Prevalence and Risk Correlates of Intimate Partner Violence Among a Multisite Cohort of Young Transgender Women

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Abstract

Purpose: Young transgender women (YTW) may experience disparate rates and distinct forms of intimate partner violence (IPV) in comparison with cisgender individuals. YTW also may experience high rates of minority stressors, including transgender-related victimization, discrimination, and mistreatment related to their gender identity and/or expression. The present study examined the prevalence and risk correlates of IPV among a sample of YTW.

Methods: Participants were a racially and ethnically diverse sample of 204 YTW ages 16–29 years from Chicago, Illinois and Boston, Massachusetts. Participants completed assessments of IPV, childhood abuse, and experiences with minority stressors, including transgender-related victimization and discrimination.

Results: Prevalence of IPV was high among this sample (42%), including experiencing distinct forms of IPV that were related to gender identity. Experiencing stressors was also high among this sample, including experiencing childhood abuse and minority stressors (i.e., transgender-related victimization and day-to-day unfair treatment and discrimination), all of which were associated with a greater risk for IPV.

Conclusion: Our findings support the need for researchers to continue to examine the risk correlates of IPV among transgender individuals and to examine how the relationship between IPV and minority stressors may relate to coping strategies and mental health outcomes. Our findings have important implications for domestic violence service providers and other health professionals and highlight that providers should be trained to support survivors with histories of abuse and victimization related to gender identity and/or expression.

Keywords: childhood abuse, intimate partner violence, minority stress, transgender, victimization

Introduction

INTIMATE PARTNER VIOLENCE (IPV) is an issue of public health concern: an estimated 1 in 3 women and 1 in 4 men experience a form of partner violence in their lifetime.¹ Experiencing IPV is associated with a host of negative outcomes, including chronic health conditions, reproductive illnesses, mental health disorders, substance abuse, and/or suicide attempts.² To date, the majority of research has stud-

ied the prevalence and consequences of, and risk factors for, IPV among heterosexual, cisgender individuals, with less known about IPV among sexual and gender minority individuals.³⁻⁵ Prevalence estimates and research understanding the risk factors of IPV are even less available for transgender individuals—individuals whose gender identity or gender expression is not congruent with their sex assigned at birth.⁶ It is imperative to understand the prevalence of and stressors associated with IPV among transgender individuals, as studies

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have found that IPV is associated with multiple negative health outcomes in this population.^{7,8} The present study sought to contribute to this underdeveloped area of research by examining the prevalence and risk correlates of IPV among a sample of young transgender women (YTW).

IPV among transgender individuals

A few studies have reported high prevalence of IPV and disproportionate experiences of IPV among transgender individuals in comparison with cisgender individuals. The 2015 U.S. Transgender Survey found that 35% of transgender individuals reported experiencing physical IPV in their lifetime.⁹ This finding echoes previous research finding that the prevalence of IPV ranges from 31% to 50% among transgender individuals.^{10,11} Studies also have found that rates of IPV tend to be higher among transgender individuals (31%) than cisgender individuals (20%).¹¹

Another study examined the prevalence of IPV in the past year, finding that transgender women experienced six times higher odds of physical IPV than cisgender women.¹² This study also provided evidence for examining IPV prevalence by gender identity subgroups, finding that of all transgender groups, the odds of experiencing IPV were highest among transgender women.¹²

In addition to experiencing higher levels of IPV than cisgender individuals, transgender individuals also may experience IPV in distinct ways.^{13–15} IPV may have trans-negative elements (i.e., hostility toward or aversion to transgender individuals), including “assault, mutilation or denigration of body parts such as chest, genitals, and hair that signify specific cultural notions of gender.”¹⁴ Transgender individuals also may experience trans-specific forms of victimization, including economic abuse (e.g., withdrawal of financial support for hormones, surgeries), emotional or verbal abuse (e.g., harassment over cross-gender appearance or behavior), and threats (e.g., threats to reveal gender identity), all of which may magnify the negative effects of marginalized status.^{14,16,17} Traditional measures of IPV fail to capture transgender-specific violence, which not only marginalizes transgender individuals but also limits our understanding of their experiences and how best to serve and support survivors of IPV.

