NEW LENSES FOR SURVIVOR-CENTERED CARE:

LGBTQ+ Community-Informed Practice for Service Providers



National LGBTQ Institute on Intimate Partner Violence
A PROJECT OF THE LOS ANGELES LGBT CENTER
In partnership with the National Coalition of Anti-Violence Programs and In Our Own Voices, Inc.

Partnerships

The National LGBTQ Institute on Intimate Partner Violence was created to significantly enhance the safety, well-being, support, and health of LGBTQ intimate partner violence (IPV) and domestic violence survivors throughout the United States. The Institute is a project of The Los Angeles LGBT Center, the nation's oldest and largest community-based LGBTQ service and support organization, working in close collaboration with the National Coalition of Anti-Violence Program and In Our Own Voices. Utilizing ongoing input from providers, experts, and consumers, the Institute offers state-of-the-art training and technical assistance that significantly expands the capacity of public and private agencies to provide culturally relevant, survivor-centered LGBTQ IPV intervention and prevention services. The program also works to enhance the visibility of LGBTQ-specific IPV needs and intervention strategies, while conducting research to identify and disseminate evidence-informed interventions and overseeing policy initiatives that have a meaningful impact on the quality, scope, and accessibility of LGBTQ IPV services nationwide.

Strength in Numbers Consulting Group (SiNCG) is a research, evaluation and strategy firm focused on LGBTQ+ and other marginalized communities. SiNCG partners with local, regional, national and international social justice organizations, including nonprofits working in service provision and advocacy and grantmakers. It is animated by the commitment to assuring that the most affected communities should be driving data collection, analysis and quantitative and qualitative representations of those communities and the issues that affect them, particularly in studies such as this one that illuminate the underlying structures that drive marginalization and the impacts of those structures.

Acknowledgements

We would like to give thanks to all those who supported this project from beginning to end. We worked with numerous LGBTQ Centers and domestic violence prevention organizations across the country that shared our survey and helped us reach as many survivors as possible. We would also like to thank the National Advisory Board within the Institute that advised this project throughout its progression. Additionally, our Community Advisory Board was immensely important to this project, offering guidance on best practices for connecting with and understanding the experiences of survivors. Lastly, we give appreciation to all LGBTQ+ survivors, as well as the LGBTQ+ victims who have lost their lives. LGBTQ+ people are powerful, resilient, and deserving of safety. Below are the people open to being publicly named as members of the Community Advisory Board or National Advisory Council:

Storm Gaustria

Brooklyn Arizmendi, Indiana Coalition Against Domestic Violence

Faria Tavacoli

Debbie (Dfox) Fox, Fox Den Consulting

Bee Woodcock

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Introduction

In recent years, there has been an increase in awareness among service providers of the elevated risk of intimate partner violence (IPV) for LGBTQ+ communities.[1] Most recent estimates suggest that LGBTQ+ people are two to four times[2] more likely to experience intimate partner violence than their cisgender and heterosexual counterparts. Transgender, bisexual, and BIPOC[3] LGBTQ+ people experience even higher rates. However, less is known about how many of these survivors seek out services and how they describe their experience once they have accessed those services.

This report is for survivor advocates, case managers, therapists, and other service providers who work at mainstream domestic violence service providers not focused on the LGBTQ+ community—that is, those who work in mainstream IPV, domestic violence (DV), or other settings, and will almost certainly encounter LGBTQ+ survivors. It is for new providers as well as those who have been practicing for a long time. The study was designed to answer some of the common questions that the National LGBTQ Institute on Intimate Partner Violence and their partners receive when they conduct outreach, training and technical assistance and to raise new questions about what survivor-centered care can look like for LGBTQ+ people seeking services.

This study is unique in that over half of survey participants were living with a disability (51%); nearly half (47%) were transgender, gender nonconforming, or nonbinary (TGNCNB); and 69% were bisexual, pansexual, and/or queer (bi+). All of these populations are typically underrepresented in research.

The report highlights three categories of recommendations, emphasizing those that are achievable and actionable within the categories: *Build and Collaborate with a Robust Referral Network of Trustworthy Providers, Continue Your Learning Journey, and Have Open Conversations*.

It also focuses on specific populations and issues that emerged from the study, including people living with a medical condition or disability, people who are bi+, and TGNCNB people.

Highlight Findings and Recommendations

This study was created by the National LGBTQ Institute on Intimate Partner Violence to illuminate the diverse experiences of LGBTQ+ survivors. As the introduction demonstrates, there are more studies of intimate partner violence than ever before, but very few of them illuminate the variety of survivors' lived realities. While each survivor's experience is unique, studies like this one can show patterns in disparities within the community that allow for creative and effective solutions.

Domestic violence service providers are essential partners to LGBTQ+ communities—both those who identify as a member of the community and those who are eager to learn more. One of the key ways that providers can contribute is to participate in training and encourage others to do the same.

You can request free training and technical assistance from the National LGBTQ Institute on Intimate Partner Violence by going to our website to learn more.

This study shows . . .

In this study, the most common form of abuse was emotional (83%). Stalking (61%), isolation (53%), and physical abuse (39%) were also very common.

Nearly half (45%) of survivors successfully obtained services related to IPV from a professional in the past three years. Many had accessed multiple services in that time, with the most common being a therapist (85%). About one in six (18%) were most recently served by a rape crisis center, domestic violence shelter, or similar survivor services organization.

Concerningly, just one in five (20%) survivors who saw a provider saw one who could address their physical health needs—and those who experienced sexual abuse were no more likely to have seen this type of provider than those who did not (22% vs. 19%). Survivors of sexual abuse were not meaningfully more likely to be screened by service providers for sexual health needs or reproductive coercion than survivors who did not experience sexual abuse (24% vs. 20%).

Service providers were less able to increase survivors' access to concrete, material needs such as financial resources (20%) and housing (23%) than they were to meet emotional needs such as affirmation (66%). In contrast, about two thirds (67%) said the recent service provider they saw increased their access to safety, and over half (55%) said the service provider increased their ability to leave the abuser.

The report highlights the unique experiences of transgender, gender-nonconforming, and nonbinary participants. GNCNB participants were about 50% more likely to experience emotional abuse (87%) than were all other participants (81%). Transgender participants were 70% more likely to have experienced identity abuse (36% vs. 25% of those who did not identify as transgender). Transgender participants were also more likely to experience financial abuse (25% vs. 16%).

TGNCNB participants were nearly as likely to access services as cisgender participants (46% vs. 43%), but the overall level of service-seeking is low and remains concerning.

Participants living with a disability were nearly twice as likely to experience sexual abuse (43% vs. 29%) or identity abuse (35% vs. 24%) and more than twice as likely to experience emotional abuse (92% vs. 84%).

The report also highlights how all service providers working with LGBTQ+ IPV survivors can develop their skills and knowledge, examine any internal biases or misconceptions they may hold, and develop and curate a robust network of referral resources.

It offers information specifically for *DV Service Providers and for Individual Therapists, Psychiatrists, and Psychologists* and contains sections focusing on specific populations represented in the survey: people living with disabilities and medical conditions; bisexual, queer, and pansexual (bi+) communities; and trans, gender-nonconforming, and nonbinary communities.

Methods for Survivor-Centered Research

This methods section focuses on the choices made by the researchers that are most impactful and of interest to a broad audience. More detailed methods are available by request to the authors.

This survey was designed by the National LGBTQ Institute on IPV and Strength in Numbers, utilizing community input from an LGBTQ+ survivor advisory board. It is reflective of community-based outreach and is not a representative sample of LGBTQ+ survivors. All LGBTQ+ survivors who were adults living in the United States and Puerto Rico were invited to take the survey; surveys were included if the participants met these criteria, consented, and completed all questions on demographics and IPV experiences.[4] There were 465 surveys used in the analyses for this report.

Questions about race, gender, sexual orientation and experiences were designed for the survey participants to select all options that reflected their identities and experiences. Participants could also write in responses to these questions, which were recoded into existing or new categories. The survey included a list of specific abuse experiences that are common for IPV survivors, but it did not include all possible types of harmful behavior and did not exclude those who identified as survivors but did not select any of the listed behaviors. All data is self-reported. Questions about IPV and service provider experiences in this study refer to the "past three years (2023-2025)" unless otherwise noted.

Many of these questions are sensitive, so most included answers such as "not sure" or "prefer not to say." Except where noted for context, these responses are excluded from analyses.

In order to protect participants, no statistics are shown that reflect fewer than 20 survey responses to a question or fewer than 5 responses in any given response to the question.

All differences noted in the text (e.g. "larger than" or "twice as" or similar phrasing)[5] are statistically significant ($p<.05$). In rare cases, when tests approach but do not meet statistical significance *and* the differences are large and have a practical significance or interest to the audience, this is noted in the text using the phrase "approaches significance." When percentages might appear to be different from one another but are not statistically different, the text indicates that one was "not meaningfully" larger or more likely than the other. Instead of comparing the raw percentages directly (for example, 50% vs. 25%), the report uses odds ratios, which describe how much more likely one group is to experience something compared to another group. This is why the report might say "TGNCNB participants were twice as likely to experience physical abuse," even though the percentage of TGNCNB participants is not a simple doubling of the percentage of cisgender participants. For more information on the methods used, please contact the authors.

Language

Language and terminology that people in the LGBTQ+ community utilize can vary across time, location, cultures, and subcultures. The survey uplifts how participants identify (their internal sense of who they are) rather than their assigned sex or gender expression. The design for the survey allowed for participants to self-identify in the ways that best fit them, asking: "What is your current gender identity? Please check all that apply." Rather than "woman" and "man," offered responses included: "woman/female/femme/feminine" and "man/male/masculine."[6]

All gender identity categories that use data from this survey include participants who also selected gender identity categories *other* than the category being referenced. For example, references to "male" participants include those who selected "male" only, as well as those who selected "male" and other categories including "transgender," "nonbinary," and/or other genders.

This section highlights a few of the evolving and fluid terms used by the LGBTQ+ survivor community and explains how we identified those community members using the data collected for this report. For more information, please consult the LGBTQ+ Glossary provided by the Institute.

> **A transgender person** is a person whose sex assigned at birth (male, female, or intersex) does not align with their gender identity. The report uses "trans" interchangeably to identify participants who selected "transgender." Transfeminine participants selected transgender and woman/female/femme, while transmasculine participants selected transgender and man/male/masculine.
>
> "Transfeminine and transmasculine people" refers to people whose gender is aligned with femininity or masculinity—whether or not they identify strictly as a "woman," a "man," a "transgender woman," or a "transgender man."
>
> **Nonbinary people** understand their gender to exist outside of the gender binary. This report uses the category GNCNB to also include those who identified their gender on the survey as gender-nonconforming or genderqueer. Genderqueer and gender-nonconforming people often use those terms to signal resistance to cultural norms around gender. For example, a woman/girl whose gender expression is not feminine might describe themselves as gender-nonconforming.
>
> **A cisgender person** is someone whose gender identity aligns with the sex they were assigned at birth; in the survey, cisgender participants are those who selected male or female and no other genders.

A binary variable was created with two mutually exclusive categories: TGNCNB (those who selected at least one of the following, regardless of how many other genders they selected: transgender, nonbinary, or gender-nonconforming) and cisgender (those who did not select any of the preceding options and selected only "female" or "male"). This excludes a small number of participants who did not fall into either category.

