

Sociodemographic Differences in Intimate Partner Violence Prevalence, Chronicity, and Severity Among Young Sexual and Gender Minorities Assigned Male at Birth: The P18 Cohort Study

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Christopher B. Stults,^{1,2}  Ellia Khan,³ 
Marybec Griffin,^{4,2} Kristen Krause,²
Siyan (Stan) Gao,³  and Perry N. Halkitis^{2,5}

Abstract

Intimate partner violence (IPV) is prevalent among young sexual and gender minorities assigned male at birth (YSGM-AMAB). However, few studies have examined the chronicity or distinguished between minor and severe forms of IPV among YSGM-AMAB. Furthermore, while past research has documented differences in IPV by race/ethnicity, sexual identity, gender identity, income, and education in other populations, few studies

¹Department of Psychology, Weisman School of Arts and Sciences, Baruch College, City University of New York

²Center for Health, Identity, Behavior, and Prevention Studies, School of Public Health, Rutgers University

³Sexual and Gender Minority Health Lab, Baruch College, City University of New York

⁴Department of Health Behavior, Society, and Policy, School of Public Health, Rutgers University

⁵Department of Urban-Global Public Health, and Department of Biostatistics and Epidemiology, School of Public Health, Rutgers University

Corresponding author:

Perry Halkitis, 683 Hoes Lane West, Piscataway, New Jersey 08854, United States.

Email: Perry.Halkitis@rutgers.edu

have examined these sociodemographic characteristics in relation to IPV in YSGM-AMAB. Thus, the present study aims to: (1) estimate past year prevalence and chronicity of minor and severe forms of IPV victimization and perpetration in a diverse sample of ($N = 665$) YSGM-AMAB in New York City, and (2) examine differences in IPV prevalence and chronicity by the aforementioned sociodemographic characteristics. Cross-sectional data from [BLINDED] informed these descriptive and inferential analyses. Nearly half of all participants reported past year IPV victimization and approximately 40% reported perpetration. Psychological violence was the most common form of victimization, followed by sexual, physical, and injury victimization. Psychological violence was the most common form of perpetration, followed by physical, sexual, and injury perpetration. Regarding sociodemographic differences in last year IPV prevalence, bisexual, transgender, and lower income YSGM-AMAB were more likely to report several subtypes of IPV victimization. Whereas Asian/API, bisexual, transgender, and lower income participants were more likely to report several subtypes of IPV perpetration. Regarding last year IPV chronicity, non-graduate YSGM-AMAB reported more instances of two subtypes of IPV victimization, while Black, White, cisgender, upper income, non-graduate participants reported more instances of several subtypes of IPV perpetration. These findings may be used to develop IPV prevention and intervention programs, inform future research endeavors, and develop and strengthen policies that reduce sociodemographic inequalities and promote more favorable sociopolitical conditions for YSGM-AMAB.

Keyword

intimate partner violence, young cisgender sexual minority men, young transgender and gender nonconforming people, prevalence, chronicity

Introduction

Intimate partner violence (IPV) includes acts of psychological, physical, and/or sexual aggression inflicted by or toward an intimate partner (e.g., spouse, partner, boy/girlfriend; Breiding et al., 2015), and there is growing recognition that IPV victimization and perpetration are common experiences among sexual and gender minorities assigned male at birth (SGM-AMAB), including among adults cisgender gay, bisexual, and other sexual minority men (SMM; Duncan et al., 2018; Finneran & Stephenson, 2013; Stephenson & Finneran, 2017; Stephenson et al., 2019; Suarez et al., 2018; Woodyatt & Stephenson, 2016). Indeed, studies have documented past year IPV victimization rates ranging from 41% to 47.8% among adult SMM, and past year

perpetration rates ranging from 33.6% to 50% (Stephenson & Finneran, 2017; Stephenson et al., 2019; Suarez et al., 2018). Despite the recent increase in research examining IPV among SMM, few studies have examined the chronicity (i.e., average frequency) of IPV in this population.

Research also suggests that IPV is prevalent among young sexual and gender minorities assigned male at birth (YSGM-AMAB), which includes young cis gender gay, bisexual, and other young sexual minority men (hereafter referred to as YSMM) and young transgender and gender nonconforming (YTGNC) populations. While the age range that characterizes YSMM and YTGNC samples has varied in previous studies, a number of studies have used the range of 18–25 years old. Indeed, this developmental period, which has been conceptualized by Arnett (2000) as the stage of emerging adulthood, refers to a transitional period that follows adolescence and precedes adulthood. This stage is one of instability, and it is characterized by the challenges that come with developmental change, exploration, and greater independence in a variety of areas, including school, friendships, work, and romantic relationships (Arnett, 2000). These developmental changes are especially salient for YTGNC populations, as they may intersect with transition-related processes (Bosse, 2019; Tatum et al., 2020). Therefore, it is important to understand IPV among YSGM-AMAB during this developmental period, in order to intervene early to prevent experiences of IPV and to help establish patterns of healthy intimate relationships across the lifespan (Kubicek et al., 2016).

Among cis gender YSMM specifically, studies report lifetime IPV victimization rates ranging from 39.2% to 53% (Freedner et al., 2002; Langenderfer-Magruder et al., 2016; Stults et al., 2015a), and lifetime IPV perpetration rates ranging from 12% to 30.5% (Stults et al., 2015a; Wong et al., 2010). These varying prevalence estimates may be due to differences in how IPV has been conceptually defined in previous studies as well as the different measurement tools that have been used to assess IPV in YSMM. Previous studies of IPV among YSMM have mostly relied on a few yes/no items and modified scales and have rarely made use of comprehensive and validated measures of IPV, such as the Revised Conflict Tactics Scale (CTS2). Moreover, as of this writing, only one study has examined the chronicity of IPV experiences among YSMM. Using the CTS2, researchers found that psychological victimization and perpetration were the forms of IPV most frequently reported, followed by physical, sexual, and injury victimization and perpetration (Kubicek et al., 2016). Thus, we are limited in our understanding of how chronic these IPV experiences are among YSMM. Furthermore, to our knowledge, no studies have distinguished between minor and severe forms of IPV victimization and perpetration among YSMM, indicating another noteworthy gap in the extant literature.

Few studies have examined gender identity in IPV-related research among lesbian, gay, bisexual, transgender, and queer (LGBTQ) people (Barrett & Sheridan, 2017; Laskey et al., 2019; Peitzmeier et al., 2020). Researchers often either focus on binary gender identities, treat TGNC identities as a monolith, or exclude transgender and non-binary people from their analyses, even though the limited extant literature suggests that transgender and non-binary people are at higher risk for IPV than their cisgender peers (Blondeel et al., 2017; Calton et al., 2016; Peitzmeier et al., 2020). For instance, one study of LGBTQ people revealed that 31.1% of transgender participants reported lifetime IPV victimization, compared with 20.4% of cisgender participants (Langenderfer-Magruder et al., 2016). Relatedly, in another study, 39% of transgender individuals reported lifetime IPV victimization, and 59% of those individuals indicated that the violence was related to their gender identity (Shipherd et al., 2011). In a study of LGBTQ youth, 88.9% of transgender respondents reported physical victimization, 61.1% sexual victimization, 58.8% psychological victimization, 58.8% physical perpetration, 29.4% psychological perpetration, and 17.6% sexual perpetration (Dank et al., 2014). In another study, 50% of transgender females reported physical victimization and 25% reported sexual victimization (Risser et al., 2005). The results of these studies suggest that gender minority individuals may be at heightened risk for experiences of IPV, as compared to their cisgender LGBTQ peers.

