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Experiences of Intimate Partner Violence Among Lesbian, Gay, Bisexual, and Transgender College Students: The Intersection of Gender, Race, and Sexual Orientation

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Abstract

Lesbian, gay, bisexual, and transgender (LGBT) college students experience disproportionate rates of intimate partner violence (IPV) compared with their heterosexual and cisgender counterparts. Some studies report rates of IPV among lesbian, gay, and bisexual college students as high as 50%, and 9 times greater among transgender students compared with their cisgender peers. Few studies have investigated the impact of intersectional identity on experiencing different types of IPV, such as emotional, physical, and sexual IPV. The present study utilized the National College Health Assessment–II from 2011 to 2013 ($n = 88,975$) to examine the differences in types of IPV among college students based on sexual orientation, gender identity, and the intersection of these two identities. Bivariate Rao–Scott chi-square and multilevel logistic regression was used to test the associations between sexual orientation, gender identity, and the intersection of these identities on multiple types of IPV. Adjusting for covariates and school clustering, LGBT college students had higher odds of reporting emotional IPV (adjusted odds ratios [AORs] = 1.34–1.99), physical IPV (AOR = 1.58–2.93), and sexual IPV (AOR = 1.41–6.18). Bisexual and transgender college students demonstrated the highest odds of reporting IPV based on sexual orientation and gender identity, respectively. Intersectional identities were not significantly associated with IPV. These findings demonstrate a need for clinicians working with college students to be aware of the disproportionate prevalence of IPV among LGBT individuals, particularly for those clients those who identify as bisexual and/or transgender and participate in continuing education related to these populations. Furthermore, these findings illustrate the need for additional intersectional research with LGBT college students.

Keywords

lesbian; gay; bisexual; transgender; intimate partner violence; National College Health Assessment; intersectionality

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Introduction

Intimate partner violence (IPV) is a serious societal problem for lesbian, gay, bisexual, and transgender (LGBT) young adults (Reuter, Newcomb, Whitton, & Mustanski, 2017). IPV is an abusive behavior occurring within the context of dating, intimate, and romantic relationships, consisting of physical (e.g., hitting, punching, and kicking), sexual (e.g., forced and nonconsensual sexual contact), or psychological (e.g., emotional or verbal) abuse (Graham, Jensen, Givens, Bowen, & Rizo, 2016; Reuter et al., 2017). Estimates of the prevalence of IPV among young adults range from 10% to 20%, with some studies suggesting rates of IPV among college students to be as high as 50% (Kaukinen, 2014). Historically, research into this societal problem has focused on heterosexual relationships, though research specific to LGBT persons is amassing (Graham et al., 2016; Langenderfer-Magruder, Whitfield, Walls, Kattari, & Ramos, 2016). The extant literature on IPV among LGBT populations suggests the prevalence in this community is comparable to or higher than in heterosexual populations (Langenderfer-Magruder et al., 2016; Reuter et al., 2017). One study of college-age couples found that 80% of participants reported experiencing IPV within their relationship, with LGBT participants couples reporting higher rates of IPV compared with their heterosexual counterparts (Graham et al., 2016). Furthermore, there is contradictory evidence in differences in rates of IPV by racial identity, with some racial groups experiencing greater rates of IPV compared with White populations while other studies show no differences in rates of IPV by racial identity (Barrick, Krebs, & Lindquist, 2013; Field, Kimuna, & Lang, 2015; Próspero & Kim, 2009; Raghavan, Rajah, Gentile, Collado, & Kavanagh, 2009).

Much of the extant research on IPV in LGBT samples lacks a nuanced examination of how the intersection of gender identity, sexual orientation, in addition to other social identities, might impact victimization (Edwards, Sylaska, & Neal, 2015). Unpinning the current study is the theory of intersectionality. The theory asserts individuals possess interdependent social identities that shape their experiences due to the power dynamics of each identity (Bowleg et al., 2017; Crenshaw, 1989). In those with marginalized identities, these inextricable identities may shape their experiences of marginalization, with persons with multiple marginalized identities experiencing greater levels of oppression (Bowleg, 2013; Collins, 1991). The present study examines the IPV victimization experiences of LGBT college students by examining, individually and intersectionally, sexual orientation, gender identity, and race/ethnicity as predictive identities.

IPV Among LGBT Adults

Estimates of IPV consistently demonstrate elevated rates of IPV among LGBT adults compared with their cisgender, heterosexual counterparts (Edwards et al., 2015; Mustanski, Andrews, Herrick, Stall, & Schnarrs, 2014). Although historically IPV research has focused on the experiences of heterosexual women, national data indicate the lifetime prevalence of this group to be 35%, lower than the prevalence for both lesbian (43.8%) and bisexual women (61.1%; Walters, Chen, & Breiding, 2013). Rates of IPV among gay men range from 12% to 78% depending on the type of violence and sampling method (Finneran & Stephenson, 2013; Houston & McKirnan, 2007; Walters et al., 2013); though similar to

women, bisexual men demonstrate the highest prevalence of lifetime IPV victimization (37.3%) compared with gay (26.0%) and heterosexual men (29.0%; Walters et al., 2013). Messinger (2011) similarly found that bisexual individuals were more likely to experience all forms of IPV compared with heterosexuals, gay men, and lesbians (Messinger, 2011). While cisgender gay and lesbian individuals face higher rates of IPV compared with heterosexual individuals, limited research suggests IPV prevalence among transgender individuals is even higher (Ard & Makadon, 2011). A Massachusetts study found that 34.6% of transgender individuals reported lifetime physical abuse by a partner compared with 13.6% of nontransgender persons (Landers & Gilsanz, 2009). More recently, Langenderfer-Magruder et al. (2016) found a similarly significant difference in lifetime IPV prevalence among a community sample of transgender (31.1%) and cisgender LGBQ (20.4%) participants in Colorado.