In this report, GNCNB will be used to represent participants who selected one or both "nonbinary" and "gender-nonconforming." TGNCNB includes these participants and those who identified as trans.

In this survey, trans nonbinary participants are those who selected trans as a gender identity and either both male or

female or neither male nor female (regardless of what other genders they selected).

We use the words "survivors" and "(survey) participants" interchangeably throughout this report to illustrate that those who took the survey are both participants in research (not passive subjects) and survivors of IPV. We use the term "IPV" when discussing the abuse experiences of survey participants and when identifying IPV survivors specifically. We recognize that many service providers may see a broader category of survivors who experience domestic violence. Domestic violence is generally seen as encompassing IPV as well as abuse within familial relationships that are not intimate partnerships, such as elder abuse and child abuse.

> **Homophobia** and **transphobia** reflect hostility and violence towards LGBTQ+ people, while **cissexism** and **heterosexism** reflect a view that being cisgender and heterosexual is the default or norm. Even in the absence of overt homophobia and transphobia, cissexism and heterosexism can cause great harm to LGBTQ+ people. IPV experienced by LGBTQ+ survivors can have elements of all four of these.

Rather than conducting and writing up a traditional literature review, we offer examples of high-quality peer reviewed papers in the endnotes of the report for those who are curious to read more. We highlight resources to address the issues raised in the report in special pull-boxes and illustrations.

This report focuses on relationships between one primary aggressor and one survivor; however, it is important to note that IPV can and does occur in polyamorous relationships, triads/throuples, consensually non-monogamous relationships (CNM) and other non-dyadic intimate relationships. This study also did not focus on relationships that involve consensual eroticization of power and domination, such as kink or BDSM; it uses language such as "Followed you or watched you when you didn't want them to" to emphasize the importance of identifying lack of consent as the feature that distinguishes abuse.[7]

Findings

Findings are organized into a description of the survey participants, experiences with service providers and outcomes of experiences with services providers. Additionally, there are key takeaways, recommendations, and resources, as well as spotlight sections about TGNCNB participants, bi+ participants (referring to those who identified as bisexual, pansexual, and queer) and people living with disabilities or affected by medical abuse.

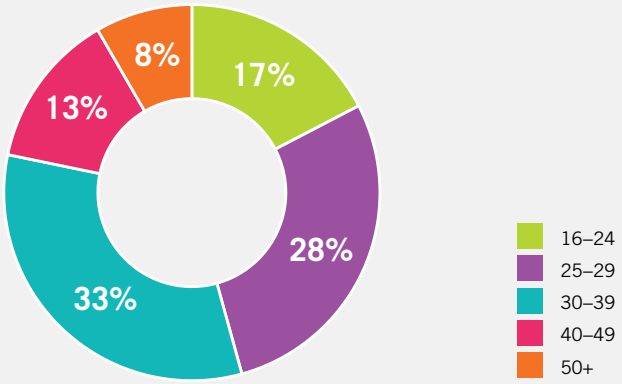
Who Took the Survey?

Along with demographics such as age, race, gender, sexual orientation, income, education, and others, the survey collected data on experiences that both create barriers and vulnerabilities for survivors of IPV and are more common among LGBTQ+ people than their cisgender and heterosexual counterparts.

As this section shows, survey participants—and LGBTQ+ people more generally—are more likely to have been homeless,[8] in foster care,[9] to be living with a disability, and to have experience in the sex industry. IPV survivors are also more likely to have experienced homelessness and housing instability,[10] foster care,[11] and to be living with a disability.[12]

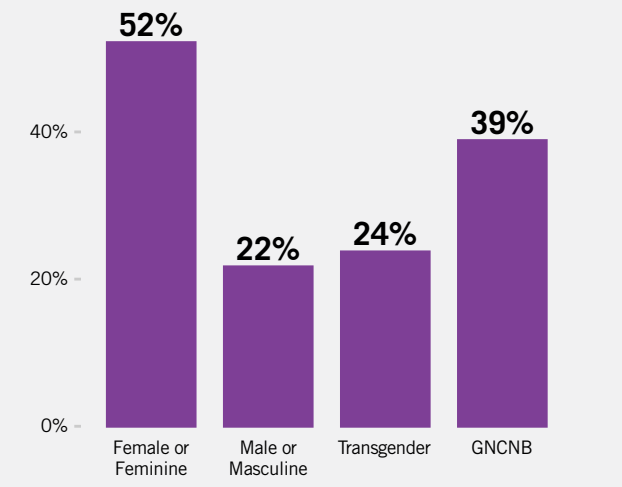
While survey participants ranged throughout the life course, the largest number were in their middle years (25-39), with younger and older survivors less represented in the sample.[13]

Age

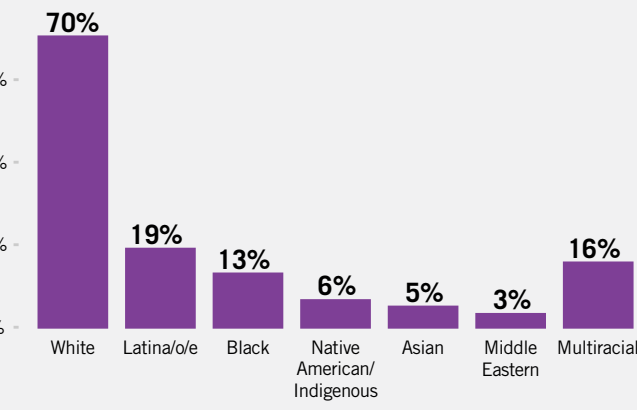


Over half of the sample identified as female (52%), while fewer identified as male (22%). Large numbers also identified as gender non-conforming, genderqueer and/or nonbinary (39%). Just over half (53%) identified as only male or only female and no other genders (a category called here "cisgender").

Female, Male, Trans and GNCNB Gender Identities



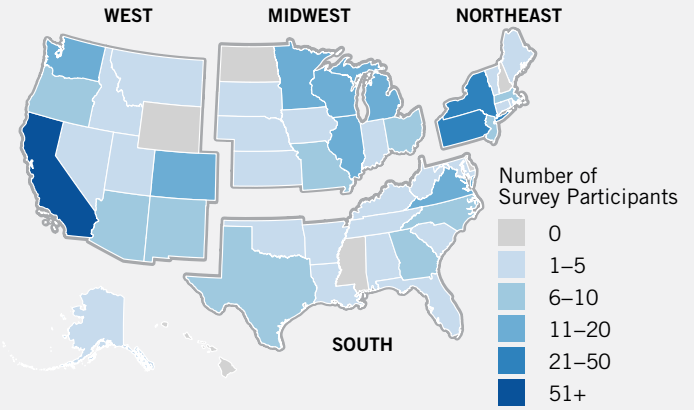
Race and Ethnicity



About two in five (42%) participants identified as BIPOC (one or more of: Latina/o/e, Black, Native, Asian, Middle Eastern), and about one in six identified as multiracial (16%). Among participants of color, the largest number identified as Latina/o/e (45%), with fewer identifying as Black (31%).

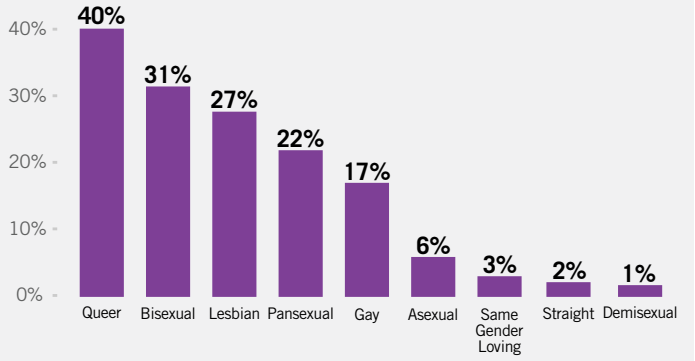
Over one-third of survey participants were from the Western region (36%), followed by 24% from the South, 21% from the Midwest, and 18% from the Northeast.

Region



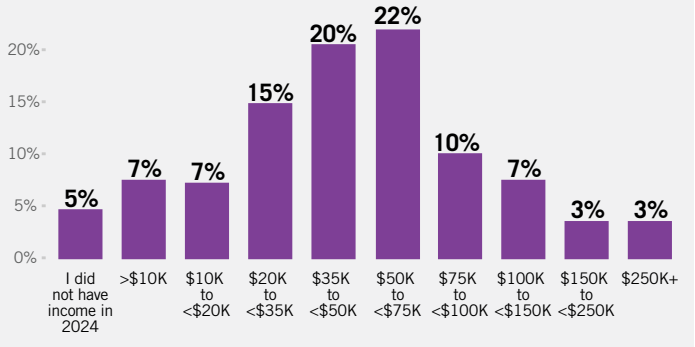
Fully 69% of survey participants identified as bisexual, pansexual, and/or queer, while smaller numbers identified as lesbian (27%) or gay (17%). Further information on bisexual, pansexual, and queer survivors (referred to here as "bi+") is in the Spotlight on page 10.

Sexual Orientation



Survivors of all income levels were represented; just over half (54%) had incomes below $50,000 in 2024.

2024 Income



Around one in five (21%) were currently enrolled in school. Of those 25 or older, just six percent had a high school education or less. Fully 70% of this group had a college degree or professional degree as their highest level of education, making this a very well-educated group of survey participants.

Just 14% were married, with a further 25% dating. The remainder were single, partnered but not married, divorced, separated, or widowed. About 18% had children living at home. Just 3% of those who answered questions about citizenship were noncitizens (18% did not respond[14]).

About half (51%) were living with a disability (see Spotlight on p. 9).

Experiences with unstable housing—such as having been in foster care (8%) or being currently (3%) or recently (19% in the past five years) homeless—were reported commonly among survey participants, mirroring the experiences of LGBTQ+ people and IPV survivors alike in the general population.

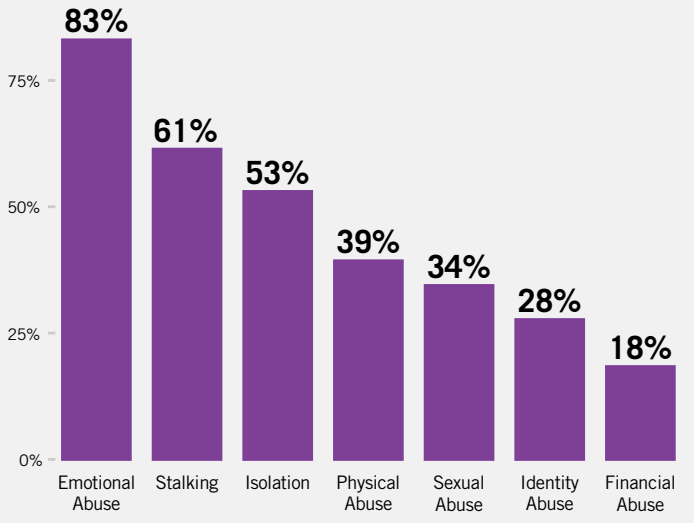
Experiences working in the sex industry are more common among LGBTQ+ people,[15] particularly transgender women.[16] About one in six (16%) survey participants reported having exchanged sex for money or other things of value in the past five years.

