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Identity Abuse as a Tactic of Violence in LGBTQ Communities: Initial Validation of the Identity Abuse Measure

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Abstract

Intimate partner violence (IPV; i.e., physical, sexual, or psychological abuse by a current or former partner) remains a public health concern with devastating personal and societal costs. Lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals are also vulnerable to a dimension of IPV called identity abuse (IA); that is, abuse tactics that leverage systemic oppression to harm an individual. Yet, we know little about its relative prevalence in subgroups of the LGBTQ community. This study developed and evaluated a measure of IA, and explored its prevalence in a sample of 734 sexual minority adults. The sample included women (53.1%), men (27.4%), and transgender or gender nonconforming "TGNC" (19.3%) participants. The majority of participants identified as queer or pansexual (38.7%), then gay (23.6%), lesbian (22.8%), and bisexual (13.6%). Participants completed an online survey that included measures of IA and physical, sexual, and psychological abuse. The IA items formed a unidimensional factor structure with strong internal consistency and construct validity. Nearly one fifth of the sample (16.8%) experienced past year IA and 40.1% reported adult IA. Women experienced greater exposure to IA in adulthood than men, and TGNC participants reported higher rates of IA in adulthood and in the last year compared to their

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cisgender counterparts. The odds of queer or bisexual participants reporting IA in adulthood were almost three times higher than gay participants, and two times higher than lesbian participants. Findings have implications for advancing assessment of partner abuse in the LGBTQ community, LGBTQ-competent clinical care, and training of practitioners.

Keywords
LGBTQ, intimate partner violence, domestic violence, identity abuse, prevalence

Intimate partner violence (IPV; i.e., physical, sexual, or psychological harm by a current or former partner) remains a public health concern with serious personal and societal costs (Center for Disease Control [CDC], 2014).[1] Within lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities, prevalence rates are at least as high if not higher than in the cisgender, heterosexual community (Langenderfer-Magruder, Whitfield, Walls, Kattari, & Ramos, 2016). Further, IPV in this community occurs in the context of ongoing heterosexism and homo-, bi-, and transphobia, which already place LGBTQ individuals at a disproportionate risk for psychological distress (Lehavot & Simoni, 2011; Meyer, 2003). One type of IPV that has received little empirical attention despite its apparent salience for LGBTQ communities is identity abuse (IA; i.e., abuse tactics within an intimate partnership that leverage systemic oppression such as ableism, sexism, and racism to harm an individual; Ard & Makadon, 2011; West, 2012). This current project attempts to fill this gap by (a) developing and evaluating a broad measure of IA specific to LGBTQ individuals and (b) conducting a preliminary exploration of the relative prevalence of IA within subgroups of the LGBTQ community.

Examining IPV Prevalence Rates Within the LGBTQ Community

IPV in the LGBTQ community is receiving increased attention as a public health concern. For example, a recent study based on a national probability sample of 18,049 respondents found that 61.1% of bisexual women, 43.8% of lesbian women, 37.3% of bisexual men, and 26% of gay men reported rape, physical violence, or stalking by an intimate partner in their lifetime (Walters, Chen, & Breiding, 2013). The few studies examining IPV in transgender and gender nonconforming (TGNC) populations indicate that these rates are similarly high, with one study reporting that 21.6% of the TGNC population has experienced IPV in their lifetime (Langenderfer-Magruder et al., 2016).

Further, there is emerging evidence to suggest differential risk of IPV within the LGBTQ community, with increased rates of exposure to IPV reported by bisexual and TGNC individuals (Black et al., 2010; Langenderfer-Magruder, 2014; Valentine et al., 2017).

Identity Abuse

Many scholars have noted that systemic oppression such as ableism, sexism, and racism can be leveraged to cause psychological harm or to control an individual (Ard & Makadon, 2011; Balsam & Szymanski, 2005; Bornstein et al., 2006; FORGE-Forward, 2013; Guadalupe-Diaz &Anthony, 2017; West, 2012). For the purposes of this article, we use the term "identity abuse" to describe the set of tactics of IPV that leverage heterosexism and cissexism against LGBTQ survivors. Despite practitioners' growing awareness of this phenomenon, few studies have explored it quantitatively. One exception is the work of Balsam and Szymanski (2005), who developed a five-item measure to assess IA in a sample of 272 LGB women. A total of 34.4% of their sample endorsed at least one of the five items, providing compelling evidence that IA is common among LGB women. However, these authors did not discuss how these particular items were generated; the items focused solely on women, omitting types of IA that may be specific to male-identified, or TGNC people; and the study did not report on the internal consistency of the IA items as a scale.