IPV Among LGBT Young Adults

Research on LGBT young adults (aged 18–25) is limited, with more research focusing on LGBT adolescents (below age 18); however, young adults demonstrate similarly high rates of IPV compared with cisgender heterosexual young adults (Edwards et al., 2015). For example, at a 4-year follow-up in a longitudinal study of LGBT young adults (aged 16–20 at baseline), lesbian (52.0%), gay (39.2%), bisexual (37.5%), and those who identified their sexual orientation as “other” (30.8%) reported high prevalence of ever experiencing IPV, with verbal abuse being more prevalent than physical abuse across sexual orientations (Reuter et al., 2017). This same study found that those who experienced verbal or physical IPV were significantly more likely to identify their gender as cisgender women or transwomen compared with cisgender men or transmen (Reuter et al., 2017). Similarly, in a recent study of LGBT college students, transgender students were 9 times more likely to report being in a sexually abusive relationship compared with their cisgender men counterparts (Griner et al., 2017). Studies with college-age LGBT samples have similarly found elevated rates of IPV (e.g., Graham et al., 2016). Edwards and Sylaska (2013) found that between 14% and 20% of their sample reported victimization in their current relationship, with nearly three fourths perceiving the violence to be related to their sexual orientation. Perpetration prevalence was slightly lower, ranging from 10.5% to 19.9%, depending on the form of abuse (Edwards & Sylaska, 2013).

Health Outcomes Associated With IPV

The effects of IPV exacerbate the problem itself, given the negative physical and psychological health outcomes (Campbell, 2002; Graham et al., 2016; Reuter et al., 2017). In particular, research found that survivors of IPV have elevated rates of physical injury, depression, posttraumatic stress disorder (Black et al., 2011; Howard, Wang, & Yan, 2007), substance abuse (Coker et al., 2010), sexually transmitted infections (Campbell, 2002), suicide ideations and attempts (Chiodo et al., 2012), and obesity (Ackard & Neumark-Sztainer, 2002). Cisgender men and women who experience IPV have been found to have negative mental health outcomes, including a higher likelihood of experiencing depressive symptoms, substance use, isolation, anxiety, and suicide threats (Coker et al., 2002; Du Mont et al., 2013; Elliott, Mok, & Briere, 2004). The higher prevalence of IPV among

LGBT young adults may put these communities are greater risk for negative health outcomes.

Theoretical Framework for IPV Among LGBT Young Adults

Scholars have applied multiple theories to explain IPV among LGBT communities (Edwards & Sylaska, 2013; Jones & Raghaven, 2012; Kubicek, 2016). One of the prevailing theories used to study IPV among LGBT individuals is social-ecological theory (Dardis, Dixon, Edwards, & Turchik, 2015), which examines the influence of different social levels (individual, relational, community, and societal) on sexual and gender minorities in the context of same-sex relationships. Adapting social-ecological theory to sexual minority stress, Dardis and colleagues (2015) suggest that the stress experienced by sexual and gender minorities because of their marginalized identity has the potential to manifest in IPV. The stress of marginalization may present in enabled IPV as a way to release the stress of oppression. Complementing this theory, disempowerment theory argues those who experience marginalization, and thus have constraints on their agency, are at risk for asserting their power in social contexts where they may have more agency and power, such as in intimate relationships (Edwards & Sylaska, 2013). The conceptual model of intersectionality of sexual identity, and gender and the effect on IPV among men who have sex with men (MSM) suggest that the intersectionality of social identities contributes to IPV among MSM (Kubicek, 2016). This framework argues that, in addition to the marginalizing factors on social identities, gender roles and traditional sexual scripts (e.g., acceptability of sexual aggression among men) that LGBT individuals adopt due to the lack of sexual scripts for sexual and gender minorities perpetuate violence in intimate relationships (Kubicek, 2016).

These theories may explain why bisexual individuals are at greater risk for IPV, as Messinger (2011) suggests same- and opposite-sex perpetrators may abuse for different reasons. Specifically, same-sex partners may be abusive toward their bisexual partner in an attempt to regain power (i.e., as a result of minority stress), while opposite sex-partners may not be able to relate to their bisexual partner's sexual orientation (e.g., lack of sexual scripts; Kubicek, 2016) and thus abuse as a form of homophobia. Similarly, transphobia may explain the high prevalence of IPV victimization among transgender persons (Langenderfer-Magruder et al., 2016). Brown (2008) posits that homophobia-related minority stressors are a major distinction between heterosexual and sexual minority IPV, thus it is reasonable that transphobia acts similarly as a potential risk factor for IPV affecting transgender persons (Langenderfer-Magruder et al., 2016).

Although several theories contribute to the explanation as to why IPV occurs (e.g., social learning theory; Ali & Naylor, 2013), historically, much of the IPV literature has focused on how a patriarchal world allows males to exert power, control, and privilege over cisgender women (e.g., Bledsoe & Sar, 2011; Seidman, 2008) in a cisgender, heterosexual context. As our understanding of sexual and gender identities has expanded beyond binary conceptualization, so too has our understanding of power and control. Many perpetration tactics, such as coercion and threats, economic abuse, and emotional abuse (Domestic Abuse Intervention Programs, 2017), can apply to individuals regardless of sexual or gender

identity. However, the abusive tactics themselves may look different in LGBT relationships. Messinger (2017) summarizes perpetration tactics noted across LGBT IPV research, such as closeting (i.e., forcing concealment of identity), outing or threatening to out (i.e., disclosing identity), withholding medications or funds necessary for a transgender partner's medical treatment, and telling a bisexual partner they should be gay/lesbian. In their qualitative study of IPV among young MSM, Kubicek, McNeeley, and Collins (2015) found that the lack of relationship role models or scripts for same-sex relationships is particularly meaningful for young adults who may lack relationship experience and perceive same-sex relationships as "more sexual" and "less permanent" than heterosexual relationships (p. 96). Thus, jealousy, a noted correlate of cisgender, heterosexual violent relationships (e.g., Foran & O'Leary, 2008), might be associated with IPV perpetration in LGBT relationships as well, such as controlling communication with others (Kubicek et al., 2015), albeit for different reasons. These unique perpetration tactics support the use of sexual minority stress (Dardis et al., 2015) and disempowerment theories (Edwards & Sylaska, 2013) to contextualize LGBT IPV.