Survivors' IPV Experiences

Types of IPV[17]

Discussions of IPV tend to focus on physical abuse, sexual abuse, and stalking behavior over other types of abuse.[18] Fewer people think of emotional abuse (sometimes also called "coercive control") and financial abuse[19] as part of IPV. Further, identity abuse—which can include forceable "outing," revealing something about the survivor that may be stigmatizing, or invoking stereotypes or myths about a survivor's identities—is one of the most important but least understood forms of abuse experienced by LGBTQ+ survivors. Resources about identity abuse for DV service providers and others can be found here. DV service providers can also encourage other types of professionals who work with LGBTQ+ survivors to obtain training about easy-to-miss forms of abuse (see "Easy to Miss" on p. 8).

Types of Intimate Partner Violence



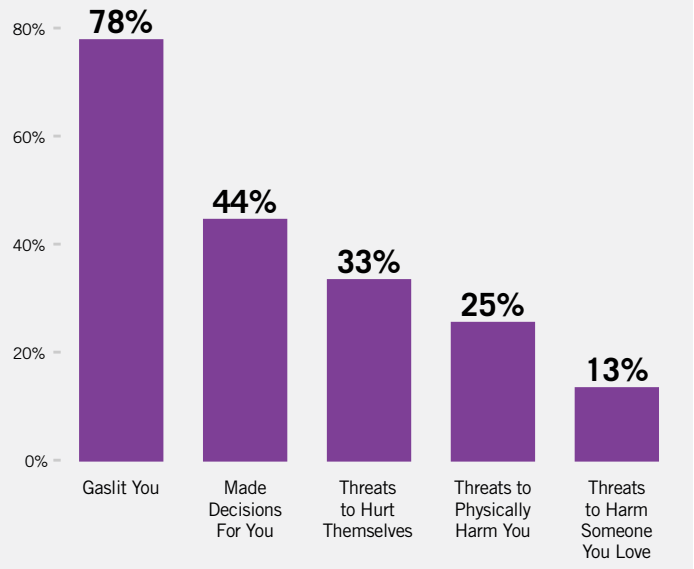
This study asked participants to identify which of 17 abuse experiences[20] applied to them. They were able to select multiple responses, and on average, five were selected. Along with three additional types of abuse that were applicable only to a subgroup of participants, these abuse experiences were organized into eight major types of abuse, which are described in the chart below and on the following pages (medical abuse is presented separately because it was only relevant to participants who were using assistive devices or medications).[21]

In this study, the most common form of abuse was emotional (83%); physical abuse (39%) and sexual abuse (34%) were also very common. On average, participants experienced three types of abuse, with the most common overlapping patterns including combinations of stalking, emotional abuse, and isolation.

This section outlines the behaviors that define each abuse type. For some types, like emotional abuse, survivors could have experienced one or many of several behaviors. For others, such as identity abuse, only one question defined the type. All graphs show how common the specific experience was among *all* survivors.

Emotional abuse, which was experienced by over four in five survivors (83%), took many forms, including gaslighting or "Ma[king] you question or second guess your own feelings, memories, instincts, and/or sanity." Abusers also made decisions for the survivor (44%) or threatened to hurt themselves (33%), the survivor (25%), or someone loved by the survivor (13%).

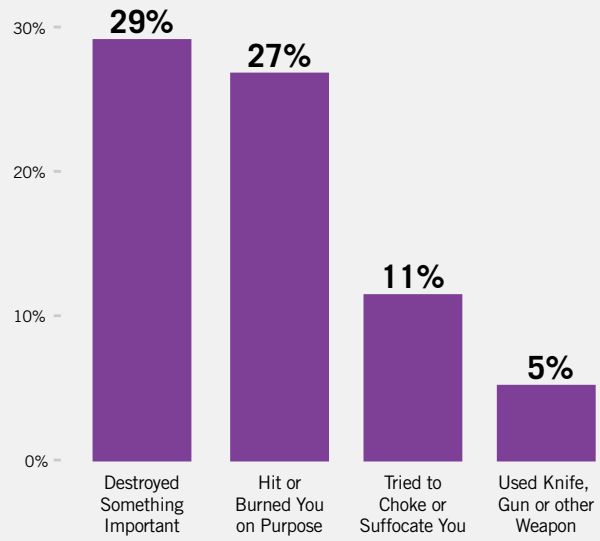
Experiences of Emotional Abuse



Identity abuse—revealing something about the survivor's identity that they wanted kept private—was common among survey participants (28%). This is significant because, as described in the accompanying text box, *Easy to Miss*, identity abuse relies on the need some survivors feel to keep stigmatized identities private.

When discussing intimate partner violence, the most common image of a survivor is one who has experienced physical abuse (39%). Over one in four participants had experienced being slapped, pushed, kicked, hit, or burned on purpose (27%). As the next section discusses, too few of them sought medical attention for their experiences. It was far less common for perpetrators to use a knife, gun, or other weapon, with just one in twenty (5%) of participants reporting this happened to them.

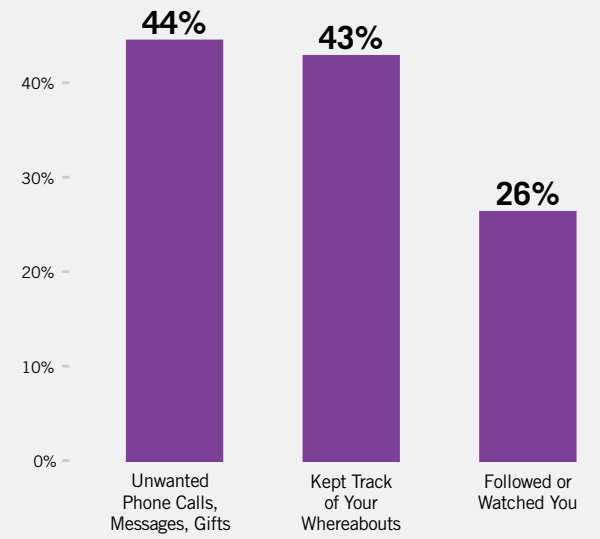
Experiences of Physical Abuse



Survivors are often isolated by perpetrators because isolation from family and friends can increase the perpetrator's sense of control over the survivor. Over half (53%) of survivors reported this, with being "kept from … family and friends" reported as the most common form of isolation (47%).

Stalking (61%) was reported by almost two-thirds of survivors. This included three experiences of abuse that are not always well understood, including sending unwanted phone calls, messages, or gifts (44%); keeping track of the survivor (43%); and "following" or "watching" the survivor when the survivor did not want them to (26%).

Experiences of Stalking



Into Focus

Easy to Miss: Survivor-Centered Perspectives on Emotional, Identity, and Financial Abuse

Emotional abuse (83%) was very common among survivors, as were identity abuse (28%) and financial abuse (18%). These are sometimes under-recognized by service providers. Emotional abuse involves "persistent emotional mistreatment by an intimate partner" and often includes gaslighting, threats, and insults.[22] Identity abuse is sometimes wrongly treated as a subset of emotional abuse, rather than as a specific type of abuse related to threats to reveal something private and stigmatized about the survivor or their identity/identities. Fully 28% of survivors who participated in this survey indicated that the abusive partner had revealed something about the survivor's identity that they wanted to remain private.

Financial abuse is beginning to be recognized more fully by providers, but it is still not fully incorporated into our understanding of IPV more generally. Like emotional abuse and identity abuse, financial abuse affects the LGBTQ+ community more than it does cisgender or heterosexual people, with this being particularly true of TGNCNB people.[23] As noted on p. 14 in the section discussing reporting to police, those who experienced financial abuse were more likely to want to report it than those who did not experience financial abuse (32% vs. 20%)[24]—but those who experienced financial abuse were not meaningfully more likely than others to say they discussed this with a provider (60% vs. 54%).

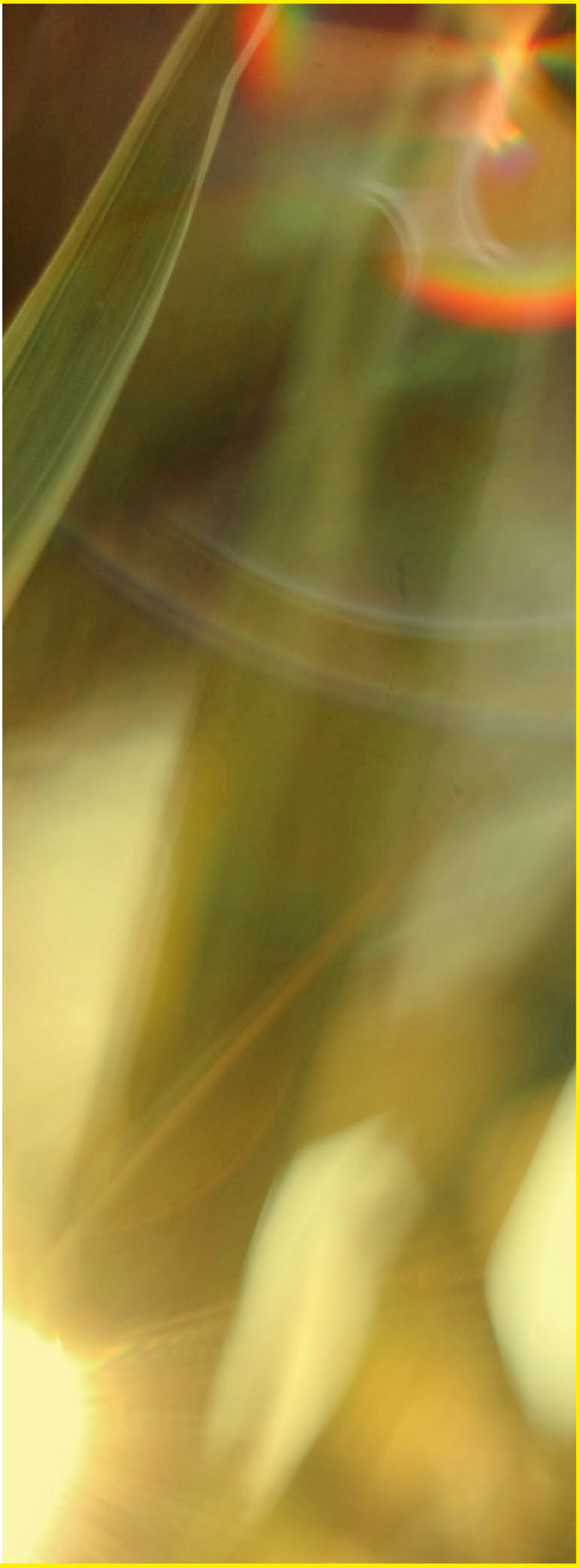
Having Open Ended Conversations: Ask About Under-Recognized Forms of Abuse

While screening tools exist for emotional and identity abuse in the general population, they can include heterosexist and transphobic assumptions. Experienced providers at the Institute suggest that these types of abuse are more likely to surface through conversations between providers and survivors.

One financial abuse screening tool that is promising for LGBTQ+ survivors (as well as cisgender heterosexual survivors) can be found on page 9 of this resource.

Continue Your Learning Journey About Identity Abuse

Like emotional and financial abuse, identity abuse can be experienced by any survivor. LGBTQ+ survivors are particularly vulnerable to this type of abuse because they are part of stigmatized and marginalized communities and may be working to hide those identities. Identity abuse among LGBTQ+ survivors can include forms of stigma other than transphobia and homophobia. For example, survivors living with a disability were almost 75% more likely to say they had experienced identity abuse than those who were not living with a disability (35% vs. 24%).