Risk correlates of IPV

A minority stress framework can be used to explain factors associated with higher rates and distinct forms of IPV among transgender individuals. Meyer’s minority stress model suggests that individuals from socially stigmatized minority groups experience stressors (“minority stressors”) that are distinct from and/or additive to the general stressors that are experienced by all people.¹⁸ This model has been adapted to encompass the distinct experiences of transgender individuals, a framework that is particularly useful in understanding the processes by which stressors are associated with negative outcomes among transgender individuals.¹⁹ For example, gender minority-related stressors, including transgender-related victimization, rejection, and internalized transphobia, can lead to an array of negative mental health outcomes and adverse experiences among transgender individuals.²⁰

Studies have found that transgender individuals experience high levels of physical (27%–60%) and sexual (13%–

46%) victimization^{21–23} and face high levels of discrimination and harassment, within their homes and work environments, related to their gender identity.^{24–26} Each of these minority stressors may increase vulnerability to negative outcomes, including psychological distress,^{27,28} depressive symptoms,^{29,30} lower relationship quality,³¹ and post-traumatic stress disorder symptoms.²⁰ Experiencing high levels of minority stressors may also lead to greater emotional dysregulation, negative affect, and substance use, and increased levels of distress, tension, poor communication, and maladaptive behaviors within a relationship, all of which are associated with an increase in experiencing IPV.³² However, little research exists that examines if these minority stressors are associated with a greater risk for IPV among transgender individuals.

In addition, to obtain a more complete understanding of the relationship between stressors and IPV among transgender individuals, research is needed to examine these minority stressors alongside stressors experienced by cisgender individuals. One of these stressors is childhood abuse, which is considered one of the strongest risk factors for IPV among all individuals.³³ Childhood abuse can increase the risk for experiencing family conflict and stress, relationship instability, poor mental health, emotional dysregulation, and poor conflict resolution skills, all of which can increase the risk for IPV during adulthood.³⁴ It is critical to expand the empirical literature to also examine the relationship between childhood abuse and IPV among transgender individuals.

The present study

The prevalence and risk correlates of IPV among transgender individuals remain underdeveloped in the literature. Previous literature has found that childhood abuse is a strong risk factor for IPV among cisgender individuals.³³ Minority stressors, including stressors experienced distinctly by transgender individuals, also may affect IPV.³² However, to our knowledge, no studies have examined this combination of general and minority stressors in relation to IPV among a sample of transgender women. The present study contributes to this nascent area of research through several aims. First, we present prevalence statistics of IPV and IPV related to gender identity among a sample of YTW, a group at highest risk for IPV.¹² Second, we present the prevalence of minority stressors, including transgender-related victimization and unfair treatment and discrimination. Finally, we examine childhood abuse and minority stressors in relation to IPV. We hypothesized that these stressors would be positively associated with IPV.

Methods

Study design and participants

Data from Project LifeSkills (2012–2015), a multisite trial in Chicago, Illinois and Boston, Massachusetts, were used for the present study. Project LifeSkills tested a group-delivered HIV prevention intervention among YTW ($N=300$). Participants were eligible if they (1) were ages 16–29 years, (2) were assigned a male sex at birth and now self-identify as a woman, female, trans female, transgender woman, male-to-female, or other identity on the trans-feminine spectrum, (3) spoke English, (4) reported sexual risk behavior,

and (5) reported no plans to move from the local area during the 12-month study period. Details on recruitment and the intervention can be found in the study protocol for Project LifeSkills.³⁵

For the present study, data were used from baseline (wave 1) and the 4-month follow-up (wave 2). Wave 1 measures assessed demographic variables and wave 2 measures assessed experiences of childhood abuse, minority stressors, and IPV. Participants were included in the study if they participated in waves 1 and 2 ($n=204$). The following demographic data were collected: gender identity (“how do you identify in terms of gender?”), sexual identity (“how do you describe your sexual identity?”), and racial/ethnic identity (“what do you consider to be your primary race or ethnic background?”). Response options, as shown in Table 1, were provided for each of these questions, including an option of “other” if the participant did not feel that the response options were accurate. Although the sample included individuals who identify outside of the traditional gender binary, most of the participants self-identified as female, trans female, or a transgender woman. Thus, we use the term “transgender woman” to reflect the demographics of the sample and as an umbrella term to capture the array of gender presentations and identities. Demographic data were also collected on participants’ highest level of education, employment status, household income, and information regarding having health insurance, receiving federal assistance, and ever being a ward of the court/state. Assessments were completed through a computer-assisted self-interview. Participants completed written informed consent. For participants younger than 18 years, written assent and a waiver of parental consent were obtained. Procedures were approved by Institutional Review Boards at both study sites (Ann & Robert H. Lurie Children’s Hospital of Chicago and The Fenway Institute of Boston).