Sociodemographic Differences in IPV

Past research suggests that IPV prevalence and chronicity may differ by a number of different sociodemographic factors, including race/ethnicity, sexual identity, income, and education. Such findings are useful in determining what subgroups of people may be at elevated risk for certain types of IPV victimization and perpetration and can be used to further improve IPV assessment and prevention efforts. Even though IPV is common among YSGM-AMAB, there is little data regarding the differences in the prevalence and chronicity of these experiences by relevant sociodemographic factors. Previous studies using samples of adult SGM-AMAB and/or other populations may be useful in understanding which sociodemographic factors may be most relevant for better understanding IPV among YSGM-AMAB.

Previous research has documented differences in IPV by race/ethnicity. Among heterosexual men, Black and Hispanic/Latino men reported higher rates of physical and sexual IPV victimization than White men, and White men reported higher rates of injury victimization than Black and Hispanic/Latino men (Spencer et al., 2016). Among heterosexual and sexual-minority women, Black and Hispanic/Latina women reported higher rates of IPV than

White women (Clark et al., 2016; Spencer et al., 2016; Steele et al., 2020). These findings suggest that prevalence of IPV may differ by race/ethnicity, yet very few studies have examined these potential differences among adult SGM-AMAB, and among YSGM-AMAB specifically. One of the few existing studies found no significant differences in current or past IPV among adult SMM by race/ethnicity (Houston & McKirnan, 2007). There are contradictory findings regarding racial/ethnic differences in IPV among cisgender YSMM. A recent study found no significant differences by race/ethnicity among YSMM (Langenderfer-Magruder et al., 2016). By contrast, an earlier study found that Black YSMM reported higher rates of sexual IPV victimization and overall IPV perpetration than White YSMM, and White YSMM reported higher rates of psychological and physical IPV victimization than Black YSMM (Wong et al., 2010). Mixed findings are also present among TGNC adults, including YTGNC populations. For instance, a national study in the United States found that TGNC adults of color, especially indigenous individuals, were more likely to report lifetime physical, emotional, sexual, financial, and overall IPV victimization (James et al., 2016). However, other studies of diverse samples of YTGNC individuals did not find significant differences in the prevalence of lifetime IPV victimization by race/ethnicity (Garthe et al., 2018; Goldenberg et al., 2018).

There may also be differences in IPV by sexual identity. For example, two studies found that cisgender SMM were more likely to report past year (Goldberg & Meyer, 2013) and lifetime IPV (Goldberg & Meyer, 2013; West, 2012) than heterosexual men. In other studies, gay and bisexual men were more likely to report lifetime IPV victimization, as compared to heterosexual men (Chen et al., 2020; Messinger, 2011; West, 2012). Similarly, another study found that gay and bisexual men were twice as likely to report all types of IPV victimization than heterosexual men (Messinger, 2011). Additionally, bisexual men reported the highest prevalence of IPV, as compared to gay and heterosexual men (West, 2012). Likewise, recent studies of IPV among young men indicate that IPV may vary by sexual identity. Young gay and bisexual men reported higher rates of physical (Dank et al., 2014; Martin-Storey, 2015) and sexual victimization and perpetration (Dank et al., 2014; Graham et al., 2019) than young heterosexual men. In other studies, young bisexual men were five times more likely to report threats of outing by a partner than young gay men (Freedner et al., 2002), and were more likely to report physical victimization and perpetration than other YSMM (Edwards et al., 2016). Moreover, young men with unknown or unsure sexual identities reported higher prevalence of IPV, as compared to young gay and bisexual men (Langenderfer-Magruder et al., 2016; Martin-Storey, 2015).

IPV may also vary by income level. Lower income has been associated with IPV victimization in samples of heterosexual men (Spencer et al., 2016),

heterosexual women (Clark et al., 2016; Honeycutt et al., 2001) and sexual minority women (Steele et al., 2020). Similarly, lower- and middle-income cisgender SMM were more likely to report IPV victimization and perpetration than upper income SMM (Edwards, Sylaska, & Neal, 2015; Houston & McKirnan, 2007). Limited research on TGNC populations also suggests that TGNC adults with lower incomes have few resources to escape from abusive partners and thus may be more vulnerable to IPV, especially financial abuse (Messinger, 2020). And those who are forced into the underground economy due to discriminations in legitimate employment are especially vulnerable to IPV victimization (James et al., 2016). Despite these findings in other populations, to our knowledge, no studies of YSGM-AMAB have examined differences in IPV by income level.

Previous research also suggests that IPV may differ by education level. Among sexual minority women, women with a college education were less likely to report past year (Goldberg & Meyer, 2013; Steele et al., 2020) and lifetime IPV victimization (Goldberg & Meyer, 2013). Among SMM, one study found that IPV perpetration was associated with lower educational attainment among adult gay men (McKenry et al., 2006). Similarly, cisgender SMM with a college education were less likely to report any type of past year IPV victimization, as compared with SMM who had a high school education or less (Pruitt et al., 2015). Taken together, these findings suggest that there may also be differences in IPV by education level among YSGM-AMAB, yet no such studies have examined these potential differences thus far.

Although there has been a recent increase in research regarding IPV among YSGM-AMAB, the extant literature is limited in several ways. First, previous studies have primarily focused on estimating the prevalence of IPV, with few examining the chronicity of IPV in their samples. As a result, it is unclear whether IPV is a chronic health problem in this population, or if these experiences are primarily isolated incidents. Second, most studies have not used comprehensive measures of IPV, such as the CTS2, thereby limiting our understanding of the prevalence and chronicity of various forms of IPV victimization and perpetration (e.g., psychological aggression). Third, as a result of the aforementioned measurement limitations, most studies of IPV among YSGM-AMAB do not distinguish between minor and severe forms of IPV, thus preventing a fuller understanding of these experiences in this population. Finally, while past research suggests that YSGM-AMAB are disproportionately affected by IPV, there is a paucity of research examining specific sociodemographic characteristics in relation to IPV victimization and perpetration in this population. Thus, little is known about what subgroups within the larger population of YSGM-AMAB may be at heightened risk for experiences of IPV.

Given the demonstrated gaps in the extant literature, this study aims to: (a) estimate past year prevalence and chronicity of minor and severe forms of IPV victimization and perpetration among a diverse sample of $N = 665$ YSGM-AMAB in New York City using the CTS2 and (b) examine sociodemographic differences (i.e., gender identity, race/ethnicity, sexual identity, income, and education) in IPV prevalence and chronicity in this sample.

Methods

Study Design and Participants

The data for the present analyses come from the baseline data of Project 18 (P18), an ongoing cohort study of YSGM-AMAB in the New York City metropolitan area. Complete details regarding the purpose and design of the cohort study have been previously published (Halkitis et al., 2013). In short, between March 2014 and March 2016, 274 participants who were enrolled in a previous version of the P18 study consented to participate in a continuation of the study. During that same timeframe, an additional 391 participants were recruited via active (e.g., use of social media sites, gay-identified events and venues, community centers, and city streets and parks) and passive (e.g., flyers, internet advertisement, snowball sampling) recruitment methods, yielding a final purposive sample of 665 YSGM-AMAB. In order to be eligible for the study, participants had to: (a) be age 18–19 (at the time of enrollment into the original study period) or be age 23–24 (if newly recruited into the continuation of the study), (b) be assigned male at birth, (c) report sex with a male partner in the six months preceding enrollment (either into the original study period or the study continuation), and (d) report an HIV-negative serostatus (at the time of enrollment into either the original or continuation study periods). Participants who seroconverted (i.e., tested positive for HIV) during the original study period were eligible to be retained for the continuation of the study. The New York University Institutional Review Board approved the study protocol, and the study holds a federal Certificate of Confidentiality.

Measures

At each wave of data collection, participants completed Audio Computer-Assisted Self-Interviews (ACASI) to provide information on sociodemographic characteristics as well as experiences of IPV.