The authors conducted a broad review of the existing literature on IPV in the LGBTQ community to develop a framework for understanding IA. We searched two online databases (Medline and Psychinfo) using the terms intimate partner violence and domestic violence in combination with various sexual and gender identity labels and acronyms, including lesbian, gay, bisexual, transgender, queer, transgender, TGNC GLBT, GLBTQ, LGBTQ, LGBT, LGB, and TGNC. Article reference lists were reviewed for useful publications that were not captured by the initial searches using these terms. In addition to searching online databases, the authors conducted google searches for materials from programs serving LGBTQ survivors, and national reports on IPV among gender nonconforming and sexual minority samples (e.g., The National Coalition of Anti-Violence Programs). This review of practice-based literature (e.g., FORGE-Forward, 2013; National Center on Domestic & Sexual Violence [NCDSV], 2014), theoretical work (e.g., Hart, 1986; West, 1998), qualitative studies (e.g., Bornstein, Fawcett, Sullivan, Senturia, & Shiu-Thornton, 2006), and quantitative studies (e.g., Balsam & Szymanski, 2005; McClennen, Summers, & Vaughan, 2008; National Coalition of Anti-Violence Programs [NCAVP], 2013) indicated four broad categories of IA tactics used in the LGBTQ community, described in greater detail below.

Outing

One set of IA tactics involves threatening to disclose a partner's LGBTQ status or "out" them without their consent. Doing so can expose the individual to harassment, threaten their employment or housing security, and limit their access to networks that may not be LGBTQ affirming (Ard & Makadon, 2011; Dank, Lachman, Zweig, & Yahner, 2014; FORGE-Forward, 2013). Studies on the prevalence of threats to "out" a partner produce strikingly similar results across subgroups of the LGBTQ community: In one study of 100 lesbian-identified IPV survivors, 11% indicated that their abuser had threatened to "bring them out" (Renzetti, 1992). In addition, a study of 60 gay male-identified survivors of IPV indicated that 14.1% endorsed that their abusive partner "threatened to out" them(McClennen et al., 2008). Finally, 13% of 60 trans-identified survivors of IPV reported that their partner "threatened to tell people about your trans identity or background who you don't want to know" (Roche, Richie, & Morton, 2010).

Undermining and Belittling Identity

Another category of IA tactics includes undermining, attacking, or denying a partner's identity as an LGBTQ person (Balsam & Szymanski, 2005; FORGE-Forward, 2013; Guadalupe-Diaz & Anthony, 2017; NCDSV, 2014; Roche et al., 2010). In one study based on focus groups with 22 LBT IPV survivors, participants described the ways their abusers questioned or challenged their LBT identities, using tactics such as accusing the participant of being straight, questioning their authenticity (e.g., you're not a "real" lesbian), or telling them they were not "good enough" at their chosen gender identity (Bornstein et al., 2006). Transgender IPV survivors describe tactics such as being made to feel ashamed about their transgender identity, being prevented from expressing their gender identity (e.g., monitoring the survivors' attire), being prevented from using their preferred pronouns or name, or having a partner draw attention to parts of their body that they feel uncomfortable with (Roche et al., 2010).

Using Homophobic/Transphobic Language

A third set of IA tactics involves the use of slurs or derogatory language regarding the target's sexual orientation or gender identity (e.g., calling a partner a "tranny," "fag," "dyke"; FORGE-Forward, 2013; NCDSV, 2014). There is virtually no empirical literature documenting the prevalence of such language as a tactic of IPV, though such attacks are included as a form of

verbal abuse in the practice-based literature and thought to target internalized homo/bi/transphobia (FORGE-Forward, 2013; NCDSV, 2014).

