

Intimate Partner Violence in LGBTQ Communities

Intimate partner violence (IPV) is common in LGBTQ communities, although it is often overlooked or misunderstood. Research shows that IPV may take on forms that draw on the experiences of LGBTQ individuals, such as ‘outing’¹ or restricting a person’s access to items that are central to their gender or sexual identity. Furthermore, existing strategies to address IPV and the supports available to survivors often focus on the experiences and needs of cisgender heterosexual women in relationships with men. This factsheet aims to provide an overview of the existing research on IPV in LGBTQ communities, as well as steps that service providers can take to address the needs of LGBTQ survivors of IPV.

IPV in LGBTQ communities: What is it? How common is it?

- Intimate partner violence (IPV) encompasses all forms of violence between individuals in a romantic or sexual relationship, including physical, psychological/emotional, and sexual violence. While IPV is often considered in the context of monogamous, heterosexual relationships, it also occurs in relationships involving sexual and gender minority individuals. In such cases, IPV may take on specific forms that reflect particularities of LGBTQ identities. The estimated prevalence of IPV in LGBTQ communities varies widely. Research generally shows that physical violence is less prevalent in LGBTQ relationships than psychological or emotional violence (Bartholomew & Regan, 2008; Bimbi, Palmadessa, & Parsons, 2008; Kelly et al., 2011; Matte & Lafontaine, 2011; Messinger, 2011; Porter & Williams, 2011; Barrett & St-Pierre, 2013; Badenas-Ribera et al., 2015).

IPV among lesbian and bisexual women

- A meta analysis of studies assessing IPV prevalence among lesbians found the mean prevalence for physical violence to be 18 percent and the mean prevalence for psychological or emotional violence to be 43 percent (Badenas-Ribera et al., 2015). Experiences of physical IPV are particularly common among bisexual women: 38.9 percent of bisexual women in a recent Canadian study reported at least one episode of IPV over the five previous years (Barrett & St-Pierre, 2013).

IPV among gay, bisexual, and men who have sex with men

- A systematic review of studies addressing IPV among men who have sex with men, including men who identify as gay or bisexual, found the prevalence of physical violence reported by studies ranged from 11.8 percent and 45.1 percent; the prevalence of psychological violence reported by these same studies ranged from 5.4 percent to 73.2 percent (Finneran & Stephenson, 2013).

¹ In this context, outing involves the disclosure of a person’s sexual or gender identity in a context where this could cause harm to their partner.

IPV among trans individuals

- There is very little information about the prevalence of IPV among trans people. Research conducted in the United States in the 1990s found that 8 percent of trans men had experienced physical abuse in a romantic or sexual partnership in the preceding year. This same study found that 16 percent of trans women respondents had experienced physical abuse in a romantic or sexual partnership in the preceding year (Clements, Katz, & Marx, 1998).

Challenges in assessing IPV in LGBTQ communities

- Assessing prevalence of IPV in LGBTQ communities is difficult. Intimate partner violence often goes unreported; internalized homophobia, stigma, sexism, and a lack of recognition of abusive behaviours are all reasons why this is so. Those experiencing IPV may not recognize it as abuse. Furthermore, researchers have tended to rely on convenience samples that may not reflect the experience of LGBTQ communities more broadly (West, 2002; Lewis et al., 2012).
- Differences in how researchers assess IPV compound these problems. For instance, some studies examining sexual minority women's experiences of IPV consider the gender of the abuser, while others do not. This matters because sexual minority women may have experienced IPV from a cisgender heterosexual male partner. Some studies assess lifetime experience of IPV, while others are more limited in timeframe. The former generally find higher prevalence of IPV than the latter.
- Regardless of its actual prevalence, it is clear that 1) IPV occurs in LGBTQ communities, 2) IPV has deleterious effects on survivors, 3) IPV in LGBTQ communities may take on particular forms not found among non-LGBTQ communities, and 4) service providers must be aware of IPV in LGBTQ communities, for it has implications for their practice.