Grounded in these theories and conceptual models, we surmise, similarly to other scholars, that LGBT college students experience higher rates of marginalization because of their sexual orientation and gender identity (Edwards & Sylaska, 2013; Graham et al., 2016; Kubicek, 2016). Furthermore, the stress of experiencing discrimination and harassment because of their marginalized identities will manifest negatively in intimate relationships as IPV. Based on the relationship scripts learned by LGBT college students, we propose differential rates of IPV among LGBT college students based on their sexual orientation and gender identity, whereby gay/lesbian, cisgender women, and transgender students are likely to experience higher rates of IPV, regardless of type. Based on empirical evidence, we posit rates of IPV will be higher among students who identify as a racial/ethnic minority. Intersectionally, the highest rates of IPV likely occur among sexual and gender minorities who are persons of color.

Current Study

Existing research suggests LGBT young adults and adults have a higher prevalence of experiencing IPV compared with their cisgender, heterosexual peers. Studies of IPV among college students, specifically, suggest higher prevalence of IPV among same-sex couples. With reports that find collegeaged LGBT individuals are more likely to attempt suicide, have a mental health condition, and have poorer mental health and health outcomes compared with their cisgender, heterosexual peers (Blosnich & Bossarte, 2012; Russell, Van Campen, Hoefle, & Boor, 2011; Seelman, 2016), it is important to understand the experience of IPV among LGBT college students, irrespective of their relationship status and its association with health outcomes for LGBT college students. Recently, Griner and colleagues (2017) examined the National College Health Assessment (NCHA) Data, finding that transgender students experienced disproportionately higher odds of victimization, including IPV. Using the same data set, we expand on their analysis by examining gender identity, sexual orientation, and race/ethnicity as predictors of IPV victimization, individually as well as intersectionally. Thus, the present study aimed to (a) examine the prevalence of different forms of IPV among college students irrespective of relationship status and (b) examine

differences in IPV forms based on sexual orientation, gender identity, race/ethnicity, and intersectional identities. In the field of violence, language is important. We acknowledge that participants may identify as victims or survivors. For consistency/brevity, we use the term *victims* throughout.

Method

Study Design and Participants

The data for analysis in this study came from the 2011–2013 waves of the NHCA survey. The survey is administered by the American College Health Association. Member higher education institutions volunteered to participate in the survey administration. A total of 120 higher education institutions were included in the final sample. Representativeness of the data was maintained by only including schools that sampled randomly selected students, sampled students in randomly selected classrooms, or sampled all students at their school in the final data set released to researchers. The survey was administered at the institutional level via paper or web-based surveys. The response rate for the paper survey ranged from a mean response proportion rate of 71% in 2011 to 100% in 2013. The mean response proportion rate for the web-based survey ranged from 16% in 2011 to 21% in 2013. A total of 88,975 students completed the survey. Each participating higher education institution's institutional review board (IRB) approved the original study procedures. The current study was approved by the IRBs at the University of Pittsburgh and Florida State University.

Measures

Outcomes.—Our three dependent variables were past-year experiences of IPV, including emotional, physical, and sexual victimization. These three outcomes were assessed with the following questions, “Within the last 12 months, have you been in an intimate (coupled/partnered) relationship that was: (1) emotionally abusive? (e.g., called derogatory names, yelled at, ridiculed); (2) physically abusive? (e.g., kicked, slapped, punched); (3) sexually abusive? (e.g., forced to have sex when you didn't want it, forced to perform or have an unwanted sexual act performed on you).” All questions offered yes/no response options to participants.

Key exposure variables.—Sexual identity was assessed with the following question: “What is your sexual orientation?” Participants selected one of the following options: *heterosexual, gay/lesbian, bisexual, or unsure*. Gender identity was assessed with the following question: “What is your gender?” Participants selected one of the following options: *female, male, or transgender*. As done previously (Coulter et al., 2017), we refer to participants as cisgender women, cisgender men, and transgender people, respectively. Race/ethnicity was assessed with the following question: “How do you usually describe yourself?” Participants selected one or more of the following options: *White, Black, Hispanic or Latino/a, Asian or Pacific Islander, American Indian, Alaskan Native, or Native Hawaiian, Biracial or Multiracial, or Other*. Due to small cell sizes for some groups, we created five categories: *White, Black, Hispanic or Latino/a, Asian or Pacific Islander, and Other*.

Covariates.—We controlled for race/ethnicity, age, year in school, relationship status, and survey year. Age in years was assessed continuously, but we created the following categories based on sample size and interpretability: 18, 19, 20, 21, 22, 23–24, 25–29, 30–39, and 40 years or more. Relationship status was measured with the following: “What is your marital status?” with response options of *single*, *married/partnered*, *separated*, *divorced*, and *other*. We collapsed this into four categories: *single*, *married/partnered*, *separated/divorced*, and *other*. Year in school was measured with the following: “What is your year in school?” with response options of *1st year undergraduate*, *2nd year undergraduate*, *3rd year undergraduate*, *4th year undergraduate*, *5th year or more undergraduate*, *graduate or professional*, *not seeking a degree*, or *other*. Due to small cell sizes, we combined “other” and “not seeking a degree” into a single category. Survey year was 2011, 2012, or 2013.

Analyses

Missing data for all outcomes were low, ranging from 0.6% for emotional IPV to 1.3% for sexual IPV; thus, we removed the 1.6% of participants missing any IPV outcomes. Of the remaining participants, missing data for each variable ranged between 1.7% for age and 2.3% for year in school. Because total missingness was low (5.0%), we used listwise deletion, creating an analytic sample of 83,139 participants.

