Intimate Partner Violence

10

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Purpose

The purpose of this chapter is to define intimate partner violence, explore the issues around this complex and sensitive topic, outline challenges unique to LGBT communities, and provide clinicians guidance to confront and address this public health challenge.

Learning Objectives

After reading this chapter, learners will be able to:

- Discuss the risk factors, effects on health, and public health impact that intimate partner violence (IPV) has on LGBT communities *(PC5)*
- Identify at least three differences in individual and structural challenges in addressing IPV for same-sex relationships compared to opposite-sex relationships *(KP4, SBP1)*
- Discuss forms of abuse and social challenges exclusively faced by transgender individuals *(KP3, PC3, SPB4)*
- Discuss opportunities for healthcare providers to communicate with LGBT patients, address, and document concerns about IPV *(ICS1, ICS2)*

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Introduction

Intimate partner violence (IPV) is defined as the physical, emotional, psychological, or sexual harm inflicted on an individual by a current or former partner or spouse. IPV describes patterns of abusive behavior used by one partner to gain or maintain control over the other, including physical and sexual violence or threats of violence, social isolation, psychological aggression, stalking, economic deprivation, neglect, and controlling a partner's sexual or reproductive health. According to the National Intimate Partner and Sexual Violence Survey (NIPSVS), more than one in three women (35.6 %) and more than one in four men (28.5 %) in the United States have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime [1]. It is estimated that the costs of intimate partner rape, physical assault, and stalking exceed $5.8 billion each year, nearly $4.1 billion of which is for direct medical and mental health care services. Many survivors of these forms of violence can experience physical injury, mental health consequences such as depression, anxiety, low self-esteem, and suicide attempts, and physical health consequences such as gastrointestinal disorders, substance abuse, sexually transmitted diseases, and gynecological or pregnancy complications [1]. These consequences can lead to hospitalization, homelessness, disability, or death.

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The effects of IPV are wide reaching, affecting not just those abused, but also their families, friends, businesses, and economic productivity. The total costs of IPV include nearly $0.9 billion in lost productivity from paid work and household chores for those suffering from nonfatal IPV and $0.9 billion in lifetime earnings lost by victims of IPV homicide [2]. Though IPV has been a serious and preventable public health issue for decades, until a significant grassroots movement gained momentum in the late 1970s and 1980s, little in the way of research or policy addressed it, due in part to the lack of awareness and stigma surrounding IPV and abuse [3]. Furthermore, despite the significant burden of violence, only limited policies, procedures, and programs have been enacted to address this costly and preventable public health challenge.

The LGBT community in particular faces unique challenges regarding IPV. Research suggests that prevalence of IPV is at least as high for same-sex couples compared to their opposite-sex counterparts [4]. Same-sex IPV is more likely to go unacknowledged and less likely to be addressed adequately by healthcare providers, law and policy makers, educators, and social services.

Traditionally, addressing IPV was under the exclusive purview of the legal system and penal code, but as focus shifts towards a more holistic approach to IPV prevention and treatment of individuals suffering from abuse social workers and healthcare providers serve a critical role as first-line responders to survivors. History, however, reflects a failure on the part of physicians to adequately address IPV, particularly for the LGBT community, due to lack of cultural competency, paucity of resources, and incomplete or absent educational tools. This chapter will explore the issues around this complex and sensitive topic, outline challenges unique to LGBT communities, and provide clinicians guidance to confront and address this public health challenge.

Defining Abuse

The lack of standardized definitions of abuse and violence contributes to a failure in cultural competency on the part of physicians and remains a major obstacle in addressing IPV in a systematic and effective way. This confusion stems from the development of terminology within multiple disparate domains: healthcare, social services, and the legal system. Lawmakers now face the task of consolidating different operative legal definitions from 50 states, which may differ from those definitions used by professionals in violence and abuse prevention [5].

In order for physicians to adequately respond to such sensitive issue, they must familiarize themselves with some basic terminology:

Physical violence and/or abuse is the intentional use of physical force or power, threatened or actual, against another person or against oneself or against a group of people, that results in or has a high likelihood of resulting in injury, death, psychological harm, or deprivation. Physical violence or abuse includes, but is not limited to scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, hair pulling, slapping, punching, hitting, burning, and use of restraints or one's body, size, or strength against another person. The unwarranted administration of drugs and physical restraints, force-feeding, and physical punishment of any kind are additional examples of physical abuse. Physical violence includes, but is not limited to, use of a weapon against a person [6].

Sexual violence and/or abuse is divided into three categories: (a) the use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed; (b) an attempted or completed sex act involving a person who is unable to consent to the act or understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in a sexual act due to age, illness, disability, influence of alcohol or other drugs, intimidation or pressure; and/or (c) abusive sexual contact. Sexual contact includes, but is not limited to, unwanted touching, and sexually explicit photographing [6].

Psychological/emotional abuse encompasses a range of verbal and mental methods designed to emotionally wound, coerce, control, intimidate, harass, insult, and psychologically harm. Isolation and withholding of information from the target of

said behaviors also falls under this title of psychological aggression and emotional abuse [6].