Isolating Survivors From the LGBTQ Community

Isolation is a well-documented tactic of abuse. When isolation is used against LGBTQ survivors in particular, the result may be even more damaging than for heterosexual and cisgender survivors. Many LGBTQ couples share a single community and these communities of support or "families of choice" often play a central role in providing social support for LGBTQ people who have experienced rejection from their families of origin (Barrett & Sheridan, 2017; Bornstein et al., 2006; Walters, 2011). In one focus group study (Bornstein et al., 2006), 22 LBT IPV survivors identified isolation as a central tactic of abuse. Similarly, in a Scottish study of transgender-identified participants, 15% endorsed that they have had a partner "stop them from engaging with other trans people or attending transgender social groups and support groups" (Roche et al., 2010, p.15).

These preliminary findings support the existence of IA as a unique dimension of partner abuse in LGBTQ communities. However, research has yet to develop a broad-based, psychometrically valid measure that would allow closer examination of the nature and relative prevalence of IA across subgroups of the LGBTQ community. This is a critical gap given that members of the LGBTQ community have multiple intersecting identities that shape exposure to different types and degrees of abuse (Bograd, 1999; Mendez, 1996; Meyer, 2010). We therefore set out to (a) develop a valid measure of IA and (b) explore variations in the prevalence of IA within the LGBTQ community based on gender, sexual orientation, and race/ethnicity. This is a critical first step towards eventually understanding how IA might affect the mental health and wellbeing of various subgroups of the LGBTQ community (Longobardi & Badenes-Ribera, 2017).

Method

Participants

Participants included 734 sexual minority adults, ranging in age from 18 to 61 years (M_{age} = 33.49, SD = 12.91). Half of participants identified as women (53.1%), and about a quarter (27.4%) identified as men. Participants who identified as transgender and identified as either man or woman were initially grouped under a "Trans-binary" label and participants who identified their gender as genderqueer were grouped under a "Gender nonbinary" label.

These groups were examined on all violence and outcome measures and there were no significant differences. They were combined under the umbrella term "TGNC" (19.3%).

Participants identified their sexual orientation as gay (23.6%), bisexual (13.6%), lesbian (22.8%), and queer or pansexual (38.7%). Nine participants (1.2%) identified as straight and also as TGNC. Given the small number of participants in each group, these participants were assigned to the queer group.

The majority of participants identified as White (81.1%), followed by Asian American or Pacific Islander (7.5%), Hispanic or Latina/o American (6.5%), biracial or multiracial (4.5%), Black or African American (3.7%), a race/ethnicity identity label that was not listed in the response options (i.e., "Other"; 3.7%), First Nation, Native American, American Indian, or Alaska Native (2%), Middle Eastern or Arab American (1.6%), and Native Hawaiian or other Pacific Islander (0.6%). Given the small percentage of respondents in several of these subgroups, racial/ethnic groups were collapsed into the following categories: White (78.5%), people of color (POC; 15.9%), and "other" (5.6%).

Regarding geographic location, participants reported living in the following U.S. regions: northeast (33%), west or northwest (26.3%), south/southwest (18.7%), midwest (16.9%), or other U.S. territories (5.0%). Finally, participants varied across their highest educational level achieved: bachelors or associate degree (38.1%), master's degree (30.1%), a doctoral or professional degree (16.25%), and some high school or a GED or equivalent (15.5%).

Procedure

Participants were recruited through LGBTQ-specific online forums and listservs that focused on IPV, LGBTQ concerns, or both. Recruitment sites were chosen based on the size of their constituency and their inclusion of as wide a swath of the LGBTQ community as possible, including people who identify as IPV survivors and those who do not. If sites had a moderator (as in the case of listservs), they were contacted to obtain permission to forward a study announcement to its members or directly post on the site. We also used snowball sampling by sending this announcement out to colleagues and friends connected to the LGBTQ community. Participants were required to be at least 18 years of age and identify as a sexual or gender minority. We made a concerted effort to recruit racially and ethnically diverse LGBTQ participants by recruiting through culturally specific groups as well as online forums and listservs. Overall, we contacted 122 LGBTQ community groups specifically

geared toward LGBTQ communities of Color, and 301 community groups in total. Groups were invited to participate in a study on relationships in the LGBTQ community, and offered the opportunity to enter a raffle to win one of five $25 gift cards.

Measures

Demographics. Demographic variables included participants' age, self-identified gender identity, educational attainment, racial/ethnic identity, and sexual orientation.