Sociodemographic characteristics. Gender identity was assessed using a single item (“Do you consider yourself to be”) with several response choices:

“male,” “female,” “transfemale,” “gender queer,” “I do not identify with a gender,” “refuse to answer,” and “not applicable.” Given the distribution (Table 1), for the present analyses, the gender identity variable was recategorized into two categories: (a) cisgender or (b) transgender, genderqueer, or other (transgender/other).

The race/ethnicity of the participants was obtained using two closed-ended survey items (“Are you of Hispanic or Latino origin?” and “What is your race?”). For the present analyses, these two items were collapsed to create a single race/ethnicity variable with five categories: (a) Asian/Asian Pacific Islander (Asian/API), (b) Hispanic/Latino (Latino), (c) Black non-Hispanic (Black), (d) White non-Hispanic (White), or (e) multiracial/other (Table 1).

Sexual identity was assessed using a single item (“Do you consider yourself to be”) with several response choices: heterosexual/straight, gay, lesbian, bisexual, refuse to answer, or not applicable. Given the distribution of the original variable (Table 1), for these analyses, the sexual identity variable was recategorized into two categories: (a) gay or (b) bisexual or other sexual identity (bisexual/other).

Income level was assessed using a single item (“What was your total annual income during the past year?”) with 12 response choices: \$0–4,999, \$5,000–9,999, \$10,000–14,999, \$15,000–19,999, \$20,000–24,999, \$25,000–34,999, \$35,000–44,999, \$45,000–54,999, \$55,000–64,999, \$65,000–74,999, \$75,000–99,999, and \$100,000 and over. Given that more than one-third of the sample reported earning less than \$5,000 in the past year (Table 1), potentially indicating poverty among a large subset of the sample, past year income was recategorized as: (a) less than \$5,000 or (b) more than \$5,000.

Education level was assessed using a single item (“What is the highest level of education that you have completed?”) with several response choices: junior high school diploma, high school diploma or GED, associate’s degree, bachelor’s degree, graduate degree, and refuse to answer. Given the distribution (Table 1), for the present analyses, the variable was recategorized as: non-graduate and graduate (i.e., graduate of college).

Intimate partner violence. The Revised Conflicts Tactics Scale (CTS2; Straus et al., 1996) was used to assess past year IPV. The CTS2 has four subscales of IPV victimization and perpetration respectively: psychological aggression (8 items), physical assault (12 items), injury (6 items) and sexual coercion (7 items). Each of the 8 subscales can be further classified into minor and severe subscales, resulting in a total of 16 subscales (e.g., minor psychological victimization). Each item in the CTS2 assesses the number of instances that participants and their partner(s) engaged in different types of IPV behaviors in the past year, using the following response choices: zero

times, once, twice, 3–5 times, 6–10 times, 11–20 times, more than 20 times, not in the past year but it did happen before, not applicable, refuse to answer, and don't know.

IPV chronicity refers to the number of times a set of IPV behaviors took place among participants and their partner(s) who reported such behaviors. The chronicity score was calculated by first recoding the original IPV items to reflect the following scheme: zero times = 0 instances; once = 1 instance; twice = 2 instances; 3–5 times = 4 instances; 6–10 times = 8 instances; 11–20 times = 15 instances; more than 20 times = 25 instances, and all other responses = 0. The corresponding recoded items were then summed to create chronicity subscales (e.g., minor psychological victimization). This coding scheme, which allows for the original ordinal level variables to be converted into continuous variables, was proposed by the developer of CTS2 (Straus, 2004). To conduct our analyses of IPV chronicity, a filter was used to only include cases with IPV chronicity subscales greater than 0. Thus, only those participants who reported one or more instances of a set of IPV behaviors (i.e., within each subscale) will be included in the corresponding chronicity analyses.

In order to calculate the prevalence of the various IPV domains (e.g., minor psychological victimization), each of the IPV chronicity subscales were dichotomized. Thus, participants who reported one or more instances of a set of IPV behaviors were coded as 1, while all other participants were coded as 0. Unlike the chronicity analyses, the prevalence estimates are based on the entire sample and no cases were excluded.

Additionally, to create the overall category variables for each of the types of IPV victimization and perpetration (e.g., overall psychological victimization), the corresponding minor and major subscale variables were collapsed into a single dichotomous variable. Similarly, to create the overall category variables for IPV victimization and perpetration respectively (e.g., overall victimization), the corresponding overall subscale variables were collapsed together to create a single dichotomous variable.

Analytic Plan

First, descriptive statistics for all variables of interest were computed. Second, binomial logistic regression models were constructed to examine the independent associations between the sociodemographic and IPV prevalence variables, and to produce unadjusted odds ratios (*UORs*) and 95% confidence intervals (95% CI). Finally, independent samples *t*-tests were used to examine differences in the means of the IPV chronicity variables by the sociodemographic variables of interest.

Table 1. Descriptive Statistics Summarizing the Original and Recategorized Sociodemographic Characteristic Variables from a Sample of ($N = 665$) YSGM-AMAB in New York City.

Original variable	<i>n</i> (valid %)	Recategorized variable	<i>n</i> (valid %)
Gender identity		Gender identity	
Male	621 (93.4)	Cisgender	621 (93.4)
Female	4 (0.6)	Transgender/other	44 (6.6)
Transfemale	5 (0.8)		
Genderqueer	22 (3.3)		
Do not identify	13 (2.0)		
Race/ethnicity		Race/ethnicity	
Asian/API	51 (7.7)	Asian/API	51 (7.7)
Latino	214 (32.2)	Latino	214 (32.2)
Black	182 (27.4)	Black	182 (27.4)
White	167 (25.1)	White	167 (25.1)
Multiracial/other	51 (7.7)	Multiracial/other	51 (7.7)
Sexual identity		Sexual identity	
Gay or lesbian	544 (83.3)	Gay	544 (83.3)
Bisexual	103 (15.8)	Bisexual/other	109 (16.7)
Heterosexual or straight	6 (0.9)		
Past year income		Income	
\$0–4,999	219 (34.6)	Less than \$5,000	219 (34.6)
\$5,000–9,999	77 (12.2)	\$5,000 or more	414 (65.4)
\$10,000–14,999	79 (12.5)		
\$15,000–19,999	44 (7.0)		
\$20,000–24,999	74 (11.7)		
\$25,000–34,999	60 (9.5)		
\$35,000–44,999	35 (5.5)		
\$45,000–54,999	22 (3.5)		
\$55,000–64,999	9 (1.4)		
\$65,000–74,999	5 (0.8)		
\$75,000–99,999	6 (0.9)		
\$100,000 and over	3 (0.5)		

continued

Original variable	<i>n</i> (valid %)	Recategorized variable	<i>n</i> (valid %)
Education		College	
Junior high school degree	14 (2.1)	Graduate	268 (40.4)
High school degree or GED	304 (45.8)	Non-graduate	396 (59.6)
Associate's degree	78 (11.7)		
Bachelor's degree	260 (39.2)		
Graduate degree	8 (1.2)		

Table 2. Descriptive Statistics Summarizing Past Year Prevalence and Chronicity of IPV Among a Sample of ($N = 665$) YSGM-AMAB in New York City.