Forms of intimate partner violence in LGBTQ communities

- To understand IPV, we must consider the entire context in which it occurs. While gender and sexual identity may influence the forms that IPV takes, other aspects of identity, such as race (Kasturirangan, Krishnan, & Riger, 2004), ability (Brownridge, 2006), or class (Goodman, Smyth, Borges, & Singer, 2009) may also be salient. A confluence of multiple, unique actors informs each person's experience of IPV (e.g. Cramer & Plummer, 2009).
- Certain forms of IPV unique to LGBTQ populations draw on homophobia, biphobia, transphobia, and transmisogyny² and may include the threat of outing. IPV may also involve the undermining of an individual's queer or trans identity: specifically, a perpetrator may dismiss their partner's claim to a specific identity or tell them that they insufficiently embody that identity (Ristock & Timbang, 2005; Barrett, 2015).
- Transphobia and transmisogyny may inform the type of abuse that transgender individuals face (Goldmark, 2013; Greenberg, 2012; Goldberg & White, 2013). For instance, an abuser might mock or assault body parts that are important signifiers of their partner's gender identity, or they might impede access to objects that are central to their partner's expression

² Transmisogyny is oppression, such as discrimination or violence, directed at trans women and trans-feminine. Transmisogyny is rooted in the devaluation of femininity relative to masculinity.

of their gender identity, such as clothing, binders³, or wigs (Goodmark, 2013). Immigration status may influence both the forms that IPV takes, as well as the likelihood that survivors will seek help (Raj & Silverman, 2002; Erez, Adelman, & Gregory, 2008; Goodmark, 2013). An abuser might use their partner's immigration status as a means of control, threatening to compromise their application (especially in the case of spousal sponsorship) or reveal their undocumented status.

- In Canada, court decisions have effectively criminalized non-disclosure of HIV-positive status to a sex partner under certain conditions. An abuser whose partner is living with HIV/AIDS might exploit this legal context, either leveraging it as a form of abuse or as a means of preventing their partner from ending the relationship or seeking help (see Symington, 2013; Adam et al., 2014). This has the potential to isolate individuals who are both living with HIV and experiencing IPV.

Impact of intimate partner violence in LGBTQ communities

- IPV may lead to poor physical and mental health outcomes.
- Research has linked both the perpetration and experience of IPV with poor mental health outcomes such as depression, suicide ideation, including post-traumatic stress disorder among young MSM survivors of IPV (Ristock & Timbang, 2005; Houston & McKirnan, 2007; Stults et al., 2015)
- Numerous studies have explored the relationship between IPV and substance abuse in LGBTQ communities. Research shows co-occurrence of alcohol use and IPV among lesbians (Bimbi, Palmadessa, & Parsons, 2008; Lewis et al., 2012), and gay and bisexual men (Houston & McKirnan, 2007).
- Research with LGBT survivors of IPV suggests that negotiation of safer sex practices may be difficult in a violent relationship. Participants reported being forced into having sex. Likewise, they reported feeling unsafe asking their partner to engage in safer sex practices and/or that they feared their partner's response to safer sex (Heintz & Melendez, 2006).

Barriers to help seeking

- Because many existing resources presume a heterosexual female audience, sexual and gender minority survivors of IPV may not know where to turn for information or services that addresses their experiences (St. Pierre & Senn, 2010).
- Individuals may be reluctant to acknowledge or address IPV for fear of it reflecting negatively upon LGBTQ people (Davis & Glass, 2011; Turell et al., 2012). This concern may be particularly pertinent to contexts in which the community is small and/or isolated, such as rural settings. In these contexts, LGBTQ people may fear that drawing negative attention to their community could add to stigma or discrimination they already face (see Davis & Glass, 2011; Duffy, 2011).
- Research suggests that the tight-knit nature of some LGBTQ communities may prove a barrier to identifying and addressing IPV (Bornstein et al., 2006; Davis & Glass, 2011). If both persons experiencing IPV are members of the same community, it may be difficult for the individual experiencing IPV to seek support from this community without their partner's

³ A binder is an article of clothing that individuals may use to lessen the prominence of breasts. Binders are commonly used as gender-affirming articles of clothing.

knowledge (Walters, 2011). Accordingly, perpetrators of IPV in these contexts may actively seek to isolate their partner and undermine their ability to seek support from their community.