Measures

IPV. Lifetime IPV was assessed with five items ($\alpha=0.88$) developed for the Transgender Youth Research Project that asked participants about violence in physical, psychological, and sexual forms (e.g., “Has a partner ever tried to control most or all of your daily activities?”), as well as transgender-specific forms (e.g., “Has a partner made you do something that did not agree with your gender identification?”).³⁶ For the present study, responses were scored 0=*never experienced IPV* and 1=*ever experienced IPV* and then summed across the five items for a total IPV score. All items can be found in Table 2.

Childhood abuse. Three questions ($\alpha=0.65$) assessed experiences with childhood abuse (“before your 18th birthday”), including physical (“How often did a parent or adult caregiver hit you with a fist, kick you, or throw you down on the floor, into a wall, or down stairs?”), psychological (“how often did a parent or other adult caregiver say things that really hurt your feelings or made you feel like you were not wanted or loved?”), and sexual (“how often did a parent or other adult caregiver touch you in a sexual way, force you to touch him or her in a sexual way, or force you to have sexual relations?”) forms of childhood abuse. These items were from the National Longitudinal

TABLE 1. DEMOGRAPHIC INFORMATION FOR PARTICIPANTS ($N=204$)

	n	%
Gender identity		
Female	104	51
Trans female/male-to-female	58	28
Transgender woman	29	14
Woman	0	0
Other ^a	13	7
Sexual identity (not mutually exclusive)		
Gay/homosexual	47	23
Lesbian	12	6
Bisexual	43	21
Heterosexual	83	41
Other ^b	19	9
Racial/ethnic identity		
Black/African American	96	47
White	51	25
Spanish/Hispanic/Latino/a	26	13
Asian	6	3
American Indian/Alaskan Native	3	1
Native Hawaiian/Pacific Islander	2	1
Other ^c	20	10
Highest level of education		
8th grade or some high school	45	22
GED or high school diploma	73	36
Trade school certificate	7	3
Some college	63	31
College or graduate degree	16	8
Ever been ward of the court/state		
Yes	44	22
No	158	77
Don’t know	2	1
Currently employed ^d		
Yes, full-time	19	9
Yes, part-time	32	16
No, unemployed	153	75
Received federal assistance		
Yes	136	67
No	62	30
Not sure	6	3
Household income (last 12 months) ^a		
<\$10,000	97	61
\$10,000–19,999	27	17
\$20,000–29,999	8	5
\$30,000–39,999	10	6
\$40,000–69,999	9	6
\$70,000 or more	7	5
Health insurance		
No insurance for healthcare	50	25
No insurance for mental healthcare	69	34

^a“Other” examples of gender identity included androgynous, gender queer, and questioning.

^bExamples of “Other” sexual identities (not mutually exclusive) that were written in included pansexual, queer, open, self, 3rd gendered, transgender, and confusing/not sure/questioning.

^c“Other” examples of racial/ethnic identity (not mutually exclusive) included multiracial or multiethnic, Brazilian, Belizean, and Haitian.

^d $n=158$.

GED, general education development or diploma (high school equivalency certificate).

TABLE 2. PREVALENCE OF INTIMATE PARTNER VIOLENCE AND MINORITY STRESSORS AMONG YOUNG TRANSGENDER WOMEN ($N=187$)

<i>IPV and minority stressors</i>	<i>n</i>	<i>%</i>
IPV		
Ever experienced at least one incident of IPV	78	42
A partner controlled most or all of their daily activities	53	28
A partner repeatedly put them down, embarrassed them in front of other people, or made them feel bad about themselves because of their gender identity	41	22
A partner made them scared for their physical safety because of anger or threats	37	20
A partner forced or made them do something sexual that they did not want to do	30	16
A partner made them do something that did not agree with their gender identification	33	18
Transgender-related victimization		
Ever experienced at least one incident of victimization (because they are or were thought to be transgender)	140	75
Verbal insults	119	64
Threats of physical violence	80	43
Had objects thrown at them	43	23
Were punched, kicked, or beaten	39	21
Threatened with a weapon	37	20
Attacked sexually	32	17
Had someone threaten to tell someone else they were transgender	48	26
Chased or followed	56	30
Had property damaged	33	18
Spit at	24	13
Day-to-day unfair treatment and discrimination		
Ever experienced one form of discrimination	159	85
Experienced all nine forms of discrimination	82	44

IPV, intimate partner violence.