We tested the bivariate associations between key exposure variables (gender identity, sexual orientation, race/ethnicity) and IPV outcomes using Rao–Scott chi-square tests to account for the clustering of students within schools. To examine multivariable associations of our IPV outcomes, we used multilevel logistic regression models with random intercepts, allowing IPV outcomes to vary by school. For each outcome variable, we fit a model containing the main effects of key exposure variables, adjusting for covariates. In subsequent models, we added all two-way and three-way interaction terms between sexual orientation, gender identity, and race/ethnicity. Because the three-way interaction terms were nonsignificant for all forms of IPV (all p values $> .25$), our final models only included all two-way interaction terms between our key exposure variables. We conducted analyses in Stata version 15 (College Station, TX).

Results

The demographic characteristics for the total sample stratified by sexual orientation and gender identity are presented in Table 1. The majority of participants reported their sexual orientation as heterosexual (91.4%). For gender identity, two thirds (66.7%) of participants identified as cisgender women. The racial/ethnic identity of the sample was predominantly White (66.6%) with a small proportion of participants reporting their racial/ethnic identity as Other (11.6%). More than half (52.1%) of participants reported their age as between 18 and 20 years of age. More than three quarters (86.7%) of participants indicated their marital status as single. Almost two thirds (64%) of the sample indicated their academic level as being between a first-year to third-year undergraduate student.

Emotional IPV

Overall, 9.23% of the sample reported experiencing emotional IPV (Table 1). There was a statistically significant association between emotional IPV and sexual orientation, $F(2.80, 333.44) = 88.24, p < .001$ (Table 2). Bisexual students had the highest percentage of reporting emotional IPV at 16.86%, followed by gay/lesbian students (11.9%), students who reported their sexual orientation as unsure (11.73%), and then heterosexual students (8.78%). There was also a statistically significant association between emotional IPV and gender identity, $F(1.92, 228.01) = 163.23, p < .001$. Students who reported their gender identity as transgender had the highest percentage of reporting emotional IPV at 18.41%, followed by cisgender women (10.54%) and then cisgender men (6.53%). There was a significant association between emotional IPV and race/ethnicity, $F(3.53, 419.66) = 21.79, p < .001$, such that Asians had the lowest at 6.66% and people with other race/ethnicity had the highest at 11.45%.

Table 3 displays the results of the logistic regression model predicting emotional IPV. Gay/lesbian students had higher odds of emotional IPV compared with heterosexual students (adjusted odds ratio [AOR] = 1.55; 95% confidence interval [CI] = [1.35, 1.77]). Likewise, bisexual students (AOR = 1.91; 95% CI = [1.83, 2.11]) and students who reported their sexual orientation as unsure (AOR = 1.34; 95% CI = [1.15, 1.57]) had higher odds of emotional IPV compared with heterosexual students. Compared with cisgender men, cisgender women (AOR = 1.65; 95% CI = [1.56, 1.75]) and transgender students (AOR = 1.99; 95% CI = [1.37, 2.88]) had higher odds of emotional IPV.

Physical IPV

Overall, 2.06% of the sample reported experiencing physical IPV (Table 1). There was a significant association between physical IPV and sexual orientation, $F(2.89, 343.75) = 55.11, p < .001$ (Table 2). Bisexual students had the highest percentage of reporting physical IPV (4.71%), followed by students who reported their sexual orientation as unsure (3.83%), gay/lesbian students (3.02%), and then heterosexual students (1.88%). Similarly, there was a statistically significant association between gender identity and physical IPV, $F(1.99, 237) = 25.57, p < .001$. Transgender participants had the highest percentage of reporting physical IPV (9.95%) followed by cisgender women (2.13%), and then cisgender men (1.88%). There was a significant association between sexual IPV and race/ethnicity, $F(3.73, 443.97) = 2,049, p < .001$, such that Asians had the lowest at 1.74% and people with Blacks had the highest at 3.40%.

The logistic regression model predicting physical IPV is illustrated in Model 2 of Table 3. Gay/lesbian students (AOR = 1.58; 95% CI = [1.23, 2.03]), students who reported their sexual orientation as bisexual (AOR = 2.34; 95% CI = [1.96, 2.79]), and students who reported their sexual orientation as unsure (AOR = 1.86; 95% CI = [1.43, 2.41]) had higher odds of reporting physical IPV compared with heterosexual participants. Compared with students who identified as cisgender male, transgender students had higher odds of reporting physical IPV (AOR = 2.93; 95% CI = [1.78, 4.82]).

Sexual IPV

Overall, 1.68% of the sample reported experiencing sexual IPV (Table 1). Like both emotional and physical IPV, there is a significant association between sexual IPV and sexual orientation, $F(2.80, 333.43) = 68.50, p < .001$ (Table 2). Participants who reported their sexual orientation as bisexual had the highest percentage of reporting sexual IPV (4.43%), followed by students who reported their sexual orientation as unsure (3.77%), gay/lesbian students (1.82%), and then students who reported their sexual orientation as heterosexual (1.51%). Moreover, there is statistically significant association between gender identity and sexual IPV, $F(1.96, 232.79) = 122.30, p < .001$. Students who reported their gender identity as transgender had the highest percentage of reporting sexual IPV (10.45%), followed by cisgender women (2.04%), then cisgender men (0.88%). There was a significant association between sexual IPV and race/ethnicity, $F(3.42, 407.30) = 10.44, p < .001$, such that Asians had the lowest at 1.17% and people with other race/ethnicity had the highest at 2.26%.