	Prevalence (%)	Chronicity/ <i>M</i> (<i>SD</i>)
Victimization	313 (47.1%)	27.25 (49.71)
Psychological victimization	250 (37.6%)	18.13 (27.23)
Minor	227 (34.1%)	15.19 (21.56)
Severe	133 (20%)	8.16 (12.08)
Physical victimization	130 (19.5%)	15.08 (30.88)
Minor	121 (18.2%)	10.77 (16.49)
Severe	72 (10.8%)	9.13 (21.95)
Sexual victimization	147 (22.1%)	11.78 (16.36)
Minor	145 (21.8%)	10.29 (13.54)
Severe	16 (2.4%)	15.00 (15.00)
Injury victimization	28 (4.2%)	10.89 (15.71)
Minor	28 (4.2%)	5.79 (7.05)
Severe	13 (2.0%)	11.00 (14.99)
Perpetration	265 (39.8%)	25.90 (52.74)
Psychological perpetration	229 (34.4%)	17.41 (25.05)
Minor	216 (32.5%)	14.66 (19.93)
Severe	105 (15.8%)	7.82 (11.88)
Physical perpetration	116 (17.4%)	14.22 (36.53)
Minor	103 (15.5%)	10.51 (20.84)
Severe	56 (8.4%)	10.13 (25.51)
Sexual perpetration	90 (13.5%)	10.91 (15.57)
Minor	89 (13.4%)	9.19 (12.20)
Severe	9 (1.4%)	18.22 (18.89)
Injury perpetration	24 (3.6%)	10.13 (17.49)
Minor	23 (3.5%)	7.61 (11.68)
Severe	11 (1.7%)	6.18 (8.46)

Results

Prevalence and Chronicity Estimates

As displayed in Table 1, the majority of the sample identified as cisgender (93.4%), people of color (74.9%), gay (83.3%), as making more than \$5,000 in the past year (65.4%), and as a non-graduate of college (59.6%). Table 2 summarizes the IPV prevalence and chronicity variables across the entire sample, including prevalence estimates of the overall subscales, as well as each of the minor and severe subscales. In summary, past year IPV victimization was more prevalent (47.15%) than perpetration (39.8%). Within past year IPV victimization, psychological IPV was the most prevalent (37.6%), followed by sexual (22.1%), physical (19.5%), and injury victimization (4.2%). Similarly, psychological perpetration was most prevalent (34.4%), followed by physical (17.4%), sexual (13.5%), and injury perpetration (3.6%). See Table 2 for the prevalence estimates for each of the minor and severe subscales.

Regarding IPV chronicity, participants reported more instances of past year IPV victimization ($M = 27.25$) than perpetration ($M = 25.90$). Within IPV victimization, participants reported the most instances of psychological victimization ($M = 18.13$), followed by physical ($M = 15.08$), sexual ($M = 11.78$), and injury victimization ($M = 10.89$). Similarly, participants reported the most instances of psychological perpetration ($M = 17.41$), followed by physical ($M = 14.22$), sexual ($M = 10.91$), and injury perpetration ($M = 10.13$). See Table 2 for the chronicity estimates for each of the minor and severe subscales.

Sociodemographic Differences in IPV Prevalence

With respect to prevalence of past year IPV victimization (Table 3a), results of the unadjusted models indicate that transgender/other participants were more likely to report severe psychological ($UOR = 2.46$, 95% CI = 1.29, 4.70), severe physical ($UOR = 2.28$, 95% CI = 1.05, 4.96), and minor and severe injury victimization ($UOR = 3.33$, 95% CI = 1.20, 9.24; $UOR = 9.82$, 95% CI = 3.06, 31.44) than cisgender participants. Bisexual/other participants were more likely to report severe injury ($UOR = 6.15$, 95% CI = 2.03, 18.68) and severe sexual victimization ($UOR = 3.11$, 95% CI = 1.11, 8.75) than gay participants. Participants who made less than \$5,000 were more likely to report severe injury ($UOR = 3.10$, 95% CI = 1.00, 9.60), and minor and severe sexual victimization ($UOR = 1.64$, 95% CI = 1.12, 2.40; $UOR = 2.91$, 95% CI = 1.02, 8.30) than participants who made more than \$5,000. No

Table 3a. Unadjusted OR (95% CI) from Binomial Logistic Regression Analyses Examining Sociodemographic Differences in Last Year Prevalence of IPV Victimization Among (N = 665) YSGM-AMAB in New York City.

	Psychological						Physical					
	Minor			Severe			Minor			Severe		
	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)
Gender identity												
Cisgender	210 (33.8)	1.00	117 (18.8)	1.00	111 (17.9)	1.00	63 (10.1)	1.00				1.00
Transgender/other	17 (38.6)	1.23 (0.66, 2.31)	16 (36.4)	2.46 ^b (1.29, 4.70)	10 (22.7)	1.35 (0.65, 2.82)	9 (20.5)	2.28 ^b (1.05, 4.96)				
Race/ethnicity												
Asian/API	12 (23.5)	1.00	7 (13.7)	1.00	7 (13.7)	1.00	3 (5.9)	1.00				1.00
Latino	70 (32.7)	1.58 (0.78, 3.21)	48 (22.4)	1.82 (0.77, 4.29)	41 (19.2)	1.49 (0.63, 3.55)	26 (12.1)	2.21 (0.64, 7.62)				
Black	55 (30.2)	1.41 (0.69, 2.89)	34 (18.7)	1.44 (0.60, 3.48)	28 (15.4)	1.14 (0.47, 2.79)	14 (7.7)	1.33 (0.37, 4.83)				
White	69 (41.3)	2.29 (1.12, 4.69)	30 (18.0)	1.38 (0.57, 3.35)	33 (19.8)	1.55 (0.64, 3.75)	22 (13.2)	2.43 (0.70, 8.47)				
Multiracial/other	21 (41.2)	2.28 (0.97, 5.35)	14 (27.5)	2.38 (0.87, 6.51)	12 (23.5)	1.93 (0.69, 5.40)	7 (13.7)	2.55 (0.62, 10.46)				
Sexual Identity												
Gay	186 (34.2)	1.00	104 (19.1)	1.00	95 (17.5)	1.00	55 (10.1)	1.00				1.00
Bisexual/other	36 (35.0)	0.99 (0.64, 1.53)	25 (24.3)	1.39 (0.86, 2.62)	24 (23.3)	1.48 (0.90, 2.42)	14 (13.6)	1.53 (0.84, 2.79)				

continued

Table 3a. Continued

	Psychological						Physical					
	Minor			Severe			Minor			Severe		
	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)
Income												
\$5,000 or more	151 (36.5)	1.00	83 (20.0)	1.00	73 (17.6)	1.00	41 (9.9)	1.00				
Less than \$5,000	68 (31.1)	0.78 (0.55, 1.11)	46 (21.0)	1.06 (0.71, 1.59)	45 (20.5)	1.21 (0.80, 1.83)	30 (13.7)	1.44 (0.87, 2.39)				
College												
Graduate	98 (36.6)	1.00	49 (18.3)	1.00	45 (16.8)	1.00	28 (10.4)	1.00				
Non-graduate	129 (32.6)	0.83 (0.61, 1.61)	84 (21.2)	1.20 (0.81, 1.78)	76 (19.2)	1.18 (0.78, 1.77)	44 (11.1)	1.07 (0.65, 1.77)				
Gender identity												
Cisgender	23 (3.7)	1.00	8 (1.3)	1.00	133 (21.4)	1.00	13 (2.1)	1.00				
Transgender/other	5 (11.4)	3.33 ^a (1.20, 9.24)	5 (11.4)	9.82 ^b (3.06, 31.44)	12 (27.3)	1.38 (0.69, 2.74)	3 (6.8)	3.42 (0.94, 12.49)				
Race/ethnicity												
Asian/API	1 (2.0)	1.09 (0.11, 10.75)	0 (0.0)	–	13 (25.5)	1.63 (0.77, 3.43)	1 (2.0)	–				
Latino	12 (5.6)	3.25 (0.90, 11.70)	7 (3.3)	–	54 (25.2)	1.61 (0.97, 2.66)	6 (2.8)	–				