Study of Adolescent to Adult Health.³⁷ Participants rated these questions on a scale from 1 (i.e., *0 times*) to 5 (i.e., *more than 10 times*). For the present study, each question was first dichotomized (0=never, 1=1 or more times), and then a sum score was calculated for the total number of abuse instances indicated by participants.

Transgender-related victimization. An adapted version of Pilkington and D'Augelli's Victimization Scale was used in the present study.³⁸ The original scale assessed victimization among gay, lesbian, and bisexual individuals; the scale was adapted in the present study to change the terms gay, lesbian, and bisexual to transgender. Transgender-related victimization experiences were assessed with 10 items (e.g., "How many times were you verbally insulted (yelled at, criticized) because you are, or were thought to be, transgender?" $\alpha=0.84$). Participants rated these items on a scale from 1=*never* to 4=*more than twice*. For the present study, each question was first dichotomized (0=never, 1=1 or more times), and then items were summed to create a total number of transgender-related victimization experiences.

Day-to-day unfair treatment and discrimination. Nine items ($\alpha=0.95$) were asked to assess day-to-day unfair treatment and discrimination.³⁹ Participants were prompted: "How often have any of the following things happened to you over your life?" (e.g., "You have received poorer service than other people at restaurants or stores"). Participants answered on a scale of 1=*never* to 6=*all of the time*. Items were summed to create a total score of day-to-day unfair treatment and discrimination.

Covariates. Several covariates were included in all analyses, including study site (0=Boston and 1=Chicago), intervention condition (0=other condition and 1=LifeSkills intervention), race (0=other and 1=Black/African American), and age of participant.

Data analysis

All data cleaning took place in IBM SPSS Version 23 (IBM Corporation, Armonk, NY). Data were checked for assumptions of normality, linearity, and homoscedasticity. Bivariate correlations and descriptive statistics were run for all study variables. Next, a multiple regression analysis was used to examine the relationship between risk correlates and IPV. These analyses were conducted in Mplus Version 7.4, which uses full-information maximum likelihood estimation.⁴⁰ A model was run to examine childhood abuse and minority stressors (i.e., transgender-related victimization; unfair treatment and discrimination) in relation to IPV, controlling for study site, intervention condition, race, and age.

Results

Descriptive statistics

Participants ($n=204$) were ages 16–29 years (mean=23.4, standard deviation=3.57). Demographic information for the participants is presented in Table 1. Participants identified as Black/African American (47%), White (25%), Spanish/Hispanic/Latino/a (13%), Asian (3%), American Indian/Alaskan Native (1%), Native Hawaiian/Pacific Islander (1%), and "other" racial/ethnic identity (10%). Among participants,

TABLE 3. DESCRIPTIVE STATISTICS, PREVALENCE, AND BIVARIATE CORRELATIONS FOR INTIMATE PARTNER VIOLENCE, CHILDHOOD ABUSE, DAY-TO-DAY UNFAIR TREATMENT AND DISCRIMINATION, AND TRANSGENDER-RELATED VICTIMIZATION ($N=187$)

	1	2	3	4
1. Childhood abuse	—			
2. Day-to-day unfair treatment and discrimination	0.35**	—		
3. Transgender-related victimization	0.43**	0.41**	—	
4. Intimate partner violence	0.31**	0.31**	0.58**	—
Mean or sum score	1.01	22.52	2.73	1.04
Standard deviation	1.00	10.53	2.76	1.58
Range	0–3	9–54	0–10	0–5
Prevalence	58%	85%	75%	42%

** $p < 0.01$.

75% were unemployed and 67% reported that they or their family ever received federal assistance (e.g., Aid to Families with Dependent Children, Temporary Assistance for Needy Families).