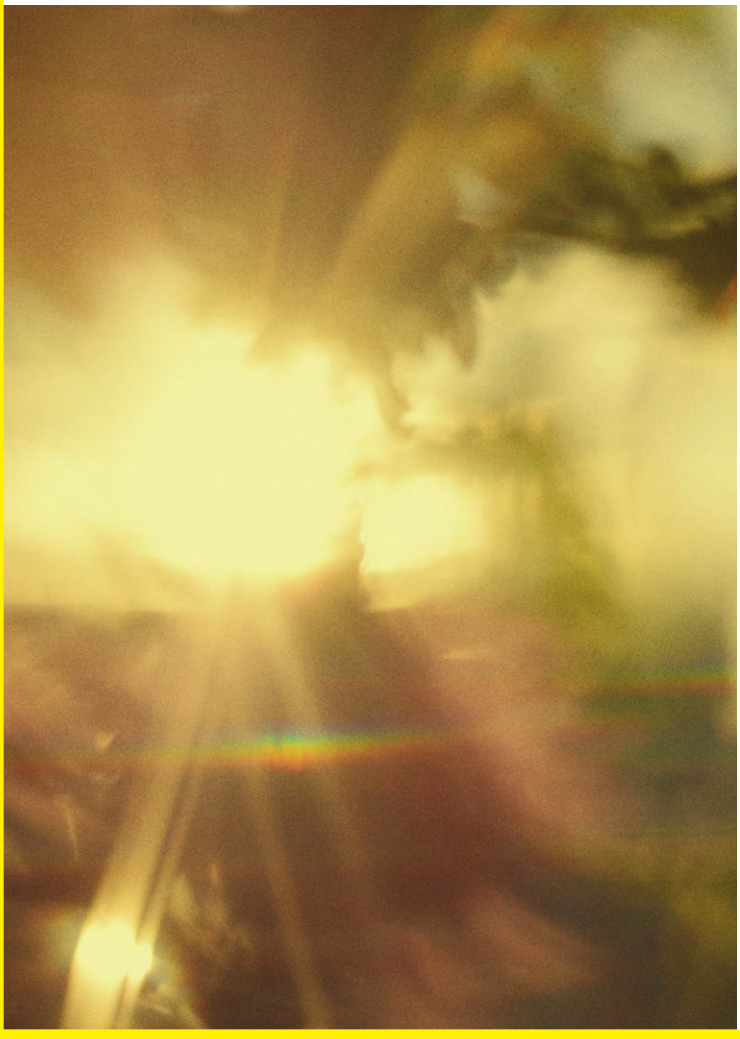


Spotlight
Survivors Living with Medical Conditions and Disabilities

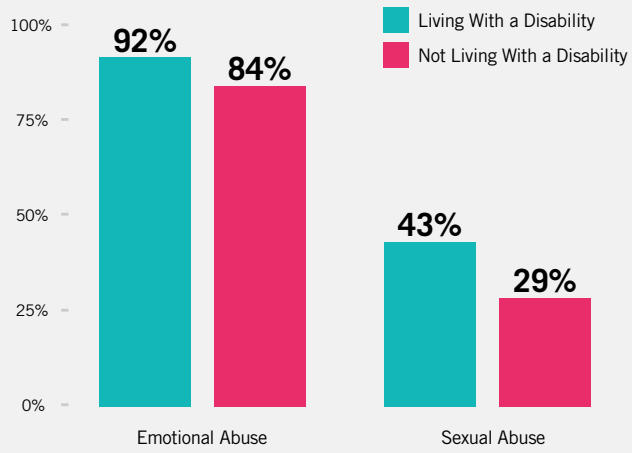
Literature on the general population suggests that people living with medical conditions and disabilities are more likely to be survivors of IPV than are those who are not.[25] Over half of survey participants were living with a disability (51%) and they were nearly twice as likely to experience sexual abuse (43% vs. 29%) or identity abuse (35% vs. 24%) and more than twice as likely to experience emotional abuse (92% vs. 84%), compared to those not living with a disability.

The survey also asked participants (including those who did not identify as having a disability) if they were denied access to assistive devices or necessary medical care for a disability (12%) or prevented from accessing needed medication (14%), including hormone therapy. These two questions were considered medical abuse, which affected 22% of the survivors who responded to these questions.

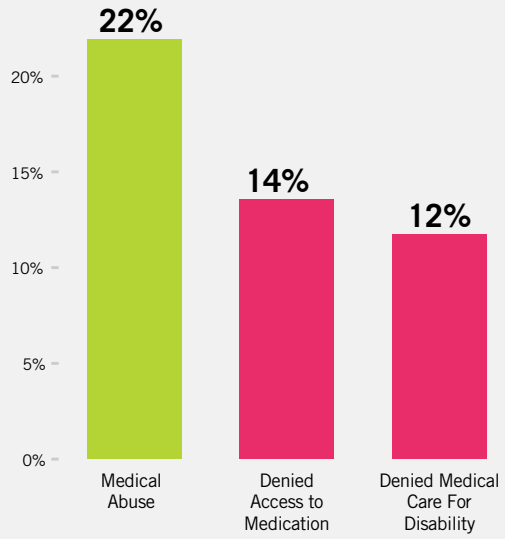
These experiences were particularly common among participants who identified as gay, with 37% saying that they were denied access to assistive devices or necessary medical care for a disability or needed medication, compared to 19% of all others. This could indicate that perpetrators are denying survivors access to HIV medication or HIV prophylaxis, as this is a well-documented form of abuse specifically affecting gay men.[26]



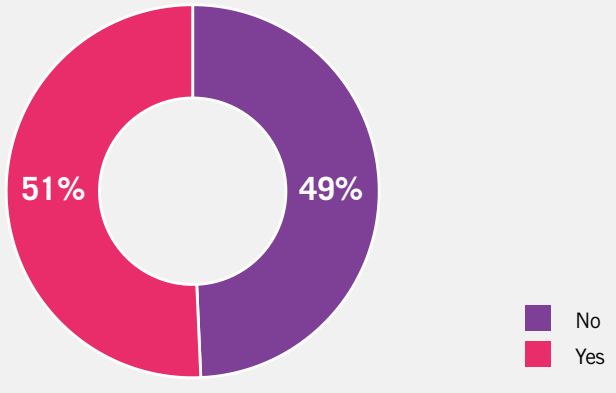
Experiences of Emotional or Sexual Abuse



Experiences of Medical Abuse



Living With a Disability



Spotlight
Bisexual, Pansexual, and Queer Communities

Nearly seven in ten (69%) survivors in this study identified as bisexual, pansexual, and/or queer, a community we refer to as "bi+." These three categories were grouped together to describe people who are not monosexual, meaning only attracted to people of one gender. This group provides an illustration of how complex identity can be for LGBTQ+ people, demonstrating the importance of focusing on identity and not on appearance or initial presentation.

Specifically, bi+ people were far more likely to select more than one sexual orientation than were those who were not in the bi+ community (49% of bi+, compared to 6% of all others); almost 15% of bi+ people selected three or more sexual orientation identities.[27]

This community experiences high rates of IPV, and they face particular challenges when seeking services. One of those challenges is that perpetrators weaponize stereotypes of bi+ people. This includes stereotypes that bi+ people "confused," or that they are "really" heterosexual or gay.[28] Another stereotype that some abusers exploit is that bisexual people are more likely to cheat or to be untrustworthy in relationships. For example, in this study, fully half (50%) of bi+ participants said that they were accused of untrustworthiness or cheating because of their bisexual identity.

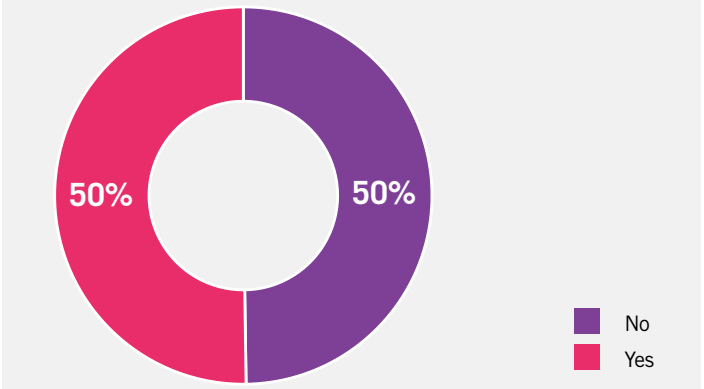
Further, bi+ survivors can be overlooked as part of the LGBTQ+ community if they are in a heterosexual-presenting relationship. People who identify bi+ can identify as any gender and can have partners of any gender. The gender of current or previous partners does not define sexual identity.

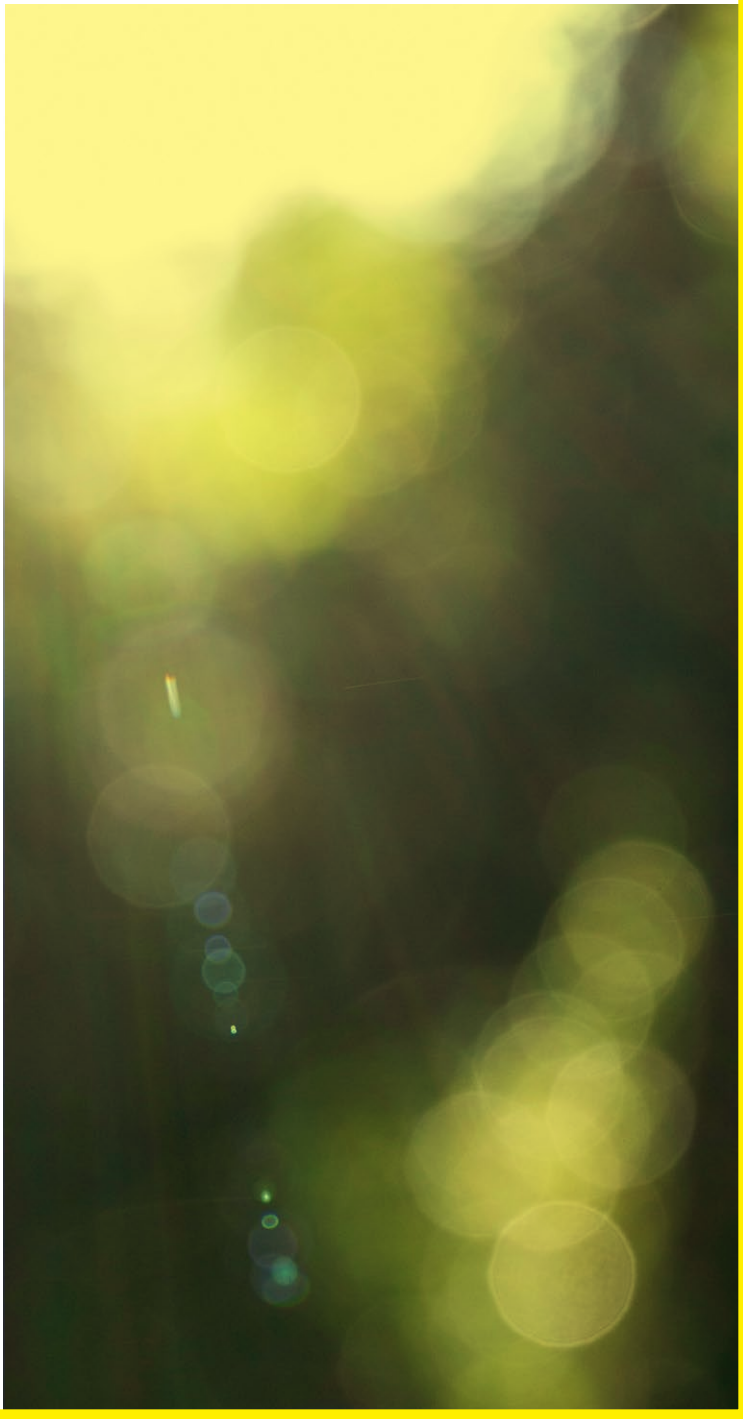
While in many ways bi+ survivors were similar to others (for example, they were no more likely to have experienced any particular type of abuse or to report more different types of abuse), bi+ survivors were less than half as likely to have most recently seen an DV service provider (15% vs. 29% of all others) or to have made a safety plan (63% vs. 79% of those not bi+).[29] They were less than one third as likely to say they always "feel seen" by their provider (53% vs. 79%).