continued

Table 3a. Continued

	Psychological						Physical					
	Minor			Severe			Minor			Severe		
	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)
Black	8 (4.4)	2.51 (0.66, 9.64)	4 (2.2)	—	33 (18.1)	1.05 (0.61, 1.83)	5 (2.7)	—				
White	3 (1.8)	1.00	0 (0.0)	—	29 (17.4)	1.00	1 (0.6)	—				
Multiracial/other	4 (7.8)	4.65 (1.01, 21.52)	2 (3.9)	—	16 (31.4)	2.18 (1.07, 4.44)	3 (5.9)	—				
Sexual Identity												
Gay	21 (3.9)	1.00	6 (1.1)	1.00	113 (20.8)	1.00	10 (1.8)	1.00				
Bisexual/other	6 (5.8)	1.71 (0.71, 4.13)	6 (5.8)	6.15 ^b (2.03, 18.68)	28 (27.2)	1.52 (0.95, 2.41)	5 (4.9)	3.11 ^a (1.11, 8.75)				
\$5,000 or more	14 (3.4)	1.00	5 (1.2)	1.00	79 (19.1)	1.00	6 (1.4)	1.00				
Less than \$5,000	14 (6.4)	1.95 (0.91, 4.17)	8 (3.7)	3.10 ^a (1.00, 9.60)	61 (27.9)	1.64 ^a (1.12, 2.40)	9 (4.1)	2.91 ^a (1.02, 8.30)				
College												
Graduate	6 (2.2)	1.00	1 (0.4)	—	57 (21.3)	1.00	3 (1.1)	1.00				
Non-graduate	22 (5.6)	2.57 ^a (1.03, 6.42)	12 (3.0)	—	88 (22.2)	1.06 (0.73, 1.54)	13 (3.3)	3.00 (0.85, 10.62)				

Note. OR = odds ratio; CI = confidence interval; ^ap < .05; ^bp < .01; — insufficient cell size.

Table 3b. Unadjusted OR (95% CI) from Binomial Logistic Regression Analyses Examining Sociodemographic Differences in Last Year Prevalence of IPV Perpetration Among (N = 665) YSGM-AMAB in New York City.

	Psychological				Physical			
	Minor		Severe		Minor		Severe	
	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)
Gender identity								
Cisgender	198 (31.9)	1.00	94 (15.1)	1.00	96 (15.5)	1.00	50 (8.1)	1.00
Transgender/ other	18 (40.9)	1.48 (0.79, 2.76)	11 (25.0)	1.87 (0.91, 3.83)	7 (15.9)	1.04 (0.45, 2.39)	6 (13.6)	1.80 (0.73, 4.47)
Race/ethnicity								
Asian/API	12 (23.5)	1.00	7 (13.7)	1.00	6 (11.8)	1.00	3 (5.9)	1.00
Latino	72 (33.6)	1.65 (0.81, 3.34)	37 (17.3)	1.31 (0.55, 3.15)	32 (15.0)	1.32 (0.52, 3.35)	21 (9.8)	1.74 (0.50, 6.08)
Black	53 (29.1)	1.34 (0.65, 2.75)	26 (14.3)	1.05 (0.43, 2.58)	26 (14.3)	1.25 (0.49, 3.22)	13 (7.1)	1.23 (0.34, 4.50)
White	60 (35.9)	1.82 (0.89, 3.74)	23 (13.8)	1.00 (0.40, 2.50)	28 (16.8)	1.51 (0.59, 3.88)	14 (8.4)	1.46 (0.40, 5.31)
Multiracial/other	19 (37.3)	1.93 (0.82, 4.56)	12 (23.5)	1.93 (0.69, 5.40)	11 (21.6)	2.06 (0.70, 6.09)	5 (9.8)	1.74 (0.39, 7.70)
Sexual Identity								
Gay	176 (32.9)	1.00	81 (14.9)	1.00	84 (15.4)	1.00	44 (8.1)	1.00
Bisexual/other	36 (35.0)	1.07 (0.70, 1.66)	21 (20.4)	1.52 (0.91, 2.56)	17 (16.5)	1.16 (0.67, 2.00)	11 (10.7)	1.41 (0.72, 2.76)

continued

Table 3b. Continued

	Psychological				Physical			
	Minor		Severe		Minor		Severe	
	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)
Income								
\$5,000 or more	146 (35.5)	1.00	66 (15.9)	1.00	66 (15.9)	1.00	30 (7.2)	1.00
Less than \$5,000	58 (26.5)	0.66 ^a (0.46, 0.95)	36 (16.4)	1.04 (0.66, 1.62)	36 (16.4)	1.04 (0.66, 1.62)	25 (11.4)	1.65 (0.94, 2.88)
College								
Graduate	89 (33.2)	1.00	39 (14.6)	1.00	42 (15.7)	1.00	18 (6.7)	1.00
Non-graduate	127 (32.1)	0.95 (0.68, 1.32)	66 (16.7)	1.17 (0.76, 1.81)	61 (15.4)	0.98 (0.64, 1.50)	38 (9.6)	1.47 (0.82, 2.64)
Gender identity								
Cisgender	20 (3.2)	1.00	8 (1.3)	1.00	80 (12.9)	1.00	7 (1.1)	1.00
Transgender/other	3 (6.8)	2.20 (0.63, 7.71)	3 (6.8)	1.71 (0.80, 3.70)	9 (20.5)	1.74 (0.81, 3.75)	2 (4.5)	4.18 (0.84, 20.74)
Race/ethnicity								
Asian/API	1 (2.0)	1.09 (0.11, 10.75)	0 (0.00)	—	13 (25.5)	3.23 ^a (1.43, 7.29)	0 (0.0)	—
Latino	9 (4.2)	2.40 (0.64, 9.01)	6 (2.8)	—	35 (16.4)	1.85 (0.98, 3.46)	4 (1.9)	—

continued

Table 3b. Continued

	Psychological				Physical			
	Minor		Severe		Minor		Severe	
	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)	n (%)	UOR (95% CI)
Black	7 (3.8)	2.19 (0.56, 8.60)	3 (1.6)	–	18 (9.9)	1.04 (0.51, 2.10)	3 (1.6)	–
White	3 (1.8)	1.00	1 (0.6)	–	16 (9.6)	1.00	1 (0.6)	–
Multiracial/other	3 (5.9)	3.42 (0.67, 17.48)	1 (2.0)	–	7 (13.7)	1.50 (0.58, 3.88)	1 (2.0)	–
Sexual Identity								
Gay	18 (3.3)	1.00	6 (1.1)	1.00	66 (12.1)	1.00	5 (0.9)	1.00
Bisexual/other	5 (4.9)	1.41 (0.51, 3.69)	5 (4.9)	1.90 ^a (1.13, 3.22)	20 (19.4)	1.94 ^a (1.14, 3.28)	4 (3.9)	4.11 ^a (1.09, 15.55)
Income								
\$5,000 or more	11 (2.7)	1.00	2 (0.5)	1.00	48 (11.6)	1.00	2 (0.5)	1.00
Less than \$5,000	12 (5.5)	2.12 (0.92, 4.90)	9 (4.1)	1.70 ^a (1.08, 2.69)	39 (17.8)	1.65 ^a (1.04, 2.61)	7 (3.2)	6.80 ^a (1.40, 33.03)
College								
Graduate	5 (1.9)	1.00	1 (0.4)	–	33 (12.3)	1.00	1 (0.4)	–
Non-graduate	18 (4.5)	2.51 (0.92, 6.83)	10 (2.5)	–	56 (14.1)	1.17 (0.74, 1.86)	8 (2.0)	–

Note. OR = odds ratio; CI = confidence interval; ^ap < .05; ^bp < .01; – insufficient cell size.

Table 4. Results of One-Way Analyses of Variance and Independent Samples t-tests Examining Sociodemographic Differences in Last Year IPV Chronicity Among (N = 665) YSGM-AMAB in New York City.