Prevalence of IPV and minority stressors among YTW

As shown in Table 2, 42% of participants ever experienced at least one incident of IPV. YTW indicated experiencing dynamics of IPV related to gender identity: 22% of participants had a partner who repeatedly put them down, embarrassed them in front of other people, or made them feel bad about themselves because of their gender identity, and 18% of participants had a partner who made them do something that did not agree with their gender identification. Participants also reported on rates of experiencing minority stressors: 75% of participants had experienced at least one incident of victimization because they are or were thought to be transgender. The majority of participants (85%) experienced at least one type of day-to-day unfair treatment and discrimination, and 44% experienced all types. Participants largely attributed this discrimination to their gender expression (52%), sex (46%), or sexual orientation (50%). These reasons for discrimination were rated more frequently than their weight (11%), education level (14%), physical disability (5%), religion (16%), race (25%), ethnicity or nationality (16%), age (30%), or an aspect of their physical appearance (20%). Finally, as shown in Table 3, 58% of participants had experienced one form of childhood abuse. Bivariate correlations among study variables indicated that each is associated with the other at moderate ($r=0.31$ – 0.43) to high levels ($r=0.58$) (Table 3).

Risk correlates of IPV among YTW

As shown in Table 4, in the multivariate model, age was positively associated with IPV ($\beta=0.18$, $p=0.04$). In examination of stressors, childhood abuse was positively associated with IPV ($\beta=0.23$, $p=0.02$). Minority stressors also were associated with higher rates of IPV, including transgender-related victimization ($\beta=0.37$, $p=0.001$) and day-to-day unfair treatment and discrimination ($\beta=0.12$, $p=0.03$).

Discussion

The present study examined the prevalence and risk correlates of IPV among a sample of YTW. This study contributes to a nascent area of research among gender minorities, which has suggested that prevalence rates of IPV may be highest among transgender women.¹² We found that 42% of YTW ever experienced a form of IPV, reflecting a high level of vulnerability of YTW to IPV. This finding is comparable with other studies which have found a higher vulnerability among transgender individuals (31%–50%),^{10,11} in comparison with cisgender individuals (20%).¹¹ YTW's experiences of IPV also included dynamics related to gender identity, differing from those of cisgender survivors in prior studies.^{13–15} Our study makes an important contribution to the literature, as previous research has not always captured these distinct experiences of IPV among transgender individuals.⁴¹ Our results also found that this sample of YTW also experienced high rates of minority stressors, including transgender-related victimization and day-to-day unfair treatment and discrimination.

TABLE 4. RISK CORRELATES OF INTIMATE PARTNER VIOLENCE AMONG YOUNG TRANSGENDER WOMEN ($N=187$)

	<i>B</i>	β	<i>SE</i>	<i>p</i>
Covariates				
Study site	0.03	0.02	0.22	0.87
Intervention condition	−0.28	−0.14	0.17	0.11
Race: African American	−0.15	−0.08	0.21	0.46
Age	0.05*	0.18	0.03	0.04
Stressors				
Childhood abuse	0.24*	0.23	0.10	0.02
Day-to-day unfair treatment and discrimination	0.01*	0.12	0.01	0.03
Transgender-related victimization	0.14**	0.37	0.03	0.001

* $p < 0.05$; ** $p < 0.01$.

The present study also examined childhood abuse and minority stressors in relation to IPV. Higher levels of childhood abuse were associated with higher levels of IPV, which is consistent with findings among cisgender individuals.^{33,34} However, our findings also suggest that distinct experiences (i.e., “minority stressors”) of transgender-related victimization and unfair treatment and discrimination also are significantly associated with IPV. Greater frequencies of these minority stressors were associated with higher levels of IPV, even after controlling for another stressor and covariates (e.g., childhood abuse, age).

To our knowledge, no studies have uniquely examined how these minority stressors are associated with IPV among transgender individuals, which has implications for experiences of IPV victimization among this group of individuals. As theorized in the minority stress model, research needs to continue to examine the mechanisms by which childhood abuse and minority stressors are associated with negative outcomes, including IPV, among socially stigmatized minority groups.^{18,19} For example, stressors may be associated with increased vulnerability to mental health problems,^{20,29,30} dysregulation,³² and negative relationship behaviors,³¹ all of which are associated with IPV. Research using the minority stress framework has also demonstrated the importance of understanding protective factors that may buffer the relationship between stressors and negative outcomes.¹⁹ For example, social support, positive coping strategies, and characteristics of identity (e.g., integration of minority identity) may buffer this relationship.¹⁸

The present study also found that age was positively associated with IPV. National studies of IPV have found that rates of IPV victimization are highest during early adulthood.⁴² In addition, the assessment of IPV was cumulative, suggesting that with age participants have more time to potentially experience these acts of IPV. A recent study highlighted the importance of examining IPV and age using a person-centered approach, as IPV varies from adolescence to adulthood across individuals.⁴³ For example, studies have shown a variety of IPV patterns with age (e.g., increasing, decreasing, stable, curvilinear),⁴³ suggesting that the relationship between age and IPV needs to consider the heterogeneity of individuals’ experiences with IPV. Future work would benefit from examining trajectories and rates of IPV over time among classes of YTW to better understand the relationship between age and IPV among YTW.

