safe-sex practices than those in equitable relationships.⁹

Beyond physical symptoms, IPV victimization is associated with severe mental health effects, such as depression, anxiety, and PTSD.⁹ Sexual minorities who have experienced IPV are more likely to be diagnosed with depression and anxiety than their heterosexual counterparts.^{6,41} These links also are amplified within certain groups. Compared with heterosexual and gay men, bisexual men who have experienced IPV are significantly more likely to report their overall mental health as fair or poor.⁴² Psychological outcomes also can manifest through substance misuse among sexual minority men⁴³ and women.⁶ For black men who have sex with men and trans women, a history of IPV victimization also has been linked to lifetime suicidal thoughts.⁴⁴ More research is needed, however, to understand the IPV experiences of racially minoritized LGBTQ+ survivors' health outcomes, particularly because these individuals experience multiple intersecting forms of minority stress (eg, racism and homophobia) that may result in amplified health concerns.

Harrowingly, 1 survey found that 76% of trans IPV victims experience mental health consequences following victimization.¹¹ Trans individuals are vulnerable to anxiety when they have experienced IPV,³³ and black trans women survivors, specifically, report high rates of depression.⁴⁵ The poor mental health outcomes that black trans women experience appear to be related to living in a culture of white supremacy, cis-heteropatriarchy, and trans misogyny.⁴⁶ Put simply, IPV survivors' negative health outcomes should be considered within their broader social contexts.

LGBTQ+ IPV victims may feel unable to disclose victimization experiences for fear of rejection from the LGBTQ+ community,⁴⁷ causing further depression and anxiety. These fears might be amplified for racially minoritized LGBTQ+ individuals, who sometimes experience racism within LGBTQ+ communities⁴⁸ and, therefore, may lack sources of

social support and community belonging. Survivors who experience control related to their sexual orientation or gender identity are vulnerable to depression and PTSD.³¹ These health-related IPV impacts might be the presenting concern for which LGBTQ+ survivors seek care.

CLINICAL EXPERIENCES

Primary care providers are positioned to screen for, detect signs of, and respond to disclosures regarding IPV and provide resources aimed at reducing the harm IPV causes.⁴⁹ Although limited, there are some measures that have been validated for different LGBTQ+ populations, including the Identity Abuse Measure,²³ the sexual and gender minorities-specific IPV Conflicts Tactics Scale,⁵⁰ the IPV-Gay and Bisexual Men (GBM) scale,²⁴ and the transgender-related IPV Tool.²⁸ Successful screening can lead to interventions, including home visits, access to a case manager, and a patient-centered care plan.⁵¹ Such interventions, in particular, those focused on increasing self-efficacy, empowerment, and enhancing access to IPV-related resources, may lead to increased use of community-based resources/referrals, enhanced safety-promoting behaviors, improvement in physical and emotional well-being, and other positive outcomes.⁴⁹ Providers should be aware, however, that many LGBTQ+ survivors have reported unhelpful or negative experiences within health care systems and should take steps to increase their clinic's responsiveness and inclusivity.^{11,52}

Primary care providers must recognize how IPV may manifest or present differently for women in same-gender relationships, men in same-gender relationships, and trans people in relationships. Providers may not be informed about their patients' sexual history, sexual and gender identity, and current relationship context, and providers should not assume patients' sexual orientation.⁵³ Concerns about homophobia, biphobia, and transphobia may lead patients to conceal details of their identity, relationships, or history. LGBTQ+ IPV survivors may hide their sexual orientation or gender identity or feel shame related to IPV, further impeding an open, transparent provider-patient relationship. Therefore, it is important for providers to establish an affirming stance, regardless of a patient's orientation or identity.⁵³

Providers can communicate acceptance and inclusion of LGBTQ+ people through the visuals and images on a Web site and in the physical environment (eg, waiting room) as well as on office forms and paperwork.^{52,54} Single-stall or gender-inclusive restrooms, name badges with pronouns, paperwork with inclusive gender and sexuality options, and artwork featuring diverse relationship and family configurations can help patients feel comfortable sharing basic details about their sexual and gender identity, relationship contexts, and IPV information. Providers should be educated about and screen for IPV regardless of the patient's sexuality or gender⁵³ and should not make heteronormative assumptions about a patient's partner. In creating an inclusive, welcoming, and nonjudgmental environment, providers can be more confident about their ability to engender trust and honest reporting among LGBTQ+ patients.⁵²