Having the Conversation: Open-Ended Questions

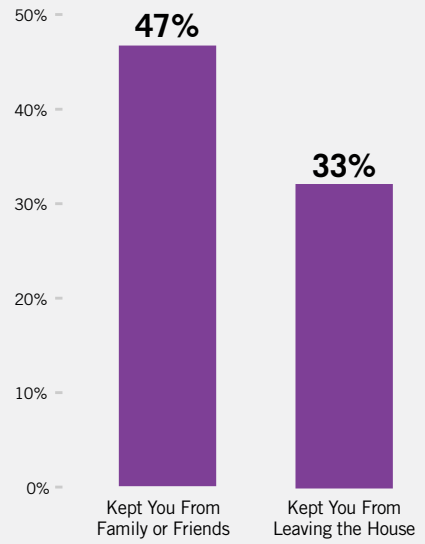
DV service providers are likely serving many bi+ survivors without realizing it. Bi+ survivors may not be receiving LGBTQ+ inclusive services and may not feel safe or comfortable sharing their identity because of heteronormative assumptions about who they are. As with all survivors, *recognition* of the important identities bi+ people hold allows providers to more fully meet their needs. Bi+ people may feel alienated from services if providers make assumptions about the gender of their partners or make assumptions about their identity based on the gender of their abusive partners. It is therefore critical that DV service providers use gender inclusive language, avoid making assumptions about clients' sexual orientations, and provide LGBTQ+ inclusive language and resources to all clients.

Bi+ Survivor Accused Of Untrustworthiness Due To Bisexual Identity

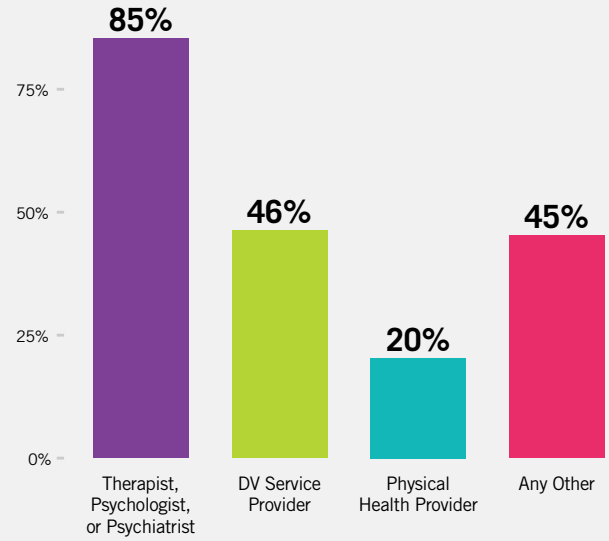




Experiences of Isolation



Types of Service Providers Seen in Past 3 Years



Seeking Services

Slightly under half of participants (45%) had seen a service provider in the past three years (2023-2025). This section includes only those participants who have seen a provider in the past three years.

Among those who sought any services, therapists, psychologists, and psychiatrists were the most common providers seen. About 85% of survey participants indicated they had seen one. Just under half (46%) had seen a DV service provider or provider at a DV specific location (such a rape crisis center or domestic violence shelter), a sexual assault service provider, a forensic nurse, or a survivor or victim advocate. Just under half (45%) had seen some other type of provider (such as going to a support group or seeing a social worker).

Concerningly, only one in five (20%) survivors who saw any provider saw a physical health provider at all in the last three years.

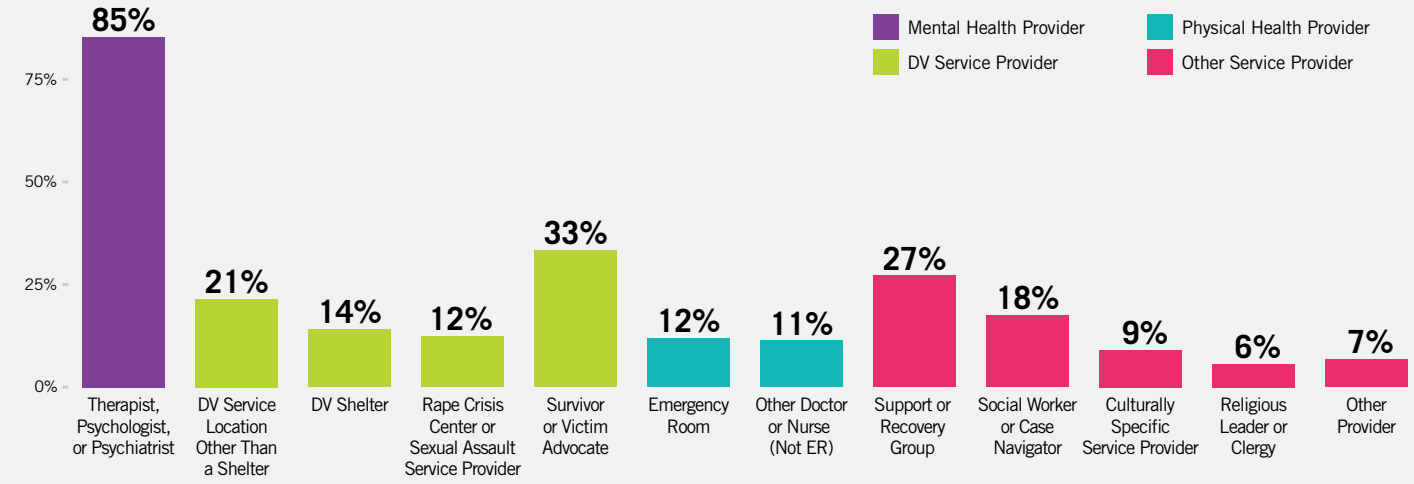
In addition to being asked if they had ever seen a specific type of service provider, they were asked about the most *recent* service provider they saw[30] to understand their experiences with specific service providers.

Survey participants were asked about their experiences with screening, receiving services around housing, safety planning, and reproductive coercion, each of which is relevant to cisgender and heterosexual survivors as much as it is to LGBTQ+ survivors.[31] About two-thirds (64%) agreed that "Someone conducted a screening to identify needs I might have," while even more said that "We made a safety plan or identified ways to stay safe" (67%).

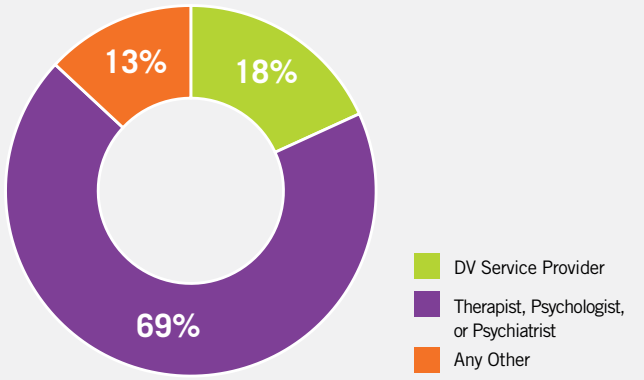
LGBTQ+ Specific Supports

Many LGBTQ+ survivors come to service-provision settings with apprehension, wondering if they will be taken seriously or if they will be treated less well because they've had bad experiences in other settings, including places where they've previously sought help to address their needs. Many of the experiences with service providers described in the survey were very positive and signaled to LGBTQ+ survivors that they are welcome. For example, 85% reported that the service provider they saw most recently always used the correct pronoun for them and 80% reported that this was true for the service providers use of pronouns for the perpetrator. Almost three in five (58%) participants in the current survey said "yes" to the

Specific Service Providers Seen in Past 3 Years



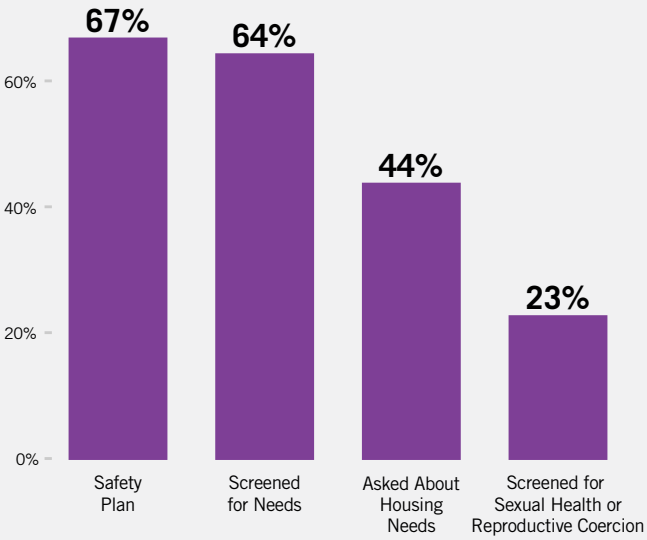
Most Recent Service Provider Seen



statement, "There were images of LGBTQ+ people present in the space, pronoun pins, rainbow flags or pins or other LGBTQ+ visuals." Survivor-centered DV providers are always working toward 100% implementation of best practices, including correct pronoun use and signaling to all survivors that they are welcome, but these numbers are very promising.

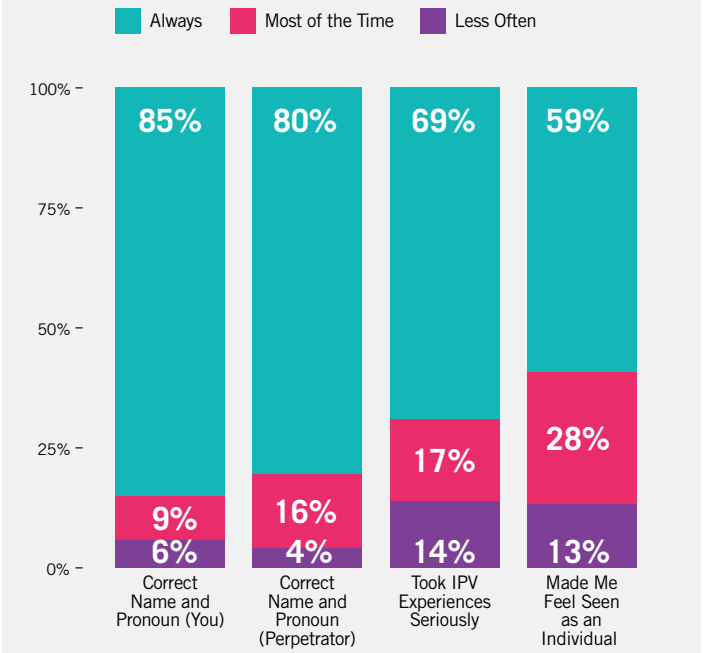
In a recent study of DV service providers by the National LGBTQ+ Institute on IPV, two-thirds (64%) of survey participants agreed or strongly agreed with the statement "our staff reflects the LGBTQ+ community," while in this study of survivors, 55% of participants selected "yes" to the statement, "The provider I saw or someone else in the space there seemed like they were in the LGBTQ+ community." This further shows that while staffing and representation of LGBTQ+ communities could improve, the gap is bridgeable. Finally, 52% of service providers in the prior study reported that "Needs around visually indicating LGBTQ+ inclusion efforts" were an area of some need or critical need. Clearly, service providers are making strong inroads—and there is still room for growth.