IPV is not only associated with stress and mental health problems but also with physical injuries and chronic health issues.^{7,8} The high rate of IPV found in this study and its relationship with minority stress and other types of victimization may have a compound effect on physical health among YTW, particularly over their lifetime. Future studies that assess this compound effect over time are warranted. Future research is also necessary to examine longitudinal relationships between these variables to determine whether minority stressors predict changes in IPV among YTW across time.

Limitations

Although the present study makes several contributions to the literature, it is not without limitations. For example, the data were not longitudinal, meaning that no causal conclusions can be made about relationships between variables

reported. We also examined a sample of YTW with high levels of sexual risk for HIV acquisition and transmission; therefore, the findings may not be generalizable to low-risk YTW. In addition, the measure of child abuse only consisted of three items,³⁷ yielding a low reliability statistic. Future researchers should consider utilizing a more reliable and comprehensive measure of child abuse. The present study also used a measure of victimization validated for gay, lesbian, and bisexual individuals³⁸; future research should continue to better conceptualize and measure victimization experiences among transgender individuals. Future researchers should also extend these findings to young transgender men who also may experience IPV. In addition, the present study relied on self-reports of all study variables, meaning that these measures captured individuals’ beliefs about experiencing these stressors. Future work is necessary to examine stressors from multiple or more objective measures. Finally, the present study assessed transgender victimization, but it is not clear if participants were reporting on victimization experienced outside of their romantic relationships or not.

Public health implications and future directions

Our findings support the need for researchers to continue to examine IPV experiences among transgender individuals. Research is urgently needed to understand the relationship of IPV to other stressors and negative outcomes that may indicate a coalescence and potential for compound effects. Furthermore, research is necessary to understand how IPV affects coping strategies and health outcomes, particularly as transgender and gender-diverse individuals may utilize distinct coping strategies to manage gender-related stress.³⁰

Increasing knowledge about the prevalence and risk correlates of IPV among YTW is critical to understand how best to serve and support survivors of IPV. Domestic violence services, which are often the first point of contact for survivors of IPV, can be seen as inaccessible to many transgender individuals.¹⁴ In addition, studies have found that transgender individuals may be apprehensive about seeking domestic violence services due to a history of mistreatment by the medical community.^{19,44,45} There also are inadequate provisions for transgender individuals within domestic violence services and screenings.^{46–48} Thus, not only do IPV services need to be open to transgender individuals but service providers also must be trained to support survivors with histories of victimization related to gender identity and/or expression.

Definitions of and domestic violence safety and planning responses to IPV also need to be more encompassing of transgender and gender-diverse individuals, as survivors of IPV currently tend to receive services that adhere to conventional definitions of gender.⁴⁶ Crisis line workers, social service and legal providers, and law enforcement personnel need trainings to effectively support transgender individuals who have experienced IPV as well as additional forms of marginalization, abuse, and victimization. For example, as demonstrated in the present study, YTW who have experienced high levels of abuse and minority stressors may be at a heightened risk for IPV and could be screened for this possibility. There has been a push in the social service and health sectors to improve IPV screening practices,⁴⁹ and assessing for minority stressors and IPV may be a critical screening practice for professionals to use when serving transgender individuals.

Conclusion

Prevalence of IPV was high among YTW, including IPV experiences related to gender identity. YTW also experienced high prevalence of childhood abuse, transgender-related victimization, and unfair treatment and discrimination, all of which are associated with a greater risk for IPV. These findings have important implications for domestic violence service providers and other health professionals. Future research should continue to examine IPV among transgender individuals, a group at disparate risk for IPV, and seek to understand protective factors for IPV to promote health equity for this population.

