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*Discussion paper:*

# Prevalence of Intimate Partner Violence and the increased health risks in the LGBTQ+ community

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*Intimate Partner Violence (IPV) within the Lesbian, Gay, Bisexual, Trans\*, and people questioning their sexual or gender identity (LGBTQ+) community is vastly under researched in comparison to within heterosexual relationships. Prevalence rates have varied but it is becoming clear within the literature that this is a significant social issue. This paper will first discuss the prevalence of IPV within the LGBTQ+ community before moving on to consider the health risks of IPV. It is essential to consider the specific needs of those within this community to be able to understand and tailor support to reduce this issue.*

## **Prevalence of Intimate Partner Violence and the increased health risks in the LGBTQ+ community**

**I**NTIMATE PARTNER VIOLENCE (IPV) is a serious societal problem, and there is a significant body of literature that has explored both the etiology and consequences of it (e.g. Archer, 2000). Acts of IPV can be defined as physical, sexual, psychological, verbal or emotional harm perpetrated by a current or former partner or spouse; these behaviours can also include controlling behaviour such as coercive control (Centres for Disease Control, n.d.). In terms of the forms of partner violence there is no 'typical' form of abuse even though some forms of abuse may be seen more frequently than others. Using IPV to describe these forms of abuse instead of the term domestic violence, gives a wider range of partner relationships within the spectrum and therefore includes Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and Other relationship (LGBTQ+; Stanley et al., 2006). Researchers argue that the term domestic violence has been associated with marital violence and that it was exclusively a heterosexual issue, and it applies to

a broader range of family violence such as violence from a child against their parent, or parent against their child.

Reported prevalence rates for IPV within an LGBTQ+ sample in the US are at around 25 per cent, with 1 in 10 individuals reporting acts of physical violence; research has estimated prevalence ranging from 25 per cent to 50 per cent in gay and lesbian relationships (Carvalho et al., 2011). A UK-based IPV charity known as SafeLives, found that within their LGBTQ+ sample 69 per cent of participants had experienced some form of IPV. Some suggest that maladaptive behaviours of partners in relationships is becoming more widespread within those relationships; this can be supported with prevalence rates of bidirectional violence being at an estimated 50 per cent (Langhinrichsen-Rohling et al., 2012).

Physical violence has been found to be 2.5 times higher in transgender individuals than in the LGB cis-gender<sup>1</sup> individuals (Whitton et al., 2016). Research suggests that 61 per cent of the transgender youth

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<sup>1</sup> Relating to a person whose self-identity conforms with the gender that corresponds to their biological sex.

have experienced sexual IPV victimisation (Zweig et al., 2013). Transgender men and women are thought to be at a higher risk for physical IPV and psychological IPV than cis-gender individuals; however, transgender women are at a higher risk of physical IPV in comparison to transgender males (Pitts et al., 2006).

As within violent heterosexual relationships, jealousy, dependency and power imbalances can also be related to manipulative behaviours within LGBTQ+ relationships. Many aspects of IPV within this community can contain different power dynamics between partners; this was particularly common within the research of the 1980s and 1990s. Some LGBTQ+ individuals who had 'come out' were ostracised from their family, lost their employment and also friendships were terminated. Some were thrown out of their homes and would move in with their partners; in a violent relationship this automatically caused an imbalance of power within the relationship, the owner of the home holding the power over their partner in order to exert control. With the fear of homelessness, many victims of IPV would not leave their partner despite this abuse. This was also true of individuals losing their employment; this power imbalance comes from their partner having financial power over their partner and using this as a means of control (Renzetti, 1992).

LGBTQ+ IPV has been found to cause serious negative health and social consequences. Health risks, including mental health issues, are already a significant problem for the LGBTQ+ community, many have experienced prior physical or psychological trauma; these are often related to minority stressors and experiences such as internalised homophobia, societal homophobia, internalised transphobia, societal transphobia and discrimination (Whitton et al., 2015). With the cyclical nature of these types of abuse in both society and within their intimate partner relationships, this increases the likelihood of mental illness

developing within this population. Previous research, has found that dating violence could increase the health risks of individuals (Stanley et al., 2006). Behaviours such as internalised homophobia, depression, suicidal ideation, self-injury, unsafe sexual encounters, isolation and drug and alcohol abuse are somewhat common amongst LGBTQ+ youths, and dating violence can increase the severity of these problems (Zweig et al., 2013). The maladaptive behaviours that develop, such as self-injury and depression, can affect other areas of life such as school/work performance and truancy, and also negatively affect the relationships between family, friends and other peers (Whitton et al., 2015).