Service Provider Screening and Planning



When asked about the most recent service provider they had seen, the survivors in this survey reported high levels of positive experiences: 69% said that they "always" felt taken seriously, and 59% said that they "always" felt seen as an individual. Fully 69% felt that they "never" received less good service than others.

Provider Pronoun Use and Affirmation



Effects of Service Provision on Survivor Well-Being

Of those who were screened for their IPV-related needs, 33% said that the service provider was able to completely address the needs identified, 40% said needs were "somewhat" addressed, and 26% said that they were not addressed at all or addressed a little bit.

Fewer survivors reported that their experiences with service providers resulted in more material resources and support, compared to those who said those experiences improved their connections to community, relationships, and their sense of a positive future. For example, just 20% of survivors who saw a service provider reported that it increased their financial security.

A larger number of participants said that the most recent service provider they saw increased their future options, safety, and ability to leave than said that their material needs were met. The same was true for connections to community. However, given the prevalence of isolation as a tactic of abuse, this area could benefit from more attention.

Spotlight

Medical Care for Survivors

Just 20% of survey participants who had seen a provider at all had seen a physical health provider, such as a provider in an emergency room or another health care provider. Those who experienced physical abuse were three times as likely as those who had not to have seen a physical health care provider (30% vs. 11%) and those who experienced medical abuse were five times as likely as those who had not (48% vs. 15%). However, those who has experienced sexual abuse sought physical health care at approximately the same rate as those who did not have this experience (22% vs. 19%).

Survivors of sexual abuse were not meaningfully more likely to be screened for sexual health or reproductive coercion than survivors who did not experience sexual abuse (24% vs. 20%). This suggests that screening and referrals in this area may need particular improvement.

Any kind of abuse can result in physical health problems (e.g. stomach and digestive problems, headaches, lack of sleep). Regardless of what type(s) of abuse a survivor has experienced, it is crucial that DV providers screen for health problems and needs and provide linkages to healthcare resources.

Referrals to Medical Providers

DV providers may find that referrals to and from medical providers are crucial to assuring that survivors receive appropriate medical care from trauma-informed and LGBTQ+ inclusive providers. Some geographic areas may find these providers more easily than others. Service providers should address physical health needs as a core part of the services they provide and build robust networks of referrals and relationships with healthcare providers.

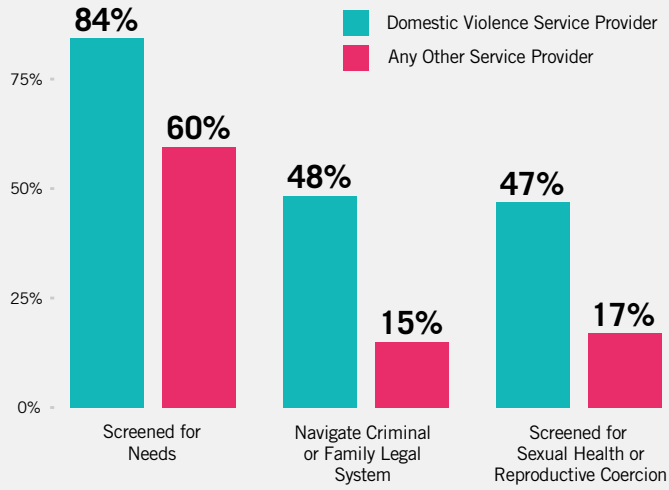
Into Focus

Survivor-Centered Strengths: DV Service Providers Meet Crucial Needs

Survivors who reported their most recent experience was with a DV service provider were over four times more likely to report that their ability to navigate the criminal or family legal systems increased (48% vs. 15% for all other providers). As a result of seeking those services, they were screened for any needs they might have related to IPV (84% vs. 60%) and for sexual health and sexual coercion (47% vs. 17%).

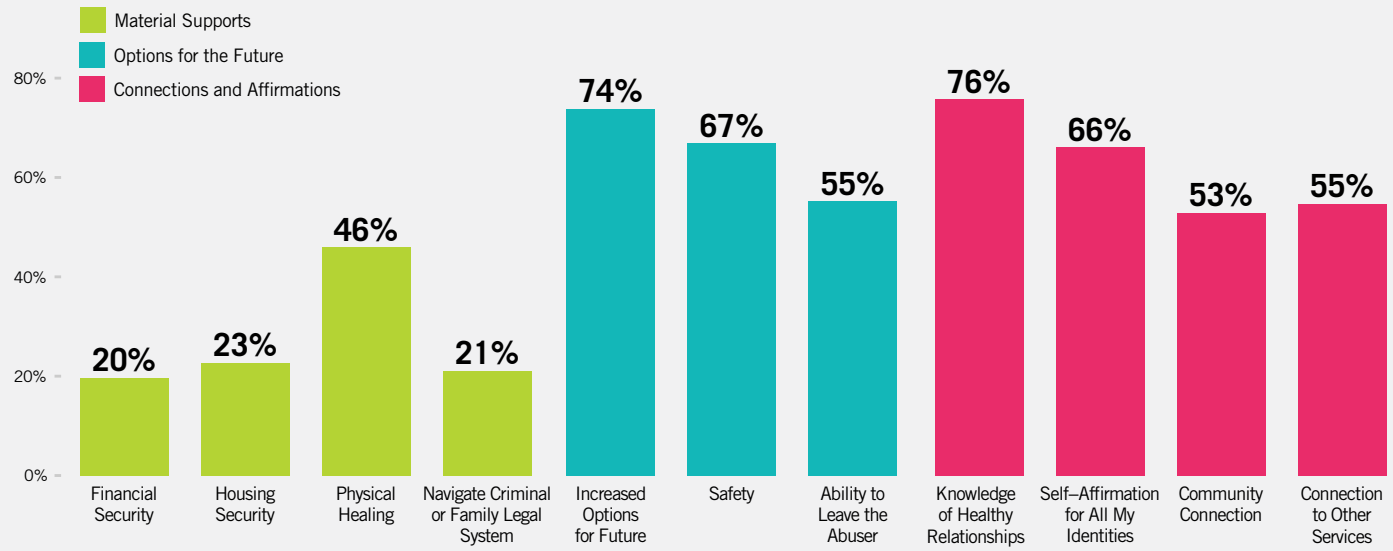
These findings suggest that providers have unique strengths in supporting survivors, and while strengthening the skills of each provider can result in improved outcomes in areas that need growth, a robust network of skilled and competent providers can also assure that survivors are able to be holistically supported.

Screening and Support





Supports to Survivors



Reporting to Police

Just 24% of survivors who saw a service provider reported that they wanted to report their experiences to the police before seeking services. Just over half of those who saw service providers (55%) discussed reporting to the police with the most recent provider they saw; nine in ten of those who had these discussions felt support for their decision to report or not report (90%).

Those who experienced physical abuse wanted to report (33%) and *discussed* reporting with providers (68%) at nearly three times the rates than those who did not experience physical abuse (15% and 43%, respectively). To a lesser extent, those who experienced financial abuse were more likely to want to report it compared to those who did not experience financial abuse (32% vs. 20%)[32]—but those who experienced financial abuse were not meaningfully more likely than others to say they discussed this with a provider (60% vs. 54%). Those who experienced sexual abuse and/or stalking were no more likely to *want* to report or to discuss reporting with providers than those that did not, although those are issues that have criminal justice responses in ways that medical abuse, emotional abuse, and identity abuse do not. Even though it is clear that many LGBTQ+ survivors did not want to report to police, it is also of concern that this was not coming up in their conversations with providers.

Given the police's history and continued mistreatment of the LGBTQ+ community, many LGBTQ+ survivors understandably have fears and reservations around involving the police.[33] For example, LGBTQ+ survivors may remember when homosexuality was criminalized in many states (prior to 2003) or have been arrested for "walking while trans."[34] Survivors may have the police involuntarily called on them by a neighbor, friend, family member, or even the abuser themselves. It is therefore critical that service providers discuss this possibility with survivors and provide information, referrals, safety planning, and legal resources if needed. If providers are uncomfortable discussing navigation of the criminal legal system, it is important to self-educate and build a robust network of referral services.

Into Focus

Continuing Your Learning Journey: LGBTQ+ Survivors and the Myth of Mutual Abuse

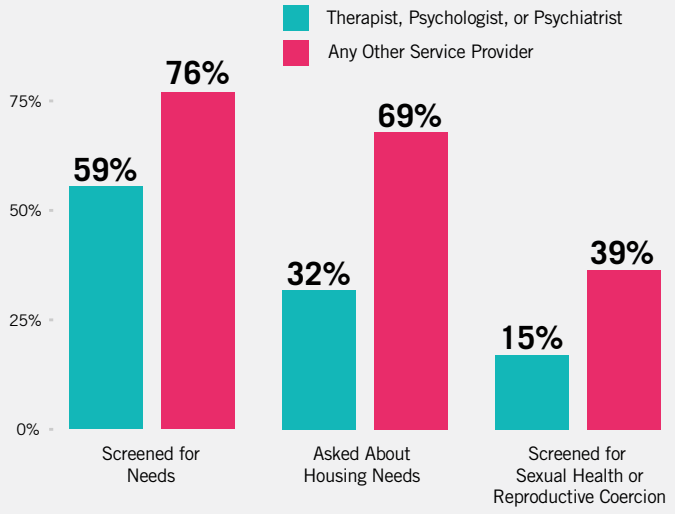
Claims by perpetrators that the survivor is also an abuser are common, but true mutual abuse is very rare.[35] Mutual abuse—the idea that people in relationships abuse each other, rather than there being one primary abuser—comes from misunderstandings about violent resistance to abuse, self-defense, and emotional reactions from the survivor.

Crossclaims by primary aggressors may raise particular challenges for service providers who are trying to assess patterns of abuse,[36] as these claims are often used as a way to control the survivor. Some research suggests that this type of behavior is more common in LGBTQ+ IPV.[37] Many resources about DV make gendered, heterosexist assumptions that primary aggressors are men and survivors are women. It may be tempting to assume that the person who is larger, more masculine, or has darker skin is the abuser; in some settings, there may be institutional bias towards primary aggressors who report the survivor as an abuser *first*, prior to the survivor asking for help.

A process for examining biases about body size, gender, and race can be a useful tool to create a more trauma-informed practice. It is also crucial for providers to avoid practicing or referring survivors and their partners for relationship therapy, which is *never* a solution for IPV.