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Disclaimer

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References

- Black MC, Basile KC, Breiding MJ, et al.: *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2011.
- Centers for Disease Control and Prevention: Intimate Partner Violence: Consequences. 2017. Available at www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html Accessed February 11, 2018.
- Edwards KM, Sylaska KM, Neal AM: Intimate partner violence among sexual minority populations: A critical review of the literature and agenda for future research. *Psychol Violence* 2015;5:112–121.
- Langenderfer-Magruder L, Walls NE, Whitfield DL, et al.: Partner violence victimization among lesbian, gay, bisexual, transgender, and queer youth: Associations among risk factors. *Child Adolesc Soc Work J* 2016;33:55–68.
- McKenry PC, Serovich JM, Mason TL, Mosack K: Perpetration of gay and lesbian partner violence: A disempowerment perspective. *J Fam Violence* 2006;21:233–243.
- American Psychological Association: Guidelines for psychological practice with transgender and gender nonconforming people. *Am Psychol* 2015;70:832–864.
- Reuter TR, Newcomb ME, Whitton SW, Mustanski B: Intimate partner violence victimization in LGBT young adults: Demographic differences and associations with health behaviors. *Psychol Violence* 2017;7:101–109.
- Testa RJ, Sciacca LM, Wang F, et al.: Effects of violence on transgender people. *Prof Psychol Res Pract* 2012;43:452–459.
- James SE, Herman JL, Rankin S, et al.: *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality, 2016.
- Brown TNT, Herman JL: *Intimate Partner Violence and Sexual Abuse Among LGBT People: A Review of Existing Research*. Los Angeles, CA: The Williams Institute, 2015.
- Langenderfer-Magruder L, Whitfield DL, Walls NE, et al.: Experiences of intimate partner violence and subsequent police reporting among lesbian, gay, bisexual, transgender, and queer adults in Colorado: Comparing rates of cisgender and transgender victimization. *J Interpers Violence* 2016; 31:855–871.
- Valentine SE, Peitzmeier SM, King DS, et al.: Disparities in exposure to intimate partner violence among transgender/gender nonconforming and sexual minority primary care patients. *LGBT Health* 2017;4:260–267.
- Guadalupe-Diaz XL, Anthony AK: Discrediting identity work: Understandings of intimate partner violence by transgender survivors. *Deviant Behav* 2017;38:1–16.
- White C, Goldberg J: Expanding our understanding of gendered violence: Violence against trans people and their loved ones. *Can Woman Stud* 2006;25:124–127.
- Yerke AF, DeFeo J: Redefining intimate partner violence beyond the binary to include transgender people. *J Fam Violence* 2016;31:975–979.
- Goldberg JM: *Trans People in the Criminal Justice System: A Guide for Criminal Justice Personnel*. Vancouver, BC: Justice Institute of BC and the Trans Alliance Society, 2003.
- Munson M, Cook-Daniels L: *Transgender/SOFFA: Domestic Violence/Sexual Assault Resource Sheet*. Milwaukee, WI: FORGE, 2003.
- Meyer IH: Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychol Bull* 2003;129:674–697.
- Hendricks ML, Testa RJ: A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the minority stress model. *Prof Psychol Res Pract* 2012;43:460–467.
- Reisner SL, White Hughto JM, Gamarel KE, et al.: Discriminatory experiences associated with posttraumatic stress disorder symptoms among transgender adults. *J Couns Psychol* 2016;63:509–519.
- Kenagy GP, Bostwick WB: Health and social service needs of transgender people in Chicago. *Int J Transgend* 2005;8: 57–66.
- Lombardi EL, Wilchins RA, Priesing D, Malouf D: Gender violence: Transgender experiences with violence and discrimination. *J Homosex* 2001;42:89–101.
- Xavier JM, Bobbin M, Singer B, Budd E: A needs assessment of transgendered people of color living in Washington, DC. *Int J Transgend* 2005;8:31–47.
- Clements-Nolle K, Marx R, Katz M: Attempted suicide among transgender persons: The influence of gender-based discrimination and victimization. *J Homosex* 2006;51:53–69.
- Bradford J, Reisner SL, Honnold JA, Xavier J: Experiences of transgender-related discrimination and implications for health: Results from the Virginia Transgender Health Initiative Study. *Am J Public Health* 2013;103:1820–1829.
- Factor RJ, Rothblum ED: A study of transgender adults and their non-transgender siblings on demographic characteristics, social support, and experiences of violence. *J LGBT Health Res* 2007;3:11–30.
- Breslow AS, Brewster ME, Velez BL, et al.: Resilience and collective action: Exploring buffers against minority stress for transgender individuals. *Psychol Sex Orientat Gend Divers* 2015;2:253–265.