Providers should also be aware that certain segments of the LGBTQ+ population (eg, transgender; immigrant) are disproportionately likely to be victims of, as well as underreport, IPV, often due to power imbalances and heightened fears.⁵⁵ For example, immigrant LGBTQ+ individuals may have fewer safety nets and less family support nearby,⁵⁶ making it difficult to leave relationships. Trans individuals who are nonwhite, are non-US citizens, and/or have disabilities are more likely to be denied quality care or entry to domestic violence shelters than those who are white, are citizens, and/or do not have a disability.⁵⁷ Therefore, it is critical for providers to have an intersectional understanding of barriers their LGBTQ+ patients face and provide care accordingly.⁵⁸

Providers should be aware of how stereotypes and assumptions might make them less attuned to IPV among LGBTQ people.^{58,59} They may be less likely to recognize or ask about IPV in male same-gender couples due to dominant masculinity norms (eg, men are able to defend themselves). These men, however, also may be likely to hide IPV due to shame related to violation of masculine norms. Sexual minority men also may be less likely identify as abuse victims if they do not relate to the idea of domestic violence.⁶⁰ Likewise, providers may fail to detect IPV in female same-gender relationships, either because they hold stereotypes of women as unlikely to physically assault others and/or because they fail to screen for IPV once they determine that she is not in a relationship with a man.⁵⁹ Additionally, if a provider assumes that a bisexual client is heterosexual because they have a different-gender partner, they can overlook bisexual-specific forms of IPV.²⁷

Experts often recommend routine screening for IPV among women by primary care providers, but a screening may not occur if providers deem it unnecessary in the absence of a male partner. Furthermore, the higher rates of IPV among men in same-gender relationships compared with men in different-gender relationships highlight how this recommendation is heteronormative (ie, assumes heterosexuality) and cisnormative (ie, assumes a cisgender identity). A more appropriate recommendation would be universal screening of all patients. Screenings should include items specifically pertaining to those in LGBTQ+ relationships.^{53,61} In addition to asking about physical IPV, providers should inquire about physical intimidation and expand questioning about controlling behaviors to include financial control and workplace monitoring as well as ask about whether patients feel threatened and/or whether others have raised questions about the patient's safety in the relationship.²⁴ Providers screening for IPV in female relationships should be attentive to different dimensions of psychological abuse in particular, because this form of abuse is more common than physical abuse in female same-gender relationships.⁶² Providers also should screen for forms of control related to patients' sexual orientation or gender identity.^{23,50}

Providers should ensure the resources they provide to patients related to safety planning are LGBTQ+ inclusive. For example, they should specify which shelters are LGBTQ+ affirming and provide LGBTQ+-focused resources when possible.⁵³ Men may face challenges gaining entry to shelters because they often are not perceived as IPV survivors.⁴ Despite federal protections, trans women frequently are barred from women's shelters when staff falsely view them as men, and trans men often lack services entirely.²¹ There are LGBTQ+-affirming resources,⁵⁸ however, and providers should be aware of them to refer all patients to inclusive spaces for care.

As discussed previously, LGBTQ+ individuals are vulnerable to IPV, including heightened rates of victimization as well as unique tactics, which are associated with detrimental health outcomes. Clinical providers are uniquely positioned to identify and provide care to these survivors. To do so, they should follow the guidelines for inclusive care outlined in this article. Early detection combined with resources to aid in leaving violent relationships can help reduce this epidemic and improve the safety and well-being of the LGBTQ+ population.

CLINICS CARE POINTS

- Clinics should have physical markers that represent an LGBTQ+-affirming stance, such as rainbow flags and images of diverse couples and families. Paperwork also should be reflective of diverse sexual orientations and genders.⁶³

- Providers should participate regularly in professional development and training with topics pertaining to antidiscrimination, LGBTQ+ experiences that have been linked to IPV, and correcting myths about IPV in LGBTQ+ relationships.^{11,58}
- Providers should avoid assuming patients' sexual orientation and gender identity and, instead, screen for sexual and relationship attractions and behaviors as well as gender identity.⁵³
- Providers should be able to recognize the unique IPV tactics that LGBTQ+ survivors experience, such as outing, controlling gender expression, or slurs.¹¹ One useful tool is the Power and Control Wheel for Lesbian, Gay, Bisexual and Trans Relationships from the Domestic Abuse Intervention Project.⁶⁴
- Providers should be trained on how to successfully conduct screenings for IPV⁶⁵ in all patients using LGBTQ+-inclusive measures,^{23,24,28,50} regardless of whether violence is reported.

DISCLOSURE

The authors have nothing to disclose.

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