Screening





Into Focus

Findings and Recommendations for Psychiatrists, Psychologists, and Individual Therapists

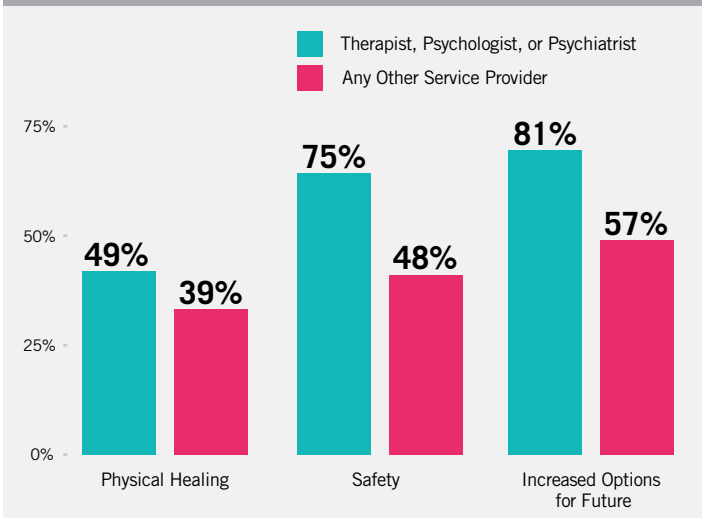
Mental health professionals who are in private practice or otherwise not working in IPV-specific or LGBTQ+ specific settings may have less access to professional development and training related to serving LGBTQ+ survivors. In this study, these clinicians were about half as likely to conduct screening for survivors' needs (59% vs. 76%), about one fifth as likely to ask about housing needs (32% vs. 69%), and about one quarter as likely to conduct sexual coercion screening (15% vs. 39%).

However, compared to other providers, they were *over three times* as likely to address future options (81% vs. 57%) and even more to address safety needs (75% vs. 48% of all other providers).

Continuing the Learning Journey and Creating Robust Referral Networks

This suggests that psychiatrists, psychologists, and individual therapists have unique strengths and also may benefit from professional development—specifically regarding screening for sexual coercion and identifying whether material needs such as housing can be met. Therapists who do not feel comfortable with these processes even with training can benefit from a robust network for referring cases.

Supports



Spotlight
Trans and Gender-Nonconforming People

With the rise in anti-trans rhetoric and legislation, understanding the needs and experiences of TNGNCB people in this era is essential. Many DV providers have questions about how to support this community; this section describes what was found in this survey and offers some additional resources and recommendations.

Nearly half of survey participants were not cisgender (47%); that is, they identified as one or more of: transgender (24%), nonbinary (29%) or gender-nonconforming/genderqueer (22%).

Among those that identified as trans, 37% identified as transmasculine, 20% identified as transfeminine, and the remaining 43% identified as both or neither (suggesting that transgender survivors may often identify in ways that defy binary categories).

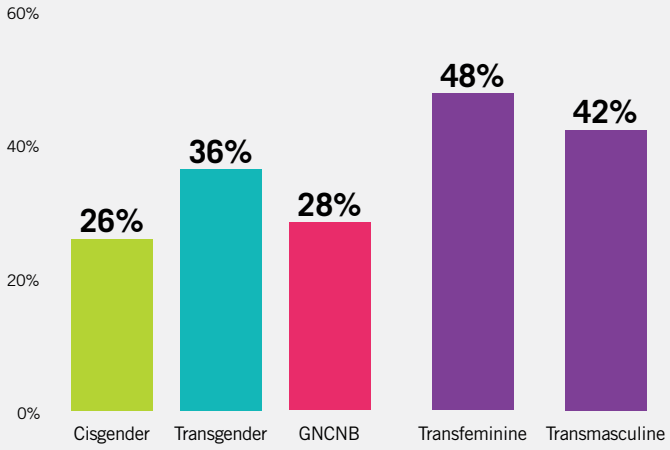
GNCNB participants were about 50% more likely to experience *emotional* abuse (87%) than all other participants (81%).[38] Transgender participants overall were about 70% more likely to have experienced identity abuse (36% vs. 25% of those who did not identify as transgender), numbers which were higher for those who also selected a binary gender (48% of transfeminine participants and 42% of transmasculine participants). Transgender participants were also more likely to experience financial abuse (25% vs. 16%).

Finally, while not all trans or TGNCNB people use hormone therapy, there were higher rates of medical abuse (which explicitly included denial of access to hormone therapy) among TGNCNB people in this survey (25% vs. 17%).[39]

TGNCNB participants were much less likely to say that providers "always" used the right pronoun for them (75% vs. 94% for cisgender participants). Similarly, while 78% of cisgender survivors felt their experiences of IPV were "always" taken seriously, 61% of TGNCNB survivors did. This could indicate that service providers have more difficulty understanding and support the experiences of survivors with fluid identities.

Intentional support for TGNCNB survivors is essential. Overall, this community is receiving care that is less supportive than their cisgender counterparts. Domestic violence service providers should receive continuous training and technical assistance to better meet the unique and specific experiences of TGNCNB survivors. Additionally, all training and technical assistance programs across disciplines can include more examples, historical education, and statistics on how to connect with this community. Additionally, DV organizations can partner with community-led organizations to be better equipped with resources.

Identity Abuse Among Cisgender, Transgender, and GNCNB Participants





Recommendations for Providers

This section offers a menu of recommendations for providers. Many of them are presented in other parts of this report, while others include common threads across the findings of this report and others. The recommendations are not exhaustive, nor are they intended to be overwhelming for providers, many of whom are confronting shrinking resources and increased demand for services. Many of the recommendations will be familiar and build on skills that survivor-centered clinicians already use, such as inviting survivors to share using open-ended conversations.

In this time of shrinking resources, no one can do everything—but organizations can do more *together* than they can separately. At the same time, many providers worry about referring LGBTQ+ survivors to organizations that may not be prepared to meet their needs or may retraumatize them. This section suggests that a combination of interventions effectuated through *Continuing Your Learning Journey, Building and Using a Robust Referral Network of Trustworthy Providers,* and *Having Open Conversations* are achievable goals for providers working to improve their survivor-centered practice with LGBTQ+ survivors of IPV.

While these are not the focus of this study, it is also an important contribution when service providers can change institutional practices. This can be difficult, especially for providers whose position in an organization does not involve setting policy. If possible, create opportunities (or take advantage of existing ones) to change intake forms or processes to make them more inclusive and to refine understandings of who is the primary aggressor and who is the survivor. Change orientation processes to make it clear that homophobia and transphobia are not tolerated at the organization. Create safe, private spaces as alternatives to selecting "male" or "female" facilities for TGNCNB people. Put pronoun pins into use and place LGBTQ+ visuals in the space, or implement other policy and infrastructure practices. Similarly, encouraging co-workers and other professional colleagues to obtain training in LGBTQ+ IPV is a huge contribution to changing the field.

The Institute provides not only training, but also technical assistance in creating these policies and practices.

Stay Curious: Continue Your Learning Journey

This report summarizes the findings of one study; there are many good resources for training and self-study, especially those provided by the National LGBTQ Institute for Intimate Partner Violence. Learning is also about practicing habits that become easier through repetition, such as noticing stereotypes that may be embedded in institutional practice, thinking through conversations about identity and pronoun use and apologizing for mistakes and moving forward with conversations.

It is difficult to notice our own internal biases, not only because they are familiar but because it is tough to acknowledge that none of us have yet achieved our goals of being free of bias. **However, myths such as the ones this study works to counter—that mutual abuse is common in LGBTQ+ relationships, that the larger or more masculine partner is always the primary aggressor, or that bi+ people are less trustworthy—have harmful impacts on survivors' ability to recognize a relationship as abusive and seek support and safety.**

Attending to one's own internal moments of curiosity is an important tool in continuing open conversations as well as learning journeys. Some service providers may find themselves wondering about a new word or experience that they have not encountered before. For example, even an experienced servicer provider may be curious about why an LGBTQ+ survivor would identify as both bisexual and a lesbian, or as trans but not a transwoman or a transman—these are patterns surfaced in this report that reflect the lives and identities of LGBTQ+ survivors.

Survivor-centered providers know that asking a survivor to educate them is not helpful to the therapeutic process but that starting an open conversation about what any meaningful identity or experience might *mean* to the survivor—whether that identity or experience is new to the provider or not—is a crucial part of therapeutic practice. Curiosity can be fulfilled not only through obtaining training, reading or researching but also by attending LGBTQ+ community events as an ally or community member.

Build Collaboration Through a Robust Referral Network of Trustworthy Providers

No service provider can do everything a survivor might need. Providers are experts in specific areas: physical health care, connecting survivors to housing and financial resources, screening and referrals, emotional support and healing, and many other areas. **However, a robust network of partnerships made up of trustworthy providers with a variety of strengths can be lifesaving for LGBTQ+ survivors.** One point of intervention for DV service providers is to create a list of potential referral partners and work with them to ensure that they are well-trained.

There are some locations where it may be difficult to identify survivor-centered locations and providers that are LGBTQ+ or trustworthy allies to the community. In some cases, as part of their network, a provider can work with them to obtain training in LGBTQ+ practices. Some trainers in LGBTQ+ practices who work with IPV providers suggest that rather than not referring at all, giving LGBTQ+ survivors an explanation of what they can expect from the experience—both positive and negative—is empowering whether the survivor chooses to use the referral or not.

Warm handoffs are particularly welcome for survivors who have experienced low quality support by providers in previous attempts to seek services. For example, an LGBTQ+ survivor who is avoiding addressing physical health needs and has had bad experiences with medical providers might benefit from a warm handoff to a medical professional who has been holistically trained to take LGBTQ+ survivors seriously and offer them support, dignity, and high-quality care.

DV providers often find the material needs of survivors—which may be more acute for LGBTQ+ survivors—the most difficult to meet. In this study, financial security issues were difficult for service providers to address. Given the disproportionate financial and employment barriers that LGBTQ+ people face, this is an area of particular concern, suggesting that referral networks are particularly essential when DV providers cannot provide cash assistance and housing options that are safe, accessible, and affirming.

Similarly, healthcare providers are often in contact with LGBTQ+ survivors in moments of crisis. However, some may not be equipped to supporting the community. Providers can work to make relationships with healthcare providers, including primary care providers and those who work in emergency rooms, so they can provide medically appropriate screenings and necessary referrals. Making providers aware of the value of LGBTQ+ friendly DV organizations and offering them information about LGBTQ+ training is also a great step. Organizations can partner with medical professionals or gear trainings for this community to be holistically trained on the signs of abuse, resources for support, and inclusive language.

Therapists, psychologists, and psychiatrists working with survivors may need to connect with a variety of people beyond their mental health network. For example, they may need assistance developing skills in screening for sexual coercion, identifying if legal needs are met, and assuring that material needs can be provided for. Similarly, others in the referral network may appreciate mental health professionals who are skilled with LGBTQ+ survivors and who reach out to them, especially if they can provide sliding scale or free services.

Have Open Conversations

IPV is a difficult conversation on its own. Adding unfamiliar language or experiences to that conversation can be intimidating for service providers. Most service providers are concerned that if they offend a survivor, that may inhibit their ability to offer them the best services. This concern can prevent DV providers from initiating and continuing conversations with LGBTQ+ survivors. **However, to be a safe space for a survivor, a DV provider needs to understand that the survivor's gender identity and sexual orientation are core parts of the survivor's identity, experiences, and relational life.** Avoiding conversations about LGBTQ+ identity may lead providers to miss invaluable moments of connection and rapport-building. It may result in losing opportunities for a client to share critical information about their safety, health, and wellbeing. Being able to have open and honest conversations about LGBTQ+ identity and having knowledge and understanding of LGBTQ+ survivors' experiences allows the provider to help the survivor feel seen and unashamed.