Predictors of experiencing sexual IPV among college students are presented in Model 3 of Table 3. Students who reported their sexual orientation as gay/lesbian (AOR = 1.41; 95% CI = [1.02, 1.94]), bisexual (AOR = 2.56; 95% CI = [2.13, 3.07]), or unsure (AOR = 2.24; 95% CI = [1.73, 2.91]) had higher odds of reporting experiencing sexual IPV compared with heterosexual students. Participants who reported their gender identity as cisgender women had higher odds of experiencing sexual IPV compared with participants who reported their gender identity as cisgender men (AOR = 2.22; 95% CI = [1.93, 2.56]). Similarly, transgender participants had higher odds of reporting sexual IPV compared with cisgender men (AOR = 6.18; 95% CI = [3.77, 10.11]).

Intersectional Identities and Predictors of IPV

The intersectional identity of sexual orientation, gender identity, and race/ethnicity were entered into a model (Table 4) examining predictors of experiencing different types of IPV among college students. In the model predicting experiencing emotional IPV, the interaction between transgender and Black was statistically significant, such that the differences between transgender and cisgender men were larger for Black people than White people. For emotional IPV, no other interactions were significant. For physical IPV, the only significant interaction was between people of unsure sexual orientation and people with other race/ethnicity, such that the disparities for people with unsure sexual orientation compared with heterosexuals were larger for people with other race/ethnicity than for White people.

For sexual IPV, more interactions were significant. The gay/lesbian–heterosexual differences in sexual IPV were smaller for cisgender women than cisgender men. Similarly, unsure–heterosexual differences in sexual IPV was smaller for cisgender women than cisgender men. In addition, the Black–White differences in sexual IPV were smaller for cisgender women than cisgender men. Finally, the Asian–White differences in sexual IPV were smaller for people who were unsure of their sexual orientation than those who were heterosexual.

Discussion

The current study explored the differences in experiencing three types of IPV (emotional, physical, and sexual) by sexual orientation, gender identity, and racial/ethnic identity among college students. The results indicate that IPV disproportionately affects students who have a minority sexual orientation, gender identity, or racial/ethnic identity. In this sample of college students, LGB students and students who identify their sexual orientation as bisexual had higher rates of reporting IPV, irrespective of type, compared with heterosexual students. In addition, the findings support our hypothesis that transgender students had higher rates of IPV compared with students who are cisgender women and cisgender men. Students who identified as bisexual consistently had the highest odds of experiencing all forms of IPV in the study. However, the rate of which gay/lesbian students and students who were unsure about their sexual orientation experiencing IPV varied depending on the type, with gay/lesbian students experiencing more emotional IPV than students unsure of their sexual orientation, but students unsure of their sexual orientation experiencing more physical or sexual IPV than gay/lesbian students. These findings suggest bisexual students might be at highest risk for being victimized by their partners. These differences also uncover the invisible risk of physical and sexual IPV for students who are questioning their sexual orientation. These findings are consistent with previous research findings illustrating sexual and gender minorities are at a higher risk for experiencing IPV compared with their heterosexual and cisgender counterparts (Langenderfer-Magruder et al. 2016; Coulter et al., 2017; Edwards et al., 2015; Graham et al., 2016; Walters et al., 2013). Experiences of IPV among the sample were mixed in terms of the effects of racial/ethnic identity. Asian participants had lower odds of reporting emotional and sexual IPV compared with White participants; however, both Hispanic and Black participants had higher odds of reporting physical IPV and Black participants had greater odds of reporting emotional IPV compared with White participants. Interestingly, persons who reported their racial/ethnic identity as “Other” had greater odds of reporting all forms of IPV compared with White participants. These findings echo the discrepant findings on the effect of race/ethnicity on IPV (Field et al., 2015; Próspero & Kim, 2009; Raghavan et al., 2009).

While the prevalence of IPV among college students is consistent with previous findings, the current study adds to the literature by investigating gender identity, sexual orientation, and racial/ethnic identity together instead of in silos. When taken together, the pattern of IPV among college students changes dramatically. In this sample, participants who identified as transgender and Black had 6 times greater odds of reporting emotional IPV and persons with an “Other” racial identity who were unsure of their sexual orientation had 2.4 times greater odds of reporting physical IPV. The other patterns observed on an individual identity level are not seen as significant at the intersectional level. These findings demonstrate the complexities of identity and the effects of identity on experiencing victimization. Intersectionality proposes individuals with minority statuses are typically unable to isolate sources of harassment, discrimination, and victimization (Bowleg, 2012, 2013). In intersectional studies of the effects of identity on experiences of discrimination and harassment, individual social identity does not predict multilevel experiences of

discrimination and harassment (Whitfield et al., 2014; Bowleg & Bauer, 2016; Lewis & Van Dyke, 2018).

While the present study did not ask about sex or gender identity of the perpetrator, as previously discussed, it is possible that bisexual individuals face victimization from partners who do not understand or accept their sexual orientation, and as an act of homophobia, aggress against them (e.g., telling a bisexual partner they should be gay/lesbian; Messinger, 2017). Those questioning their identity may similarly encounter partners who do not accept a nonbinary or unsure identity and use IPV as a form of control. Further qualitative research with bisexual and questioning individuals would help understand—from their perspectives—whether and how their sexual orientation, in conjunction with their intersecting identities, influenced their victimization.

Although research with the transgender population has increased over the years, sample sizes are typically too small to allow for nuanced analyses. However, given that certain sexual orientation (i.e., bisexual) and gender identity (i.e., transgender) groups demonstrate significantly higher prevalence of IPV than others, it is important that researchers examine data intersectionally when possible. The size of the present data set allowed us the opportunity to examine whether or not the intersection of sexual orientation and gender identity predicts IPV victimization. Although the findings were insignificant, it is important to note that some cell sizes remained small, particularly for transgender participants, even among a sample of this size. Thus, we believe it important for researchers to continue this exploration of intersectional identities within the context of IPV.