One such health risk that can affect both mental health and violence is internalised homophobia (IH) and internalised transphobia (IT), which can arise due to a person's attitudes towards the LGBTQ+ population; these views can be shaped by family, friends, other peers and outlets such as the media. Due to the common misconception that being a heterosexual or cis-gendered is 'normal' and that being a part of the LGBTQ+ community is 'not normal', youths and adults often experience bullying, which can result in the individual developing their own form of internalised homophobia/transphobia and self-dislike (Carvalho et al., 2011). The negative view that having a LGBTQ+ identity is 'bad' or 'not normal' can increase the prevalence of issues such as depression and self-injury (Frost & Meyer, 2009; Igartua et al., 2009).

IH can affect individuals within a same-sex relationship through the transference of their own IH and this can create anger and conflict within the relationship. Due to IH and other minority stressors, violence can be used within a relationship when the individual with IH believes their partner to present themselves as 'overly gay' such as the stereotypical effeminate male or a female who presents herself as masculine (Carvalho et al., 2011).

Depression, anxiety, isolation and post-traumatic stress disorder (PTSD), are often associated with IPV within heterosexual and same-sex relationships. Glass et al. (2008) found women who experience IPV within their same-sex relationship are at risk of re-assault, increasing injuries, chronic health conditions, disabilities and death. This can also be applied to the males within a same-sex relationship. Depression, anxiety, isolation and PTSD can cause many other issues within LGBTQ+ relationships, the development of mental health issues can be linked to issues such as chronic health problems arising. For example, some individuals use substance abuse as a coping mechanism to escape their abuse or in response to the minority stressors that are apparent within their lives (Ard et al., 2008). Gay males report higher use of drugs such as ecstasy within their relationships than heterosexual males; some of the explanations for this are as coping mechanisms, but males also report that these drugs cause them to become more aggressive and therefore increases the violence within their relationships. Substance abuse can become cyclical in nature and this can have an overarching effect; repeatedly using substance abuse as a coping mechanism can increase the risk of alcoholism and drug addiction (Murray et al., 2006).

It can also be argued that being under the influence of drugs and alcohol, inhibitions are decreased and this can occasionally result in unsafe sexual encounters, sometimes with strangers. By doing this, it increases the risk of sexual health problems such as HIV and other sexually transmitted infections (STI). Significant links have been found between HIV status and IPV victimisation (Murray et al., 2006). For perpetrators, they can use their own HIV status to emotionally control their partners by making their partner experience guilt in leaving them. For some, research has found that as a means of control a partner will intentionally infect their partner in an attempt to stop them leaving the relationship.

Victims with a HIV status can also be emotionally controlled by their partners as they use psychological forms of abuse in order to lower their victim's self-worth and therefore lowers the chances of the relationship dissolving (Murray et al., 2006). Furthermore, high rates of sexual violence within the LGBTQ+ community are apparent, some believe they did not feel safe asking their partners to use safer sex methods. This supports the suggestion that victims of same-sex IPV may be at an increased risk for HIV and other STIs. A common misconception is that lesbians are less likely to be at risk of sexually transmitted infections, however Ard et al. (2008) found that there are elevated levels of risk of HIV/STI for women. This misconception can affect their health as they may not engage in STI preventions; this creates an increase of the health issues in lesbian women who are not aware of the risks.

It is apparent that IPV is just as prevalent within the LGBTQ+ community and that there are a number of health risks that this violence can create. Many of the LGBTQ+ community are already vulnerable to mental health issues due to their exposure to risk factors such as stereotyping, misconceptions and discrimination; if IPV is also present, the likelihood of mental health issues increases. Minority stressors negatively affect their lives as this can increase violence within relationships. This violence then goes on to negatively affect both the perpetrator as well as the victims, as both can use coping mechanisms such as drugs and alcohol. By consuming these substances, this lowers the inhibitions which can increase the risk of sexual violence and unsafe sexual encounters, creating a more significant health risk. With this in mind it becomes apparent that IPV needs to be addressed within the LGBTQ+ community in order to both reduce the prevalence, provide additional support and tackle growing concerns about the mental and physical health risks.

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