28. Timmins L, Rimes KA, Rahman Q: Minority stressors and psychological distress in transgender individuals. *Psychol Sex Orientat Gend Divers* 2017;4:328–340.
29. Nemoto T, Bödeker B, Iwamoto M: Social support, exposure to violence and transphobia, and correlates of depression among male-to-female transgender women with a history of sex work. *Am J Public Health* 2011;101:1980–1988.
30. White Hughto JM, Pachankis JE, Willie TC, Reisner SL: Victimization and depressive symptomology in transgender adults: The mediating role of avoidant coping. *J Couns Psychol* 2017;64:41–51.
31. Gamarel KE, Reisner SL, Laurenceau JP, et al.: Gender minority stress, mental health, and relationship quality: A dyadic investigation of transgender women and their cisgender male partners. *J Fam Psychol* 2014;28:437–447.
32. Hatzenbuehler ML: How does sexual minority stigma “get under the skin?” A psychological mediation framework. *Psychol Bull* 2009;135:707–730.
33. Renner LM, Whitney SD: Risk factors for unidirectional and bidirectional intimate partner violence among young adults. *Child Abuse Negl* 2012;36:40–52.
34. Abajobir AA, Kisely S, Williams GM, et al.: Substantiated childhood maltreatment and intimate partner violence victimization in young adulthood: A birth cohort study. *J Youth Adolesc* 2017;46:165–179.
35. Kuhns LM, Mimiaga MJ, Reisner SL, et al.: Project LifeSkills—A randomized controlled efficacy trial of a culturally tailored, empowerment-based, and group-delivered HIV prevention intervention for young transgender women: Study protocol. *BMC Public Health* 2017;17:713.
36. Wilson EC, Garofalo R, Harris RD, et al.: Transgender female youth and sex work: HIV risk and a comparison of life factors related to engagement in sex work. *AIDS Behav* 2009;13:902–913.
37. Harris KM, Halpern CT, Whitsel E, et al.: The National Longitudinal Study of Adolescent to Adult Health: Study Design. 2009. Available at www.cpc.unc.edu/projects/addhealth/design Accessed September 30, 2017.
38. Pilkington NW, D’Augelli AR: Victimization of lesbian, gay, and bisexual youth in community settings. *J Community Psychol* 1995;23:34–56.
39. Williams DR, Yu Y, Jackson JS, Anderson NB: Racial differences in physical and mental health: Socio-economic status, stress, and discrimination. *J Health Psychol* 1997;2:335–351.
40. Muthén LK, Muthén BO: *Mplus User’s Guide, Version 7*. Los Angeles, CA: Muthén & Muthén, 2012.
41. Barrett BJ, Sheridan DV: Partner violence in transgender communities: What helping professionals need to know. *J GLBT Fam Stud* 2017;13:137–162.
42. Breiding MJ, Smith SG, Basile KC, et al.: Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization—National intimate partner and sexual violence survey, United States, 2011. *MMWR Surveill Summ* 2014;63:1–18.
43. Cadely HS, Pittman JF, Pettit GS, et al.: Classes of intimate partner violence from late adolescence to young adulthood. *J Interpers Violence* 2017:1–25.
44. Roch A, Morton J, Ritchie G: *Out of Sight, Out of Mind? Transgender People’s Experiences of Domestic Abuse*. Edinburgh: LGBT Youth Scotland and the Equality Network, 2010.
45. Seelman KL: Unequal treatment of transgender individuals in domestic violence and rape crisis programs. *J Soc Serv Res* 2015;41:307–325.
46. Albright M, Alcantara-Thompson D: *Contextualizing Domestic Violence from a LGBTQ Perspective*. Seattle, WA: Northwest Network of Bisexual, Trans, Lesbian and Gay Survivors of Abuse, 2011.
47. Walker JK: Investigating trans people’s vulnerabilities to intimate partner violence/abuse. *Partner Abuse* 2015;6:107–125.
48. Guadalupe-Diaz XL, Jasinski J: “I Wasn’t a Priority, I Wasn’t a Victim”: Challenges in help seeking for transgender survivors of intimate partner violence. *Violence Against Women* 2017;23:772–792.
49. Alvarez C, Fedock G, Trister Grace K, et al.: Provider screening and counseling for intimate partner violence: A systematic review of practices and influencing factors. *Trauma Violence Abuse* 2017;18:479–495.

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