	Victimization													
	Psychological				Physical				Injury				Sexual	
	Minor M (SD)	Severe M (SD)	Minor M (SD)	Severe M (SD)	Minor M (SD)	Severe M (SD)	Minor M (SD)	Severe M (SD)	Minor M (SD)	Severe M (SD)	Minor M (SD)	Severe M (SD)		
Gender identity														
Cisgender	15.60 (22.21)	8.52 (12.50)	10.95 (16.97)	9.11 (23.22)	4.87 (5.86)	5.63 (8.43)	10.37 (13.77)	15.23 (16.35)						
Transgender/ other	10.18 (9.56)	5.50 (8.16)	8.70 (9.98)	9.22 (9.92)	10.00 (10.93)	19.60 (19.98)	9.42 (11.03)	14.00 (9.17)						
Race/ethnicity														
Asian/API	8.42 (8.95)	5.00 (5.48)	4.00 (3.00)	1.67 (1.15)	4.00 (0.00)	–	5.23 (6.33)	4.00 (0.00)						
Latino	20.51 (26.67)	9.29 (11.65)	12.17 (21.03)	10.62 (29.01)	4.00 (2.56)	10.57 (15.86)	12.19 (13.83)	16.67 (19.69)						
Black	12.36 (18.92)	11.38 (17.22)	13.86 (18.27)	13.86 (25.85)	8.13 (8.87)	3.75 (2.06)	6.36 (7.38)	19.00 (14.20)						
White	12.83 (18.38)	4.53 (7.19)	8.39 (11.22)	6.05 (12.30)	1.00 (.00)	–	14.21 (19.67)	2.00 (0.00)						
Multiracial/ other	16.48 (21.68)	5.79 (5.86)	9.25 (9.38)	7.00 (9.36)	10.50 (12.61)	27.00 (21.21)	9.00 (9.91)	13.00 (10.82)						
Sexual Identity														
Gay	14.84 (22.29)	6.90 (10.17)	11 (17.43)	8.07 (21.47)	3.95 (3.47)	12.67 (16.46)	10.32 (13.88)	10.80 (17.13)						

continued

Table 4. Continued

Bisexual/ other	17.57 (18.54)	13.37 (17.14)	9.92 (12.73)	13.25 (24.28)	11.29 (11.69)	9.57 (14.77)	10.48 (12.56)	22.00 (7.29)
Income								
\$5,000 or more	15.64 (22.36)	7.75 (11.57)	9.25 (14.29)	7.83 (17.63)	5.29 (6.74)	9.80 (16.93)	12.13 (15.68)	7.17 (7.70)
Less than \$5,000	15.07 (20.93)	9.35 (13.39)	13.71 (19.78)	11.17 (27.24)	6.29 (7.57)	11.75 (14.82)	8.34 (10.43)	21.44 (16.65)
College								
Graduate	11.71 ^a (15.46)	6.33 (11.99)	9.20 (14.25)	5.75 (18.17)	5.67 (10.46)	4.00 (0.0)	5.96 ^b (7.40)	8.00 (8.72)
Non-graduate	17.83 ^a (24.97)	9.23 (12.07)	11.70 (17.71)	11.27 (24.00)	5.82 (6.15)	11.58 (15.50)	13.09 ^b (15.75)	16.62 (15.93)
				Perpetration				
				Psychological			Sexual	
				Minor	Severe	Injury	Minor	Severe
				M (SD)	M (SD)	M (SD)	M (SD)	M (SD)
Gender identity								
Cisgender	15.11 (20.51)	7.82 (12.05)	10.53 (21.36)	10.04 (26.78)	6.95 (11.85)	7.50 (9.68)	10.00 ^b (12.61)	18.57 (20.47)
Transgender/ other	9.78 (11.13)	7.82 (10.86)	10.29 (12.50)	10.83 (11.43)	12.00 (11.53)	2.67 (2.08)	2.00 ^b (1.32)	17.00 (18.38)

continued

Table 4. Continued

Race/ethnicity									
Asian/API	7.33 (7.56)	2.43 (1.90)	4.00 (3.16)	1.33 (0.58)	–	–	–	4.54 ^a (6.42)	–
Latino	18.35 (22.70)	9.19 (13.87)	15.84 (31.91)	16.38 (37.58)	5.11 (3.92)	2.17 (1.60)	11.94 (14.75)	16.75 (25.00)	
Black	11.45 (16.74)	11.65 (15.56)	12.65 (18.15)	10.23 (20.40)	13.57 (18.43)	16.33 (11.59)	7.89 ^a (10.51)	22.00 (15.72)	
White	12.70 (18.18)	3.52 (3.42)	6.54 (8.84)	3.50 (3.30)	1.00 (0.00)	1.00 (0.00)	9.88 ^a (13.04)	1.00 (0.00)	
Multiracial/ other	20.47 (24.82)	6.67 (5.40)	3.64 (2.77)	7.40 (13.22)	9.00 (13.86)	5.00 (0.00)	5.86 (4.38)	30.00 (0.00)	
Sexual Identity									
Gay	14.84 (20.89)	7.06 (11.00)	10.67 (22.23)	9.66 (26.58)	6.50 (11.38)	6.50 (10.15)	9.89 (12.40)	17.80 (23.40)	
Bisexual/ other	14.11 (15.56)	10.48 (14.75)	9.84 (13.43)	11.83 (22.09)	11.60 (13.18)	5.80 (7.05)	7.17 (11.64)	18.75 (14.86)	
\$5,000 or more	15.17 (20.75)	6.73 (10.53)	7.94 (15.09)	6.67 (14.51)	6.73 (7.75)	10.00 (11.31)	11.75 ^a (15.00)	18.50 (20.51)	
Less than \$5,000	15.16 (19.48)	10.33 (14.19)	15.50 (28.31)	14.64 (34.60)	8.42 (14.72)	5.33 (8.31)	6.41 ^a (6.89)	18.14 (20.14)	
College									
Graduate	11.44 ^a (15.62)	6.05 (10.76)	7.95 (14.76)	6.22 (17.71)	6.60 (11.41)	18.00 (0.0)	8.15 (9.57)	33.00 (0.0)	
Non-graduate	16.92 ^a (22.25)	8.86 (12.46)	12.28 (24.11)	11.97 (28.50)	7.89 (12.06)	5.00 (7.90)	9.80 (13.56)	16.38 (19.31)	

Note. ^a*p* < .05; ^b*p* < .01; – no cases.

differences in past year victimization were detected by race/ethnicity or college education.

With respect to prevalence of past year IPV perpetration (Table 3b), results of the unadjusted models indicate that transgender/other participants were more likely to report severe injury perpetration ($UOR = 5.61$, 95% CI = 1.43, 21.93) than cisgender participants. Asian/API participants were more likely to report minor sexual perpetration ($UOR = 3.23$, 95% CI = 1.43, 7.29) than White participants. Bisexual/other participants were more likely to report severe injury perpetration ($UOR = 4.31$, 95% CI = 1.29, 14.38), and minor and severe sexual perpetration ($UOR = 1.94$, 95% CI = 1.14, 3.28; $UOR = 4.11$, 95% CI = 1.09, 15.55) than gay participants. Participants who made less than \$5,000 were less likely to report minor psychological perpetration ($UOR = 0.66$, 95% CI = 0.46, 0.95), but more likely to report severe injury ($UOR = 8.83$, 95% CI = 1.89, 41.23) and severe sexual perpetration ($UOR = 6.80$, 95% CI = 1.40, 33.03) than participants who made more than \$5,000. No differences in past year perpetration were observed by college education.