Identity abuse. Items for the IA Scale were developed based on both a literature review and expert consultation. Upon reviewing the literature on IA that has emerged since the Balsam and Szymanski (2005) scale was developed, we identified four possible domains of abuse, described above. Balsam and Szymanski's (2005) scale, also described above, had captured two of these (outing and undermining and belittling identity) but not the other two (using homophobic/transphobic language and isolating the survivors from the LGBTQ community). Further, their measure focused exclusively on IA among lesbian and bisexual women and therefore used language that did not fit the broader LGBTQ community. Therefore, we made the following revisions: First, we added two items to cover specific aspects of IA not included in the original measure. Second, we changed the language of the item, "I used my partner's age, race, class, or religion against her," to apply more specifically to using gender and sexual orientation against the survivor. Third, we changed the language of all items to reflect the larger LGBTQ community. We also changed the response options to assess past year abuse and adult lifetime experiences, so that scores on this scale could be directly compared to scores on the other abuse measures.

Once we had an initial list of items, we shared them with one scholar and five practitioners with expertise on IPV in the LGBTQ community, focusing specifically on those with knowledge of communities historically excluded from LGBTQ research (e.g., racial and ethnic minority communities and TGNC communities). We asked these experts to assess the items for comprehensiveness (e.g., "are there kinds of tactics that are not represented in these items you would include") and inclusiveness (e.g., "is there language that may exclude participants on any given social identity). Based on their feedback, we made several revisions to the language of the items before finalizing the seven-item scale (See Table 3).

For each item, the participants reported whether the event had occurred once in the past year, twice in the past year, 3 to 5 times in the past year, 6 to

10 times in the past year, 11 to 20 times in the past year, more than 20 times in the past year, not in the past year but it did happen, or that the event had never happened. We developed a past year frequency variable by summing responses to the past-year item, and an adult exposure variable that coded participants with any exposure to any of the items, past year or adulthood, as having exposure and those without as not. For this investigation, the Cronbach's alpha for past year CTS was $\alpha = .79$.

Physical abuse. The Conflict Tactics Scale, short form (CTS-2; Straus & Douglas, 2004) was used to assess the construct validity of the IA Scale. It contains 20 items that assess victimization in four domains: assault, injury, psychological aggression, and sexual coercion. The survey excluded the psychological aggression items and combined the four physical assault items and two sexual assault items to form one physical abuse scale. Participants responded using an 8-point Likert scale that captures both past-year frequency and prevalence in adulthood (e.g., since age 18). Two variables were created from these scores: A continuous score for "past year frequency" that could range from 0 "did not occur" to 6 "occurred more than 20 times," and a dichotomous adult victimization score. For this investigation, the Cronbach's alpha for past year CTS was $\alpha = .89$.

Psychological abuse. The short form version of the Psychological Maltreatment of Women Inventory (PMWI; Tolman, 1999) was used to assess the construct validity of the IA Scale. The PMWI contains 14 items that assess psychological violence in relationships, and consists of two subscales: Domination/Isolation and Emotional/Verbal Abuse. The response options ask how frequently each item occurred in the past 6 months, with choices including *never, rarely, occasionally, frequently, or very frequently* (scaled 1-5). We made several adjustments to this scale, including changing the reference time period and response options to match that of the CTS-2. We also adjusted the wording of the measure so that it would apply to survivors and perpetrators of all genders. As with the CTS-2, two variables were created from these scores: a continuous score for "past year frequency" that could range from 0 (*did not occur*) to 6 (*occurred more than 20 times*), and a dichotomous adult victimization score. For this investigation, the Cronbach's alpha for past year PMWI was $\alpha = .87$.

Data Analysis

Following an analysis of missing data, we assessed the psychometric properties of the IA Measure, using exploratory factor analysis (EFA) and reliability

and validity analyses. Next, we tested for significant differences on adult exposure to IA across subgroups of the sample based on gender identity, sexual orientation, and race/ethnicity. For adult IA exposure, which is a categorical variable, chi-square test of association analyses were conducted to test for overarching significant differences across categories, followed by odds ratio (OR) computations to assess the magnitude of those differences. For past year abuse, which is a continuous variable, analyses of variance (ANOVAs) were used to test for overarching significant differences across categories, followed by Scheffe post hoc test to determine what accounted for the overall differences.