Limitations

The current study contributes to our understanding of different forms of IPV experienced by LGBT college students based on both sexual orientation and gender identity. This study highlights the disparities that exist in this phenomenon and demonstrates the need for future research to further examine these differences and the clinical significance for LGBT college students. The large sample size of the study allowed us to intersectionally examine the effects of sexual orientation and gender identity among multiple forms of IPV; however, there are several limitations of the study. As a college-based sample, these results cannot be generalized to the greater LGBT population. Moreover, social desirability bias cannot be ruled out given the sensitive nature of the primary variables included in the study (i.e., gender identity, sexual orientation, IPV victimization). However, our findings are similar to previous studies with LGBT college students (Edwards & Sylaska, 2013; Graham et al., 2016; Reuter et al., 2017), lending confidence to our results in this specific context.

Although our findings about transgender individuals are significant, the gender identity item was limited in that it was not inclusive of more gender identity options (e.g., transwomen, transmen, male to female [MTF], female to male [FTM], genderqueer). Similarly, the study did not include the standard two-question assessment of gender identity, therefore some persons who identify as male or female maybe also fit into the demographic category of transgender. Given the small proportion of the present sample that identified as transgender, it is likely that we would have had to collapse these categories for our analyses; however, additional gender identity options would have allowed for more nuanced prevalence data

regarding IPV. In addition, we could not separate out gay from lesbian. Web-based surveys had lower responses than in-person surveys, but this is common. Finally, we acknowledge that IPV is generally an underreported phenomenon (Tjaden & Thoennes, 2000), which might be exacerbated in the LGBT community due to issues such as homophobia and heterosexism (Brown, 2008). It is possible that the prevalence presented here reflects this and, in reality, might be higher.

Implications

Despite these limitations, the present findings lend themselves to several implications for research, practice, and policy. As previously noted, given the large sample size, we did not examine the interaction effects of sexual orientation and gender identity, which resulted in statistically insignificant findings. However, we encourage other researchers with access to similarly large data sets to continue examining potential interaction effects of sexual and gender identity as it relates to IPV, as this remains an emerging area of scholarship. This vein of research would be particularly appropriate for data sets with a large number of transgender participants, as small cell sizes can decrease the sensitivity of analyses. In addition, further qualitative research is needed to provide a better in-depth understanding of IPV from LGBT victims' perspectives. As quantitative transgender samples are often too small for nuanced analysis, phenomenological work with transgender or gender nonconforming individuals would be particularly useful to explore differential patterns in victimization experiences within this highly variable population.

In terms of practice, clinicians working with IPV should be aware of the disproportionate prevalence of IPV among LGBT individuals, particularly for clients those who identify as bisexual and/or transgender and participate in continuing education related to these populations. Especially considering its high prevalence, clinicians should be aware that the power and control dynamic can look different in LGBT relationships compared with exclusively cisgender, heterosexual relationships and familiarize themselves with some of the tactics unique to LGBT relationships. Individuals who work with the LGBT population, regardless of context, should be similarly aware of the high prevalence of IPV and familiarize themselves with local IPV-specific resources to assist their clients as needed. Future qualitative research examining the experiences of practitioners who work with LGBT individuals who have experienced IPV could illuminate population-specific needs and challenges and, in turn, provide direction for both resource development and practitioner continuing education.

On university and college campuses, specifically, inclusive victim advocacy programs are necessary to promote a culture of empowerment and healing for victims of all gender and sexual identities. University- and college-based advocates should consider specifically advertising their services to on-campus LGBT student groups, making particular mention of relevant confidentiality policies that might influence as student's willingness to use the services. Beyond advocacy, student health and wellness centers should be prepared to treat LGBT patients who present with physical or mental health needs following IPV victimization. Having inclusive intake forms (e.g., multiple gender identities) and culturally competent providers can help foster a supportive experience for LGBT victims of IPV.

Conclusion

The findings from this study highlight the higher rates of IPV experienced by LGBT college students compared with their heterosexual and cisgender counterparts in the United States. The results from this study indicate that lesbian, gay, bisexual students and those that identify their sexual orientation as unsure are more likely to experience all forms of IPV compared with their heterosexual counterparts. Similarly, transgender students are more likely to experience all forms of IPV compared with their cisgender college peers. Colleges and universities should be aware of the disproportionate rates of IPV experienced by LGBT students on their respective campuses to ensure the overall well-being and functioning of LGBT students. Colleges and universities should be well-equipped to provide survivors health and mental health services by providers who are culturally competent to work with LGBT students who have experienced IPV. Not only is additional research needed to provide mental health and other health services to LGBT students, but also additional institutional support and resources specifically tailored to LGBT students should be provided to these students to ensure they are provided with the supports necessary to thrive in their college or university setting.

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Table 1.

Demographics, National College Health Assessment Survey 2011–2013.

Characteristics (N = 83,139)	Sexual Orientation				Gender			Total Sample	
	Heterosexual, %	Gay/Lesbian, %	Bisexual, %	Unsure, %	Cisgender Men, %	Cisgender Women, %	Transgender, %	%	n
Sexual orientation									
Heterosexual	—	0.00	0.00	0.00	90.95	91.82	20.40	91.36	75,956
Gay/lesbian	0.00	—	0.00	0.00	4.69	1.67	18.91	2.71	2,253
Bisexual	0.00	0.00	—	0.00	2.44	4.45	35.82	3.86	3,208
Unsure	0.00	0.00	0.00	—	1.92	2.06	24.88	2.07	1,722
Gender									
Cisgender man	32.92	57.21	20.92	30.66	—	0.00	0.00	33.07	27,493
Cisgender woman	67.03	41.10	76.84	66.43	0.00	—	0.00	66.69	55,445
Transgender	0.05	1.69	2.24	2.90	0.00	0.00	—	0.24	201
Race/ethnicity									
White	67.13	63.74	63.06	55.52	65.63	67.18	55.72	66.64	55,403
Asian	8.87	6.08	6.02	12.20	10.68	7.82	2.99	8.76	7,279
Hispanic	7.80	8.43	8.10	8.83	7.50	8.03	5.97	7.85	6,529
Black	5.10	6.70	5.80	6.62	4.26	5.67	4.48	5.20	4,326
Other	11.09	15.05	17.02	16.84	11.93	11.29	30.85	11.55	9,602
Age category, years									
18	20.18	13.36	18.86	24.68	18.15	20.99	16.42	20.04	16,662
19	16.63	14.03	16.55	18.58	15.93	16.93	16.42	16.60	13,800
20	15.50	15.45	15.52	15.45	14.48	16.00	16.42	15.50	12,886
21	14.15	14.91	15.31	14.87	13.37	14.65	16.42	14.23	11,827
22	7.33	9.10	8.04	7.43	7.90	7.16	6.47	7.40	6,156
23–24	7.69	10.47	8.51	6.56	8.70	7.31	6.97	7.77	6,461
25–29	9.78	10.70	10.29	7.38	11.75	8.79	9.95	9.77	8,123
30–39	5.60	7.32	5.17	2.67	6.80	4.97	3.98	5.57	4,633
40 plus	3.15	4.66	1.75	2.38	2.92	3.19	7.96	3.12	2,591
Marital status									
Single	86.59	86.28	87.31	90.71	86.17	87.01	70.15	86.69	72,075