Sociodemographic Differences in IPV Chronicity

With respect to chronicity of past year IPV victimization (Table 4), results of the independent samples *t*-tests indicate that non-graduates reported more instances of minor psychological ($M = 17.83$, $SD = 24.97$) than college graduates [$M = 11.71$, $SD = 15.46$; $t(216.90) = 2.27$, $p = .024$], as well as more instances of minor sexual victimization ($M = 13.09$, $SD = 5.96$) than college graduates [$M = 5.96$, $SD = 7.40$; $t(132.49) = 3.67$, $p < .001$]. No differences in victimization chronicity were detected by gender identity, race/ethnicity, sexual identity, or income.

Regarding chronicity of past year IPV perpetration (Table 4), results of the independent samples *t*-tests indicate that cisgender participants reported more instances of minor sexual perpetration ($M = 10.00$, $SD = 12.61$) than transgender/other participants [$M = 2.00$, $SD = 1.32$; $t(86.99) = -5.42$, $p < .001$]. Results of the one-way analyses of variance indicate differences in minor sexual perpetration by race/ethnicity [$F(4,660) = 3.05$, $p = .016$]. Results of Tukey's HSD post hoc tests indicate that White ($M = 9.88$, $SD = 13.04$; $p = .028$) and Black ($M = 7.89$, $SD = 10.51$; $p = .031$) participants reported more instances of minor sexual perpetration than Asian/API participants ($M = 4.54$, $SD = 6.42$). Participants who made more than \$5,000 reported more instances of minor sexual perpetration ($M = 11.75$, $SD = 15.00$) than participants who made less than \$5,000 [$M = 6.41$, $SD = 6.89$; $t(68.86) = -2.20$, $p = .031$]. Non-graduates reported more instances of minor psychological perpetration ($M = 16.92$, $SD = 22.25$) than college graduates [$M =$

11.44, $SD = 15.62$; $t(214.00) = 2.13, p = .034$]. No differences in perpetration chronicity were detected by sexual identity.

Discussion

In this study, we first sought to estimate the prevalence and chronicity of minor and severe forms of past year IPV among a diverse sample of YSGM-AMAB in New York City using the CTS2. We found that nearly half of all participants reported some type of IPV victimization and nearly four in ten reported some type of IPV perpetration. These prevalence estimates were similar to or higher than those observed in other studies of YSGM-AMAB (Freedner et al., 2002; Langenderfer-Magruder et al., 2016; Stults et al., 2015a; Stults et al., 2019). One possible reason for our higher prevalence estimates is that we used a more comprehensive measure (i.e., the CTS2) than previous studies. Psychological IPV was the most common form of victimization, followed by sexual, physical, and injury victimization. Psychological IPV was the most common form of perpetration, followed by physical, sexual, and injury perpetration. These results were consistent with other studies that show that psychological aggression was the most common form of IPV victimization and perpetration among YSGM-AMAB (Dank et al., 2014; Kubicek et al., 2016; Wong et al., 2010).

Among those participants reporting past year IPV victimization, they reported the most instances of psychological IPV, followed by physical, sexual, and injury victimization. Similarly, of those reporting past year perpetration, they reported the most instances of psychological IPV, followed by physical, sexual, and injury perpetration. Our findings are consistent with the one study that examined chronicity of IPV among cisgender YSMM (Kubicek et al., 2016). However, given that few studies have examined IPV chronicity among YSMM specifically, and none have distinguished between minor and severe forms of IPV, our ability to compare our findings to other studies is limited.

We also sought to examine sociodemographic differences in IPV prevalence and chronicity among the YSGM-AMAB in our sample. We found that transgender, bisexual, and lower income participants were at elevated risk for several subtypes of IPV victimization. While few studies have examined sociodemographic differences in prevalence of IPV victimization and perpetration among YSGM-AMAB, our findings regarding the higher rates of psychological and physical IPV victimization among transgender participants are consistent with previous studies of IPV among LGBTQ youth (Dank et al., 2014) and adults (Langenderfer-Magruder et al., 2016). Our findings regarding the higher prevalence of IPV victimization among

bisexual and other participants are also consistent with past studies that have found that adult bisexual and other cisgender SMM are at elevated risk for IPV victimization, as compared to adult gay men (Edwards et al., 2016; West, 2012). However, given the dearth of research in this area, additional research is warranted.

We also found that transgender, Asian/API, bisexual, and lower income participants were more likely to report several forms of IPV perpetration. Regarding differences by gender identity, we are aware of only one study of LGBTQ youth that found that transgender participants were more likely to report physical and psychological perpetration (Dank et al., 2014). Our findings regarding higher prevalence of IPV perpetration among bisexual or other YSGM-AMAB are consistent with past research of adult SMM (Edwards et al., 2016; Langenderfer-Magruder et al., 2016; Martin-Storey, 2015). Our findings are also consistent with past studies of adult SMM that found that lower income was associated with IPV perpetration (Edwards, Sylaska, & Neal, 2015; Houston & McKirnan, 2007). As with sociodemographic differences in IPV victimization, additional research into such differences in IPV perpetration is warranted.

Differences in past year IPV chronicity were also noted. Specifically, non-graduate YSGM-AMAB reported a higher number of instances of minor psychological and sexual victimization. Regarding perpetration, cisgender, White, Black, and upper income participants reported a higher number of instances of minor sexual perpetration, whereas non-graduate participants reported a higher number of instances of minor psychological perpetration. Given that this was the first study to examine sociodemographic differences in IPV chronicity among YSGM-AMAB, we cannot compare our findings to previous research in this population. Moreover, this is the first study to examine sociodemographic differences in IPV prevalence and chronicity that distinguishes between minor and severe forms of IPV. As in research related to IPV prevalence, additional research regarding IPV chronicity among YSGM-AMAB is warranted.

Taken together, these findings suggest that IPV is a prevalent and chronic health problem for many YSGM-AMAB. Furthermore, they reveal additional sociodemographic disparities in IPV experiences in this historically marginalized group—and the intersectionality of multiple stigmatized identities—reflecting larger systems of oppression and privilege in our society. Indeed, transgender and YSGM-AMAB who do not identify as cisgender reported higher rates of IPV, suggesting that IPV is linked to gender norms and expectations, and that problematic conceptions of masculinity (i.e., toxic masculinity) may drive IPV in YSGM-AMAB and other populations (Calton et al., 2016; Langenderfer-Magruder et al., 2016). Bisexual and other

YSGM-AMAB also appear to be at greater risk for IPV, suggesting that while gay men have gained some acceptance in society at large, other YSGM-AMAB may experience alienation from their gay and heterosexual counterparts, in addition to other forms of social stigma that drive the health disparities observed in this population in other studies (Calton et al., 2016; Edwards, Sylaska, Barry, et al., 2015; Martin-Storey, 2015). Additionally, YSGM-AMAB with less income and education were also at elevated risk for IPV, suggesting that IPV is partially a function of financial strain and a lack of economic opportunity (Clark et al., 2016; Steele et al., 2020). Thus, IPV may be best conceptualized as an individual and couple-level behavioral health problem that is exacerbated by existing community- and structural-level inequality among YSGM-AMAB.

Implications and Future Directions

These findings have several implications for practice, research, and policy. First, given the prevalence of IPV among YSGM-AMAB, individual and couple-level interventions must be developed for use with this population, and they must be tested and made widely available as soon as possible. Also, programs to prevent IPV before it occurs must also be developed, tested, and included alongside existing public health campaigns that target YSGM-AMAB (e.g., PrEP campaigns). Additionally, mental, and physical healthcare providers with YSGM-AMAB patients must routinely assess for IPV and its associated mental and physical health problems (e.g., depression, substance use), and offer appropriate interventions or referrals when possible. At the most basic level, public and mental health organizations should work to reduce the stigma around IPV within LGBTQ populations through targeted health communication campaigns that increase awareness of IPV as well as connections to resources and services in the community.