Results

Missing Data

Missing data were located, analyzed, and addressed using the Missing Values Analysis procedure for IBM SPSS Statistics Version 22 (IBM, 2013). Missing data percentages ranged from 0% (on IA Measure) to 1.6% (on demographic measures), a nearly negligible amount as defined by Schlomer, Bauman, & Card (2010).

Psychometric Evaluation of the Measure

As a preliminary step of the EFA of the IA Measure, we assessed the quality of the items by examining their interitem correlations and the frequency of missing responses (DeVellis, 2011). Interitem correlations ranged from $r = .24$ to $r = .65$, falling within the recommended range (i.e., $r = .15$ to $r = .50$) and indicating that the items capture distinct aspects of the underlying latent construct (Clark & Watson, 1995).

The next step was to conduct the EFA. The Kaiser-Meyer-Olkin index (.85) indicated good sampling adequacy and Bartlett's test of sphericity was 1,697.73 ($df = 21$, $p < .001$), suggesting that the correlation matrix was appropriate for EFA. We then determined the number of factors to extract based on the Kaiser eigenvalue rule (e.g., eigenvalues over 1) and the scree plot (DeVellis, 2011; Worthington & Whittaker, 2006). We used principal-axis factoring as an extraction method with varimax rotation which yielded a unidimensional factor structure (eigenvalue = 3.50; variance accounted for = 50.06%; factor loadings = .52, .53 .56, .67, .68, .77, and .77). Communalities were at an acceptable level (from .37 to .64; $M = .50$), and internal consistency was high (Cronbach's $\alpha = .80$). The factor loadings of the individual items are presented in Table 1.

Table 1. Identity Abuse Measure Factor Loadings Using Principal Axis Factoring.

Identity Abuse Scale Item	Factor 1
Item 6: The person called me pejorative names that have to do with my LGBTQ status	.77
Item 5: The person told me I deserve what I get because of my sexual orientation or gender identity	.77
Item 1: The person threatened to tell my employer, family, or others about my sexual orientation or gender identity	.68
Item 3: The person used my sexual orientation or gender identity against me	.67
Item 7: The person prevented me from seeking support within the LGBTQ community	.56
Item 2: The person forced me to show physical or sexual affection in public, even though I didn't want to	.53
Item 4: The person questioned whether my sexual orientation or gender identity was "real"	.52
	N = 734

Note. LGBTQ = lesbian, gay, bisexual, transgender, and queer.

To assess the construct validity of the IA Measure, we examined its correlation with physical and psychological abuse. As expected, and indicated in Table 3, the variables were associated in conceptually consistent directions. Means, standard deviations, and scores indicating frequency of exposure to IA are presented in Table 3.

Relative Prevalence of IA Across Subgroups

Overall, nearly one fifth of the sample (16.8%) reported experiencing at least one form of IA in the past year and 40.1% reported IA at some point in adulthood. A full list of the prevalence of each item in the past year and adulthood is presented in Table 2. The next set of analyses describes the relative prevalence of IA (overall adult abuse and past year abuse) across gender, sexual orientation, and race/ethnicity.

Gender. Chi-square results yielded significant gender differences in reported adult IA exposure, $\chi^2(2) = 17.74$, $p < .0001$. TGNC participants reported the highest rates of adult IA exposure (49.3%) followed by women (42.8%) and men (28.4%). Based on OR calculations, the odds of TGNC-identified participants reporting IA in adulthood were almost 2.5 times higher than the odds of men experiencing such abuse (OR = 2.46, $p < .0001$, 95% CI = [1.57,

Table 2. Identity Abuse Item Frequencies.

	% Past Year Exposure (n = 734)	% Adult Exposure (n = 734)
The person threatened to tell my employer, family, or others about my sexual orientation or gender identity	1.9	6.3
The person forced me to show physical or sexual affection in public, even though I didn't want to	4.5	12.8
The person used my sexual orientation or gender identity against me	6.7	17.7
The person questioned whether my sexual orientation or gender identity was "real"	11.4	28.3
The person told me I deserve what I get because of my sexual orientation or gender identity	3	8.2
The person called me pejorative names that have to do with my LGBTQ status	3.5	10.9
The person prevented me from seeking support within the LGBTQ community	4.2	9.9
Total % with any exposure	16.8	40.1

Note. LGBTQ = lesbian, gay, bisexual, transgender, and queer.