Additionally, inclusive language and terminology is a critical component of making sure that TGNCNB survivors feel seen, understood, and supported by their providers. In moments where a provider unintentionally misgenders their client, this can disrupt the rapport in their relationship. One way providers can better meet the needs of this community is through working on improving gender-inclusive language practices and learning how to respond when they misgender someone.

LGBTQ+ people are constantly seeking better language for their identities and experiences. They are constantly adapting and responding, combining and changing words that may expand their connotations. Creative and flexible use of language is a strength of the community. Asking questions about the meaning of the new language to the survivor (rather than asking the survivor to educate the provider about the community) centers the survivor's perception and experiences.

Survivors deserve to have access to service providers who they can share their full selves with and have access to culturally responsive, and specialized care that meets the realities of their own lived experiences.

Conclusion

Service providers can be a lifesaving resource for LGBTQ+ survivors of IPV. Being a survivor-centered provider means inviting all who seek services to present their full selves, even when conversations are sensitive. This report has worked to both satisfy and pique curiosity about how to best meet LGBTQ+ survivors where they are, especially when they have few alternatives or have previously been met with hostility when trying to seek services. Each service provider can both meet the needs of the person seeking services in the moment and use the opportunity to change the standards for what is adequate or excellent practice. Someday, LGBTQ+ survivors will no longer approach services with trepidation. Instead, they will be able to expect that their specific needs will be met and that they will be well treated wherever they seek help.

Limitations and Further Research

The LGBTQ+ community is diverse, and not all identities that intersect with gender and sexuality could be extensively analyzed. Some of the limitations are a result of sample size, such as the small number of non-citizens in the survey and the insufficient sample sizes of groups of people of color. Others were simply a matter of focus (for example, income and age are important factors but were not featured due to the desire to focus on more LGBTQ+ specific and less discussed factors such as bi+ identities).

Further studies are needed of non-monogamous and kink relationships, as well as differences in seeking services for rural communities and those where politically conservative views are common.

This study also suggests the importance of attending to the physical health needs of LGBTQ+ survivors and to those with disabilities or who are vulnerable to medical abuse. Very few studies focus on these intersections, even fewer focus on preventing and responding to violence.

This study does not include information about primary aggressors or perpetrators; for example, it does not look at the gender or other demographics of the abusive partners.

References

[1] This report uses the language of "intimate partner violence" rather than the more general "domestic violence" or the more specific "dating violence," although many of the findings are also useful for service providers in these areas.

[2] The most rigorous, recent studies (since 2022) are population based and use data from the nation and from California. They can be found here: Centers for Disease Control and Prevention. (2024). *National Intimate Partner and Sexual Violence Survey (NISVS): 2023–2024 data brief*. Division of Violence Prevention, National Center for Injury Prevention and Control. (Sexual-identity tables retrieved from archived CDC materials.) CalVEX Research Group. (2023). *California Violence Experiences Survey (CalVEX): 2023 results*. California Department of Public Health.

[3] Scheer, J. R., Whitton, S. W., Xu, M., Murchison, G. R., Irani, K., & Hughes, T. L. (2025). Intimate partner violence among sexual and gender minority people. *In Intimate partner violence: A health-based perspective* (pp. 751–787). Oxford University Press. West, C. M. (2012). Partner abuse in ethnic minority and LGBT populations. *Partner Abuse*, 3(3), 336–357. Whitton, S. W., Lawlace, M., Dyar, C., & Newcomb, M. E. (2021). Exploring mechanisms of racial disparities in intimate partner violence among sexual and gender minorities assigned female at birth. *Cultural Diversity and Ethnic Minority Psychology*.

[4] Nearly a thousand people started the survey (977 records); the final dataset included 465 responses. Of those that started, six participants did not provide consent; 126 were not eligible due to age or not identifying as LGBTQ (leaving 845). A further 380 were dropped because they did not identify as survivors of IPV AND they did not endorse (select that they had experienced) any IPV experiences from the list in the survey.

[5] The report uses a conventional phrasing for significant odds ratios but does not list the precise size of the statistic in the text.

[6] A small number of participants provided a written response, and these were added to the category that most closely resembled the gender they wrote in.

[7] Taormino, T. (Ed.). (2011). *The ultimate guide to kink: BDSM, role play and the erotic edge*. Cleis Press.

[8] See e.g. Morton, M. H., Samuels, G. M., Dworsky, A., Patel, S., & Curry, S. R. (2018). *Missed opportunities: LGBTQ youth homelessness in America. Journal of Adolescent Health, 62*(2), S1–S11.

[9] See e.g. FredriksenGoldsen, K. I., et al. (2013). Health disparities among lesbian, gay, and bisexual older adults. *American Journal of Public Health, 103*(10), 1802–1809.

[10] See e.g. Pavao, J., Alvarez, J., Baumrind, N., Induni, M., & Kimerling, R. (2007). Intimate partner violence and housing instability. *American Journal of Preventive Medicine, 32*(2), 143–146.

[11] Ahrens, K. R., et al. (2011). Childhood foster care, intimate partner violence, and health outcomes. *Child Abuse & Neglect, 35*(7), 567–577.

[12] See e.g. Breiding, M. J., Armour, B. S., & Gentleman, J. F. (2014). *The association between disability and intimate partner violence in the United States*. Annals of Epidemiology, 24(2), 103–108. https://doi.org/10.1016/j.annepidem.2013.11.003 and Gupta, J., Kanselaar, S., Zhang, C., & Zaidi, J. (2023). *Disability and intimate partner violence in fragile states: A multicountry analysis*.

[13] While the survey measured more categories in the youngest and oldest age groups, sample size required that data be shown in less detailed categories.

[14] Brown, J. D., & Heggeness, M. L. (2024). *Citizenship Question Effects on Household Survey Response*. U.S. Census Bureau, Center for Economic Studies.

[15] Centers for Disease Control and Prevention. (2020). *HIV risk, prevention, and testing behaviors among men who have sex with men — NHBS, 2017*. Martin-Storey, A. (2015). *Prevalence of transactional sex among sexual minority youth. Journal of Adolescent Health, 57*(4), 442–448.

[16] E.g. Rotondi, N. K., et al. (2013). *Nonprescribed hormone use and self-performed surgeries among transgender women in Ontario, Canada. American Journal of Public Health, 103*(10), 1830–1836., National Center for Transgender Equality. (2024). *2022 U.S. Transgender Survey: Early Insights Report*.

[17] While 17 experiences of abuse (and 1 additional option for "other") were measured using questions directed at all participants, three others were related exclusively to bisexual participants, those taking medication (included in medical abuse) and those with a disability (included in medical abuse). The latter are discussed in more detail in the following section.

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[20] During the survey fielding period, an 18th option was added for "other," where participants could indicate if they had experienced an IPV incident not listed in the provided options in the survey. This "other" option was added to ensure that IPV survivors were not unintentionally getting excluded from the survey because they did not experience one of the listed incidents. In the final dataset, anyone who selected "other" had also selected at least of the provided options.

[21] Emotional abuse included 5 types of behaviors on the part of the perpetrators, physical abuse included 4, stalking included 3 and isolation and medical abuse each included 2. Sexual abuse, financial abuse and identity abuse each included one experience.

[22] Karakurt, G., Koc, E., D'Silva, R. et al. Systematic review on the treatment of emotional abuse victimization in women by an intimate partner. J Fam Viol (2025). https://doi.org/10.1007/s10896-025-00891-4.

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[24] Results approach significance, p=0.08

[25] See e.g. D'Costa, M. (2025). The increased risk of intimate partner violence for women with disabilities: A systematic review of barriers and obstacles to safety. Canadian Journal of Disability Studies, 14(1), 117–152. https://doi.org/10.15353/cjds.v14i1.121.

[26] See e.g. Stephenson, R., et al. (2019). *HIV-related health care interference among male couples: Associations with intimate partner violence*. AIDS and Behavior, 23(6), 1559–1567. Stephenson, R., et al. (2020). *HIV care interference and intimate partner violence among male couples*. Journal of Interpersonal Violence. Closson, E. F., et al. (2019). *Pre-exposure prophylaxis (PrEP) use and PrEP-related coercion among men who have sex with men*. AIDS and Behavior, 23(10), 2769–2779.

[27] Some common combinations of identities for bi+ people might include combinations of exactly two of these categories (25% of all biplus people) or all three (5%) of these categories. Some bi+ people also identify as gay (9%) or lesbian (13%), which is a different pattern from the typical way of categorizing sexual orientation in public health surveys as either "gay or lesbian" or "bisexual" but never both.

[28] See e.g. Yoshino, K. (2000). The epistemic contract of bisexual erasure. *Stanford Law Review, 52*(2), 353–461. https://doi.org/10.2307/1229482, Flanders, C. E., LeBreton, M. E., Robinson, M., Bian, J., & Caravaca-Morera, J. A. (2017). Defining and measuring binegativity: The Binegativity Scale. *Archives of Sexual Behavior, 46*(5), 1525–1538. https://doi.org/10.1007/s10508-016-0927-y, Brewster, M. E., Moradi, B., DeBlaere, C., & Velez, B. L. (2013). Navigating the layers of bisexual stigma: A qualitative investigation of therapy experiences. *Psychology of Sexual Orientation and Gender Diversity, 1*(S), 72–81. https://doi.org/10.1037/2329-0382.1.S.72.

[29] Approaches significance, p=0.06

[30] Physical health providers were included in "all other" for recent service providers to manage small samples sizes.

[31] A recent global systematic review defines reproductive coercion as "behavior that interferes with the autonomous decision-making of a woman with regard to reproductive health." Grace, K. T., & Anderson, J. C. (2018). Reproductive coercion: A systematic review. *Trauma, Violence, & Abuse, 19*(4), 371–390. https://doi.org/10.1177/1524838016663935. The NISVS 2010–2012, 9.7% of U.S. men and 8.4% of U.S. women reported lifetime reproductive coercion by an intimate partner. Basile, K. C., Smith, S. G., Liu, Y., Miller, E., & Kresnow, M. (2019). Prevalence of intimate partner reproductive coercion in the United States: Racial and ethnic differences. *Journal of Interpersonal Violence, 36*(21–22), NP12324–NP12341. https://doi.org/10.1177/0886260519888205.

[32] Results approach significance, p=0.08

[33] See e.g. Dwyer, A. (2011). *Policing queer bodies: Police misconduct, discrimination, and LGBTQ communities*. Current

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Issues in Criminal Justice, 23(3), 389–405 and Messinger, A. M. (2017). *LGBTQ Intimate Partner Violence: Lessons for Policy, Practice, and Research*. University of California Press.

[34] See e.g. Leonore F. Carpenter and R. Barrett Marshall, Walking While Trans: Profiling of Transgender Women by Law Enforcement, and the Problem of Proof, 24 Wm. & Mary J. Women & L. 5 (2017), https://scholarship.law.wm.edu/wmjowl/vol24/iss1/3.

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[37] Messinger, A. M. (2017). *LGBTQ Intimate Partner Violence: Lessons for Policy, Practice, and Research*. University of California Press.

[38] Results approach significance (p = 0.11)

[39] Results approach significance (p=0.10)