- Even when survivors are aware of services or resources available to survivors of IPV, previous negative experiences with service providers—or the perception that they could have a negative experience with a service provider—may discourage survivors from seeking help. Existing research documents these concerns and experiences across LGBTQ communities (Seelau & Seelau, 2005; Bornstein et al., 2006; Blasko et al., 2007; Brown & Groscup, 2009; Stephenson, 2011; Greenberg, 2012; Basow et al., 2012).
- Similarly, LGBTQ people experiencing violence may be reluctant to approach the police. Research highlights mistrust and low-confidence of the police in LGBTQ communities (Moran & Sharpe, 2004; Eaton et al., 2008; Durish, 2011), which is still often seen to embody homophobia (Durish, 2011).
- Bisexuals face barriers when attempting to access services designed for heterosexual people; more surprisingly they also face barriers in accessing services designed for queer people. Bisexual individuals may encounter difficulty accessing supports for survivors of IPV in both queer and heterosexual communities. This may be particularly true for bisexuals experiencing IPV in the context of a male-female relationship. While services aimed at heterosexuals may not be affirming of their identities, they may encounter resistance or hostility when accessing supports aimed at individuals experiencing IPV from a same-sex partner (Barrett, 2015).
- Transgender individuals may experience barriers to accessing resources or services for survivors of IPV. For instance, certain shelters or support organizations for women fleeing violence may turn away transwomen (Goldberg and White, 2013). Research with transmen shows that shelter policies result in survivors having to decide between hiding their identity and accessing women’s shelters, or, putting themselves at risk of violence in the men’s shelters (Brown, 2011).

Addressing intimate partner violence in LGBTQ communities

- Poon (2011) suggests that individualistic approaches to understanding IPV are not helpful. The perpetrator-survivor binary often does not reflect reality. There is a tendency to see perpetrators as wholly evil or deranged and survivors as passive, all of which may prove unhelpful when trying to address IPV. He advocates approaching IPV on a case-by-case basis without jumping to conclusions about how power is exercised in the relationship.
- If service providers are to address IPV, they can first create environments in which gender and sexual minority clients are more likely to feel comfortable accessing services. They can do so by adopting inclusive practices.
- Service providers can ask a patient about their ‘partner,’ a term that does not presume a gender identity.
- Service providers can promote inclusive practice through adopting intake paperwork that allows patients to self-identify outside of a gender binary. For instance, a form might include a field that reads: “None of these categories describes my gender identity. My gender identity is _____”. Both providers and administrative staff can ask what name and pronouns the patient uses. When the name and gender listed on a patient’s identification differs from those provided by the patient, use the latter.

- In a similar vein, service providers can ask patients how they name their body parts. Gender minority patients, in particular, may use different anatomical terms that are better aligned with their gender identity.
- Furthermore, service providers should not base assumptions about a patient's sexual practices on their sexual orientation or gender identity. We would encourage health care providers to make open-ended inquiries about the types of sexual behaviours that their patients engage in.
- Health care providers can maintain resources specific to LGBTQ people, where such resources exist. This might include a list of LGBTQ-specific support groups or web-based resources.
- As individuals may not recognize IPV, service providers can ask their clients about specific behaviours. This may yield more useful responses than simply asking clients whether they have experienced IPV.
- Current IPV resources need to be made more inclusive of gender and sexual minority people's experiences (Parry and O'Neal, 2015). For instance, a pamphlet aimed at female-identified survivors of IPV should not use language that assumes a male abuser.
- Healthcare providers can support LGBTQ survivors of IPV by providing services specific to their communities (Bornstein et al., 2006). Hiring sexual and gender minority staff is a necessary step in making services more inclusive for LGBTQ survivors: one study found that lesbian and bisexual women experiencing IPV would prefer to reach out to those with similar identities and life experiences (Turrell & Herrmann, 2008).
- Service providers can best meet the needs of LGBTQ communities by providing services and resources that acknowledge the diversity in these communities. For instance, bisexual survivors of IPV have expressed feeling left out of both services aimed at heterosexuals and those aimed at lesbian or gay survivors (Turell et al., 2012). Transgender survivors of IPV may not feel comfortable accessing services designed for or frequented by cisgender sexual minority survivors (see Greenberg, 2012).
- Service providers can also directly address the needs of LGBTQ Black, Indigenous, and People of Colour. Waldron (1996) specifically calls on service providers to advertise their services not only among LGBTQ communities, but also among racialized communities. Service providers can also promote a racially inclusive environment by hiring BIPOC at all organizational levels.
- Strengthen social support networks. Research shows that social support has a protective effect against mental health problems brought on by IPV (Coker et al., 2002). In light of this finding, service providers and organizations that address IPV can combat isolation of LGBTQ survivors of IPV by partnering with LGBTQ organizations in the community, thereby expanding opportunities for those experiencing IPV to reach out for assistance (Parry & O'Neal, 2015).

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