Table 3. Correlations Among the Abuse Measures.

	1	2	3	4	5	6
1. Identity abuse (PY)	—					
2. Psychological abuse (PY)	.57***	—				
3. Physical abuse (PY)	.44***	.39***	—			
4. Identity abuse (Lifetime)	.34***	.24***	.11**	—		
5. Psychological abuse (Lifetime)	.13***	.31***	.08*	.33***	—	
6. Physical abuse (Lifetime)	.20***	.24***	.32***	.40***	.34***	—
M (*SD*)	0.94 (3.41)	7.23 (12.85)	0.53 (2.09)	0.41 (0.49)	0.77 (0.42)	0.39 (0.49)

Note. PY = past year exposure to abuse; Lifetime = adult exposure to abuse.
*p < .05. **p < .01. ***p < .001.

3.85]), and the odds of women reporting IA were nearly two times higher than those of men (OR = 1.89, $p < .001$, 95% CI = [1.31, 2.73]). There were no significant differences between TGNC and women participants in reported adult IA exposure.

ANOVA analyses also revealed significant gender differences in past year IA exposure ($F = 4.76$, $p < .01$; $\eta^2 = .01$). TGNC participants had the highest rates of past year IA exposure ($M = .18$, $SD = .34$) followed by women ($M = .10$, $SD = .27$) and men ($M = .09$, $SD = .26$). Scheffe's post hoc test that explored these differences more closely indicated that there were no significant differences between men and women, but that there were significant differences in the scores of men and TGNC-identified participants and between women and TGNC-identified participants.

Sexual orientation. Chi-square analyses indicated sexual orientation differences in adult IA exposure, $\chi^2(3) = 28.01$, $p < .0001$. Queer-identified participants had the highest reported rates of IA (48.6%) followed by bisexual participants (48%), lesbian participants (35.3%), and gay participants (26%). The odds of queer or bisexual participants reporting IA were almost three times higher than the odds of gay participants doing so (queer: OR = 2.69, $p < .0001$, 95% CI = [1.78, 4.06]; gay: OR = 2.63, $p < .0001$, 95% CI = [1.56, 4.41]). The odds of queer or bisexual participants being exposed to IA were also almost two times higher than that for lesbian participants (queer: OR = 1.73, $p < .05$, 95% CI = [1.17, 2.56]; bisexual: OR = 1.69, $p < .05$, 95% CI = [1.02, 2.80]). However, there were no significant group differences across sexual orientation for past year IA.

Race. There were no significant differences in past year or adult IA exposure by race.

Discussion

The first aim of this study was to create a measure of IA that could be used across LGBTQ identities. A psychometric analysis of the IA Measure, based on a review of available scholarship and expert interviews, provide strong validity evidence. Items load onto a single factor, the measure has high internal consistency, and scores were correlated in the expected direction with scores on physical and psychological abuse measures, respectively. Correlations were within the moderate range, indicating that though correlated, IA is conceptually distinct from other forms of IPV. In other words, it appears that IA is a distinct form of abuse experienced by the LGBTQ community that has not yet been captured by existing measures of IPV.

IA Exposure Patterns in LGBTQ Communities

Members of the LGBTQ community have multiple intersecting identities that shape exposure to different types and degrees of abuse (Bograd, 1999; Mendez, 1996; Meyer, 2010). In an effort to better understand how intersecting identities relate to IA, we explored within-group variations of IA exposure based on gender, sexual orientation, and race/ethnicity. Findings suggest that IA differs across two aspects of identity: gender and sexual orientation. With regard to gender, women experienced significantly more exposure to IA in adulthood than men, though there were no differences in exposure over the past year. Consistent with previous research, TGNC participants also reported experiencing higher rates of IA in adulthood and in the last year compared to their cisgender counterparts (Valentine et al., 2017). With regard to sexual orientation, bisexual and queer-identified participants experienced higher rates of adult exposure to IA exposure than their lesbian and gay counterparts. There were no differences in past year adult exposure to IA across sexual orientation.