Characteristics (N = 83,139)	Sexual Orientation					Gender			Total Sample	
	Heterosexual, %	Gay/Lesbian, %	Bisexual, %	Unsure, %	Cisgender Men, %	Cisgender Women, %	Transgender, %	%	n	
Married/partnered	10.24	9.68	7.61	4.30	11.01	9.50	10.95	10.00	8,317	
Separated/divorced	1.63	0.84	2.24	1.51	1.26	1.79	9.45	1.63	1,357	
Other	1.54	3.20	2.84	3.48	1.55	1.70	9.45	1.67	1,390	
Grade										
First year	25.23	17.80	24.13	30.60	24.67	25.33	20.90	25.10	20,869	
Second year	19.04	17.89	18.86	20.85	18.57	19.27	17.41	19.04	15,827	
Third year	19.76	21.39	20.17	19.80	18.78	20.33	22.39	19.82	16,482	
Fourth year	15.83	16.87	16.24	13.65	14.77	16.34	19.40	15.83	13,162	
Fifth year	5.25	7.15	6.67	4.41	5.86	5.07	7.96	5.34	4,438	
Graduate/professional	14.03	18.15	12.91	9.23	16.52	12.76	8.46	13.99	11,635	
Other	0.86	0.75	1.03	1.45	0.83	0.89	3.48	0.87	726	

Table 2.

Prevalence of IPV by Category, National College Health Assessment Survey 2011–2013.

Characteristics (<i>N</i> = 83,139)	Emotional IPV	Physical IPV	Sexual IPV
	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
Sexual orientation			
Heterosexual	6,666 (8.78)	1,431 (1.88)	1,148 (1.51)
Gay/lesbian	268 (11.90)	68 (3.02)	41 (1.82)
Bisexual	541 (16.86)	151 (4.71)	142 (4.43)
Unsure	202 (11.73)	66 (3.83)	65 (3.77)
Gender			
Cisgender man	1,794 (6.53)	517 (1.88)	242 (0.88)
Cisgender woman	5,846 (10.54)	1,179 (2.13)	1,133 (2.4)
Transgender	37 (18.41)	20 (9.95)	21 (10.45)
Race/ethnicity			
White	4,935 (8.91)	1,004 (1.81)	912 (1.65)
Asian	485 (6.66)	127 (1.74)	85 (1.17)
Hispanic	678 (10.38)	170 (2.60)	90 (1.38)
Black	480 (11.10)	147 (3.40)	92 (2.13)
Other	1,099 (11.45)	268 (2.79)	217 (2.26)

Note. IPV = intimate partner violence.

Table 3.

Multivariable Results for IPV by Type, National College Health Assessment Survey 2011–2013.

Characteristics (<i>N</i> = 83,139)	Emotional IPV	Physical IPV	Sexual IPV
	AOR (95% CI)	AOR (95% CI)	AOR (95% CI)
Sexual orientation			
Heterosexual	1.00 (referent)	1.00 (referent)	1.00 (referent)
Gay/lesbian	1.55 [1.35, 1.77] ***	1.58 [1.23, 2.03] ***	1.41 [1.02, 1.94] *
Bisexual	1.91 [1.73, 2.11] ***	2.34 [1.96, 2.79] ***	2.56 [2.12, 3.07] ***
Unsure	1.34 [1.15, 1.57] ***	1.86 [1.43, 2.41] ***	2.24 [1.73, 2.91] ***
Gender			
Cisgender man	1.00 (referent)	1.00 (referent)	1.00 (referent)
Cisgender woman	1.65 [1.56, 1.75] ***	1.10 [0.98, 1.22]	2.22 [1.93, 2.56] ***
Transgender	1.99 [1.37, 2.88] ***	2.93 [1.78, 4.82] ***	6.18 [3.77, 10.11] ***
Race/ethnicity			
White	1.00 (referent)	1.00 (referent)	1.00 (referent)
Asian	0.89 [0.80, 0.98] *	1.15 [0.95, 1.40]	0.79 [0.63, 0.99] *
Hispanic	1.09 [0.99, 1.19]	1.31 [1.09, 1.56] **	0.81 [0.65, 1.01]
Black	1.17 [1.06, 1.30] **	1.78 [1.48, 2.13] ***	1.23 [0.99, 1.53]
Other	1.32 [1.23, 1.42] ***	1.49 [1.29, 1.71] ***	1.30 [1.11, 1.51] **

Note. All models adjusted for age, marital status, and year in school. IPV = intimate partner violence; AOR = adjusted odds ratio; CI = confidence interval.

* $p < .05$.

** $p < .01$.

*** $p < .001$.

Table 4.

Interaction Results for IPV by Type, National College Health Assessment Survey 2011–2013.