With respect to research, future studies of IPV among YSGM-AMAB should employ comprehensive measures like the CTS2, as it captures information about IPV prevalence, chronicity, and severity that is not captured by other, shorter measures. Researchers should also develop and test IPV measures that are specifically tailored to the unique experiences of YSGM-AMAB, as most of the existing IPV measures were designed with heterosexual and cisgender women populations in mind. Furthermore, researchers should conduct additional longitudinal studies of IPV among YSGM-AMAB in order to better understand the developmental trajectories of IPV and its associated mental and physical health problems.

Finally, given that the sociodemographic risk factors of IPV that we identified are likely indicators of the larger, structural inequalities in our society,

policymakers should work to promote policies that reduce these inequalities and improve the sociopolitical climate for YSGM-AMAB. Specifically, policymakers should introduce or strengthen existing antidiscrimination and hate crime laws, as these and other social climate laws have substantial impacts on the health of LGBTQ people (Hatzenbuehler, 2011; Hatzenbuehler et al., 2009; Hatzenbuehler et al., 2010). For instance, one important policy initiative is the reauthorization of the LGBTQ-inclusive Violence Against Women Act that expired in November 2019 (Thayer, 2019). Also, lawmakers should support increased funding for culturally competent healthcare for LGBTQ populations (Mayer et al., 2008), and provide legal protection to LGBTQ survivors of IPV (Ard & Makadon, 2011). Furthermore, given that IPV exacerbates other health problems that disproportionately burden YSGM-AMAB (e.g., HIV, substance use), additional resources must be directed to addressing and preventing IPV (Stults et al., 2015b, 2016).

Strengths and Limitations

The present study is strengthened by several design characteristics that allow it to make a significant contribution to the extant literature. First, this is one of the first studies to use the CTS2, the most accepted and comprehensive measure of IPV to assess IPV, adding measurement rigor to the existing literature on IPV among YSGM-AMAB and allowing for comparisons to studies of other populations. Second, this study contributes novel information about the prevalence and chronicity of several subtypes of IPV among YSGM-AMAB, addressing a key gap in the extant literature. A third strength of this study is that it distinguishes between minor and severe forms of IPV victimization and perpetration, which strengthens the extant literature on IPV among YSGM-AMAB. A final strength of this study is its use of a diverse sample of YSGM-AMAB, particularly its inclusion of a large proportion of people of color and low-income participants, which allowed for these analyses of sociodemographic differences to be conducted.

The strengths of this study should be considered in light of its limitations. First, the sample, while diverse in several ways, is geographically homogeneous. As such, it may not reflect the experiences of YSGM-AMAB living in other, non-urban contexts. Second, given that these data come from a cohort sample of participants who all were recruited at approximately the same age, these findings may not generalize to older or younger SGM-AMAB.

Third, although the primary aim of the P18 cohort study was to examine syndemic conditions among cisgender YSMM, participants were not required to report a cisgender male identity in order to be eligible for the parent study. As such, approximately 7% of the sample identified as

transgender or genderqueer at this wave of data collection. While this enrollment outcome was appropriate for the primary aim of the parent study, it resulted in a relatively low number of TGNC participants in the sample for present analyses. We encourage future researchers examining IPV among SGM-AMAB to recruit more balanced samples and/or to examine IPV in YTGNC samples specifically.

Fourth, given the distribution of some of the sociodemographic variables (e.g., sexual identity), and in relation to the most infrequently reported IPV outcomes in particular, we were required to collapse certain categories together in order to conduct these analyses. Indeed, we recognize that combining distinct categories of people together (e.g., bisexual and other-identified participants) into a single category presents some difficulties in interpreting the implications of these results. However, we believe that this limitation is offset by the benefit achieved from being able to conduct these meaningful subgroup analyses, substantially adding to the extant literature.

Fifth, our income variable does not capture whether participants are currently enrolled in school and/or financially supported by others. This limitation may be relevant to this sample, given the age range of the participants. However, in conducting follow-up analyses of these data using a variable that combined current student status with income, we observed similar trends as those reported in this manuscript using the dichotomous income variable, however insufficient cell sizes prevented us from interpreting a number of these binomial logistic regression models. As such, we chose to retain the dichotomous income variable for the present analyses.

Finally, while the CTS2 is a comprehensive tool that has been widely used to assess IPV in other populations (Straus et al., 1996), it also has two notable limitations in the context of this study. First, it generates an extensive amount of information that can be coded and presented in a number of different ways. For example, while we followed the prevalence and chronicity coding scheme published by its developer (Straus, 2004), other researchers that have employed the CTS2 have used their own coding schemes. This lack of consistency between researchers may make it difficult to compare our findings to other studies (e.g., Kubicek et al., 2016). However, we believe that by following the developer's original coding scheme, we nevertheless provide valuable and novel data on IPV prevalence, chronicity, and severity among YSGM-AMAB and bolster the existing literature. Second, as indicated before, this scale was not designed to be used with sexual or gender minority (SGM) populations. As such, it may not capture some of the ways in which IPV is manifested in the relationships of SGM people. Future researchers should consider using newer IPV measures that have been designed and tested specifically for SGM populations (e.g., the IPV-GBM Scale, Stephenson & Finneran, 2013; the Identity Abuse Scale, Scheer et al., 2019; etc.).

Conclusion

Numerous types of minor and severe IPV victimization and perpetration are prevalent among YSGM-AMAB. Among those YSGM-AMAB with past year IPV victimization and/or perpetration, many experienced repeated (i.e., chronic) experiences of IPV. Also, certain sociodemographic characteristics were associated with elevated risk for IPV prevalence and increased IPV chronicity. These findings may be used to develop IPV interventions and prevention programs specifically designed for YSGM-AMAB populations. Also, these findings may inform future research endeavors and support the development of an IPV measure designed specifically for YSGM-AMAB. Additionally, policymakers and other stakeholders may use these findings to develop and strengthen laws and policies that reduce sociodemographic inequalities and promote more favorable sociopolitical conditions for cisgender YSMM and YTGNC populations.

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ORCID iDs

Christopher B. Stults  <https://orcid.org/0000-0003-0310-5732>

Ellia Khan  <https://orcid.org/0000-0002-2605-2250>

Siyan (Stan) Gao  <https://orcid.org/0000-0003-2252-9207>

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Author Biographies

Christopher B. Stults, PhD, LMHC, is an Assistant Professor in the Department of Psychology at Baruch College, City University of New York, and Director of the Baruch College Sexual and Gender Minority Health (SGMH) Lab. His program of research examines intimate partner violence, consensual non-monogamy, and health disparities among LGBTQ people.

Ellia Khan, MA, is a Research Assistant at the Baruch College SGMH Lab. Her research interests include violence and victimization among women and LGBTQ populations.

Marybec Griffin, PhD, MPH, MA, is an Assistant Professor in the Department of Health Behavior, Society, and Policy at Rutgers School of Public Health. Her research focuses on healthcare access among LGBTQ young adults, including the role of identity and the impact of health policy.

Kristen D. Krause, PhD, MPH, is the Center Manager for the Center for Health, Identity, Behavior, & Prevention Studies at the Rutgers School of Public Health. Her research focuses on resilience among people living with HIV/AIDS, as well as the health of YSGM-AMAB and other LGBTQ populations.

Siyan (Stan) Gao, MA, is a Research Assistant at the Baruch College SGMH Lab. His research is focused on the mental health of transgender and gender diverse populations.

Perry N. Halkitis, PhD, MS, MPH, is Dean and Professor of Biostatistics and Urban-Global Public Health, as well as the Director of the Center for Health, Identity, Behavior, & Prevention Studies, at the Rutgers School of Public Health. His program of research examines HIV/STIs, drug abuse, mental health burden, and other health disparities among LGBTQ people.