These findings then beg the question of *why* TGNC and nonmonosexual subgroups experience the highest levels of risk. One reason may involve stigma, a condition that is often imposed on these subgroups at a disproportionatly high rate even compared to others in the LGBTQ community. In addition to heterosexism and homophobia, bisexual individuals experience biphobia from both LGBT and heterosexual communities (Brewster & Moradi, 2010; Friedman et al., 2014). Transgender communities experience pervasive structural, interpersonal, and individual discrimination that is increasingly connected to health disparities (Grant et al., 2011; Hughto, Reisner, & Pachankis, 2015; James et al., 2016). Recently Hatzenbuehler, Phelan, and Link (2013) defined stigma as the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination. Together, these forces undermine the availability of resources ranging from employment to power and prestige; contribute to social isolation; cause the internalization of negative social perceptions; induce stress; and lead to maladaptive coping methods. While to date there has not been an empirical tests of Hatzenbuehler, Phelan, and Link's stigma framework within the LGBTQ community, several of these outcomes are represented in TGNC and nonmonosexual groups at higher rates than in other LGBTQ groups (Bostwick, Boyd, Hughes, & McCabe, 2010; Grant et al., 2011; James et al., 2016; Pompili et al., 2014; Pyra et al., 2014; Su et al., 2016). At its heart, IA involves the exploitation of a target's vulnerabilities by attacking their most oppressed identities. It makes sense then, that the greater the stigma attached to an identity, the greater the risk of IA abuse. Using Hatzenbuehler

et al.'s (2013) framework, the root cause of group differences in IA exposure would be understood as differentially stigmatized statuses, which in turn create vulnerability to IA.

Race/ethnicity. Interestingly, there were no differences in exposure to IA across race/ethnicity in this current sample. This finding is surprising given the existing literature suggesting that LGBTQ POC experience higher rates of physical violence than their White counterparts (NCAVP, 2013, 2015). It is possible that this study did not have an adequate sample of LGBTQ POC to accurately assess differences in abuse exposure across race/ethnicity. Despite attempting to oversample LGBTQ POC, the response rate was low (15.9%). It is possible that the restricted sample size did not offer adequate power for existing differences in rates of abuse to emerge.

It is also possible that LGBTQ POC experience more IA that this study uncovered, but in a way that is qualitatively different from that of White LGBTQ individuals. As highlighted by intersectionality theory, focusing on abuse tactics that target LGBTQ identity alone may not capture the complexity of interpersonal violence for people who hold multiple intersecting marginalized identities (Crenshaw, 1991; Lewis & Neville, 2015). There is emerging evidence that suggests that there may be substantive differences in the kinds of stereotypes and discriminatory statements individuals experience based on their intersecting identities (Lewis & Neville, 2015; Nadal et al., 2015). For example, Balsam et al. developed an LGBT People of Color Microaggressions Scale, highlighting some examples of the ways that racism and hetero/cis-sexism intersect. Some of these items include, "Having to educate White LGBT people about race issues," "Feeling unwelcome at groups or events in your racial/ethnic community," and "Being seen as a sex object by other LGBT people because of your race/ethnicity" (Balsam, Molina, Beadnell, Simoni, & Walters, 2011). Following these findings, it is possible that IA against LGBTQ POC individuals might include denying a partner's LGBTQ or racial/ethnic identity because they "can't be both," telling a partner they deserve what they get or that they won't be loved due to their dual minority status, or denying racism in the White LGBTQ community. Further research could illuminate the extent to which these are common experiences among LGBTQ POC survivors.

Limitations and Implications

Despite its contributions to the existing literature, this study was limited in key ways related to sampling and generalizability, measurement, and conceptual framework, as described next. Regarding sampling, the study sample is

not representative of the population of LGBTQ individuals in the United States. Rather, it is a convenience sample based on listserv recruitment and snowball sampling. Despite deliberate oversampling in LGBTQ POC and gender-diverse communities, the study sample overrepresented White and cisgender participants, and underrepresented LGBTQ POC and TGNC people. For both of these reasons, the prevalence of IA in the overall sample cannot be considered generalizable and the relative prevalence statistics should be considered as preliminary. As for sample scope, we chose to include members of the LGBTQ community broadly because we wanted to avoid reinforcing the historic underrepresentation of bisexual, TGNC, and queer individuals within the LGBTQ literature generally, and IPV literature specifically (NCAVP, 2013, 2015). However, inclusivity came with trade-offs. Potentially most important is that the wording of some items may have prevented more nuanced findings about distinct experiences within subgroups. This speaks to the need for a broader program of research on IA within each subgroup of the LGBTQ community to ensure that the within-group differences of these communities are adequately captured.