Characteristics (<i>N</i> = 83,139)	Emotional IPV	Physical IPV	Sexual IPV
	AOR (95% CI)	AOR (95% CI)	AOR (95% CI)
Sexual orientation			
Heterosexual	1.00 (referent)	1.00 (referent)	1.00 (referent)
Gay/lesbian	1.79 [1.44, 2.22]***	1.45 [0.95, 2.23]	3.03 [1.84, 4.99]***
Bisexual	1.80 [1.38, 2.35]***	1.79 [1.11, 2.89]*	2.79 [1.58, 4.93]***
Unsure	1.36 [0.96, 1.93]	1.94 [1.11, 3.39]*	4.14 [2.29, 7.47]***
Gender			
Cisgender man	1.00 (referent)	1.00 (referent)	1.00 (referent)
Cisgender woman	1.69 [1.57, 1.82]***	1.07 [0.93, 1.24]	2.85 [2.34, 3.47]***
Transgender	2.11 [0.82, 5.43]	1.65 [0.33, 8.24]	1.86 [0.21, 16.49]
Race/ethnicity			
White	1.00 (referent)	1.00 (referent)	1.00 (referent)
Asian	1.04 [0.87, 1.24]	1.43 [1.06, 1.93]*	1.22 [0.77, 1.95]
Hispanic	1.05 [0.87, 1.26]	1.43 [1.04, 1.96]*	1.21 [0.73, 2.01]
Black	1.16 [0.92, 1.46]	1.39 [0.93, 2.06]	2.26 [1.36, 3.76]**
Other	1.28 [1.11, 1.48]**	1.30 [1.00, 1.70]	1.47 [1.01, 2.14]*
Gender × Sexual Orientation Interactions			
Cisgender Woman × Gay/Lesbian	0.81 [0.62, 1.06]	1.33 [0.79, 2.22]	0.34 [0.17, 0.67]**
Cisgender Woman × Bisexual	1.02 [0.77, 1.33]	1.47 [0.90, 2.40]	0.91 [0.51, 1.61]
Cisgender Woman × Unsure	0.95 [0.66, 1.36]	0.60 [0.34, 1.06]	0.44 [0.23, 0.82]*
Transgender × Gay/Lesbian	0.39 [0.10, 1.59]	0.39 [0.03, 4.93]	0.81 [0.06, 10.81]
Transgender × Bisexual	0.83 [0.27, 2.50]	1.43 [0.25, 8.09]	1.50 [0.15, 14.62]
Transgender × Unsure	1.16 [0.35, 3.80]	1.21 [0.21, 6.86]	2.53 [0.26, 24.55]
Gender × Race/Ethnicity Interactions			
Cisgender Woman × Asian	0.82 [0.66, 1.01]	0.74 [0.5, 1.08]	0.63 [0.37, 1.07]
Cisgender Woman × Hispanic	1.02 [0.83, 1.25]	0.92 [0.64, 1.32]	0.60 [0.35, 1.04]
Cisgender Woman × Black	1.03 [0.80, 1.33]	1.32 [0.85, 2.04]	0.50 [0.29, 0.88]*
Cisgender Woman × Other	1.01 [0.86, 1.19]	1.13 [0.83, 1.54]	0.82 [0.55, 1.22]
Transgender × Asian	0.76 [0.07, 7.79]	2.03 [0.16, 26.21]	7.49 [0.50, 111.36]
Transgender × Hispanic	0.86 [0.16, 4.57]	3.47 [0.51, 23.36]	1.33 [0.13, 14.11]
Transgender × Black	6.13 [1.20, 31.32]*	6.21 [0.88, 43.64]	2.53 [0.36, 17.55]
Transgender × Other	1.05 [0.45, 2.46]	1.63 [0.46, 5.82]	1.88 [0.56, 6.30]
Sexual Orientation × Race/Ethnicity Interactions			
Gay/Lesbian × Asian	0.58 [0.27, 1.22]	0.25 [0.03, 1.86]	0.35 [0.04, 2.70]
Gay/Lesbian × Hispanic	1.04 [0.65, 1.66]	1.18 [0.54, 2.57]	0.75 [0.21, 2.68]
Gay/Lesbian × Black	0.89 [0.53, 1.50]	1.32 [0.62, 2.82]	0.20 [0.03, 1.51]
Gay/Lesbian × Other	1.05 [0.73, 1.50]	0.82 [0.39, 1.72]	0.92 [0.40, 2.09]

Characteristics (<i>N</i> = 83,139)	Emotional IPV	Physical IPV	Sexual IPV
	AOR (95% CI)	AOR (95% CI)	AOR (95% CI)
Bisexual × Asian	0.85 [0.52, 1.39]	1.02 [0.47, 2.22]	0.92 [0.38, 2.25]
Bisexual × Hispanic	1.18 [0.83, 1.68]	0.49 [0.23, 1.07]	1.27 [0.63, 2.55]
Bisexual × Black	0.98 [0.65, 1.48]	1.00 [0.53, 1.87]	0.58 [0.24, 1.40]
Bisexual × Other	1.23 [0.96, 1.58]	1.05 [0.67, 1.65]	1.16 [0.73, 1.83]
Unsure × Asian	0.95 [0.56, 1.62]	0.76 [0.27, 2.18]	0.09 [0.01, 0.94]*
Unsure × Hispanic	1.32 [0.80, 2.17]	0.93 [0.35, 2.46]	0.59 [0.17, 2.07]
Unsure × Black	0.59 [0.29, 1.19]	1.04 [0.38, 2.88]	1.09 [0.41, 2.88]
Unsure × Other	1.10 [0.74, 1.64]	2.45 [1.30, 4.59]**	1.23 [0.64, 2.34]

Note. All models adjusted for age, marital status, and year in school. IPV = intimate partner violence; AOR = adjusted odds ratio; CI = confidence interval.

* $p < .05$.

** $p < .01$.

*** $p < .001$.