Regarding measurement, although an EFA supported the measure's validity, confirmatory factor analysis should be conducted to further demonstrate its psychometric properties. Second, several participants noted that for those who practice bondage, dominance, submission, and masochism (BDSM), the physical and psychological abuse items could have been answered "yes" without signaling the presence of abuse. Rather, these acts could have occurred within the context of a consensual sexual or romantic relationship. Assessing the context of "violent" acts would help clarify this issue in future studies. Finally, neither the CTS-2 nor the PMWI or IA Measure captured variability between participants who experienced one act of abuse in their adult lives and participants in ongoing abusive relationships for years. Therefore, critical differences in exposure were not adequately captured in this study.

Research and Practice Implications

Results of this study suggest a number of important avenues for future research. Regarding IA in particular, given the limited number of LGBTQ POC participants in the current study, an important next step in the development of this construct is exploration of the experience of IA within the POC community to clarify whether there are substantive differences in IA based on survivors' intersecting identities (Lewis & Neville, 2015; Nadal et al., 2015). This would be a precursor to further evaluation of the measure in more racially, ethnically, and gender diverse samples to confirm its factor structure and generalizability across the broader LGBTQ community. Upon further

validation, the measure could be used in a variety of ways to further explore the prevalence and impact of IA. Use of a more representative sample of LGBTQ participants would establish its overall and relative prevalence in various communities. Longitudinal research could begin to tease out the ways that IA co-occurs with other forms of abuse across time, how it shapes mental health and wellbeing, and whether in fact stigma and associated constructs might moderate or mediate its links to various outcomes. It could also be modified for use with other groups of participants facing systemic oppression and stigma, including immigrants, people with disabilities, POC, and low-income individuals.

This study also demonstrated a critical lesson for conducting research on partner violence in the LGBTQ community more generally. Such research has focused predominantly (though not exclusively) on lesbian women and gay men. Not only does this exclude bisexual and TGNC individuals, it also excludes identities that have more recently begun to emerge in the LGBTQ community including queer, asexual, pansexual, agender, and fluid identities. This study offered participants a wider range of gender and sexual identity labels, and findings suggest that these distinctions mattered. This raises questions about whether studies that force participants to choose only one label miss critical information. Allowing for more inclusive self-identification may enable LGBTQ researchers to better understand the true complexity of the community, as well as the relative risks and strengths of previously excluded identities and experiences.

Finally, study findings have implications for individual mental health practitioners and for organizations serving LGBTQ individuals. Given that nearly half of this sample reported experiencing IA in adulthood, it is likely that advocates and mental health providers will work with a client who has experienced such abuse. In the absence of training on the nature of IA, service providers are likely underequipped to assist survivors to identify these behaviors as a form of interpersonal violence. In light of this study's findings on the prevalence of IA, service providers and those who train them may consider including this topic in their training on working with IPV and the LGBTQ community.

Summary and Conclusion

The Institute of Medicine (IOM) ended their report on health disparities in the LGBTQ community by stating, "Lesbian, gay, bisexual, and TGNC individuals have unique health experiences and needs, but as a nation, we do not know exactly what these experiences and needs are" (IOM, 2011, p. 4). This study represents a significant step toward illuminating one critical set of

experiences and needs in the LGBTQ community, those related to IA. This study consolidates and further substantiates previous theoretical and empirical work on IA, demonstrating that these tactics are indeed prevalent, particularly at the margins of the LGBT community. It also provides a concrete next step to close the health disparity gap for LGBTQ survivors and a compelling rationale for further study of IA in the LGBTQ community.

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Note

1. We use the phrases intimate partner violence and domestic violence interchangeably to denote partner violence. It is worth noting that domestic violence is sometimes defined more broadly to include violence and abuse perpetrated by relatives. Although many lesbian, gay, bisexual, transgender, and queer individuals experience abuse and/or rejection from family and relatives, the dynamics of partner violence versus family violence may differ dramatically.

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