As with any complicated social dynamic, definitions of abuse and violence are informed in large part by their historical and cultural context and the evolving boundaries and challenges of relationships and commitments. The complexity and depth of social and romantic interaction may make it especially difficult at times to clearly delineate abuse or violence from poor conflict management skills, especially in conditions of psychological aggression and emotional abuse. For this reason, it is necessary to examine the intent or function of the violence in each couple. Domination, intimidation, degradation, and control may also be elements of abusive intimate partner violence, wherein a partner seeks to control the thoughts, beliefs or conduct of the other or to punish the other partner [7].

Etiologies and Epidemiology

Violence is a preventable outcome of a series of learned behaviors in which aggressors try to maintain control of their partners. While there is no singular etiology for violence, abuser tend to blame life stressors or unfulfilled expectations for their outbursts, and often individuals suffering from abuse are held responsible for exacerbating pre-existing stress or resisting control or punishment. Typically, IPV occurs in a controlling cycle, in which an assault is followed by a period wherein the abuser is remorseful, apologetic, or even loving, before tensions and abuser-perceived "transgressions" build to precipitate another episode of violence. Over time, these cycles generally become more frequent and more severe.

One of the most common myths of intimate partner violence is that it is an action perpetrated by cis-gender men against cis-gender women. The reality is that IPV affects men and women at all levels and demographics of society, regardless of race, religion, or economic status. While no one knows what exactly what causes IPV, economic stress, history of mental illness, history of abuse, perceived disparate power differentials, and social dysfunction are all correlated with violence in both same-sex and opposite-sex relationships [8]. In a cross-sectional study of MSM, depression and substance abuse were among the strongest correlates of intimate partner violence [9]. Risk markers and correlates of intimate violence in same-sex relationships are notably similar to those associated with heterosexual partner abuse. An extended list of factors can be viewed in Table 10.1.

Table 10.1 Risk factors for perpetration of violence

Multiple factors influence the risk of perpetrating IPV [13, 14]:
• History of physical or psychological abuse
• Prior history of being physically abusive
• Low self-esteem
• Low income
• Low academic achievement
• Young age
• Involvement in aggressive or delinquent behavior as a youth
• Heavy alcohol and drug use
• Anger and hostility
• Personality disorders and mood disorders
• Unemployment
• Economic stress
• Emotional dependence and insecurity
• Belief in strict gender roles (e.g. male dominance and aggression in relationships)
• Desire for power and control in relationships
• History of experiencing neglect or poor parenting as a child
• History of experiencing physical discipline as a child
Relationship factors
• Marital conflict
• Marital instability
• Economic stress
• Unhealthy family relationships and interactions
Community factors
• Poverty and associated factors (e.g., overcrowding)
• Low social capital-lack of institutions, relationships, and norms that shape the quality and quantity of a community's social interactions
• Weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence)
• Patriarchal gender norms (especially those concerning female submission and male dominance)

Until the 1990s, few studies had examined the prevalence of IPV in same-sex couples. More robust research has since developed to address the major disparities in research and policy. Meta-analyses of the research to date suggest that LGBT individuals are at least as likely—if not more likely—to be abused by their partners as heterosexual men and women. According to the National Coalition of Anti-Violence Programs (NCAVP), LGBT and queer (LGBTQ) youth, people of color, gay men, and transgender women were more likely to suffer injuries, require medical attention, experience harassment, or face anti-LGBTQ bias as a result of IPV. Although it is unknown whether the severity of abuse is comparable between opposite-sex and same-sex couples, gay individuals suffering from IPV were almost twice likely to require medical attention as a result of violence [10]. In a 2009 study, males suffering from same-sex IPV reported more verbal abuse than males suffering from of opposite-sex IPV. Females suffering from (lesbian, bisexual, and straight), by contrast, did not report differences by type of IPV [11]. In an analysis of the California Health Interview Survey, 1250 of the 31,623 respondents who identified as LGB or WSW/MSM reported higher rates of physical and sexual violence than their heterosexual counterparts, though this figure was significant only for bisexual women and gay men. Notably, for bisexual women, 95 % of violent incidents were perpetrated by a male partner [12].

The Gender, Violence and Resource Access Survey found that 50 % of transgender respondents reported assault or rape by a partner, while 31 % identified as an IPV survivor [10]. Transgender survivors, specifically, were twice as likely to face threats/intimidation, 1.8 times more likely to experience harassment, and over four times (4.4) more likely to face police violence as a result of IPV than people who did not identify as transgender. Moreover, transgender people of color and transgender women experienced this violence at even higher rates and were more likely to face these abuses as part of IPV [15]. It should also be noted that, although transgender people comprise approximately 8 % of the LGBT community, of the 21 LGBT IPV homicides reported in 2012, 3 (14 %) of the individuals suffering from IPV identified as transgender [10].

Despite considerable challenges in research, studies on intimate partner violence in LGBT youth relationships have yielded compelling results. Studies estimate that around 25–40 % of gay, bisexual and lesbian youth report at least one lifetime incident of emotional, physical, or sexual abuse by a same-sex partner, figures that are similar to or higher than lifetime reports of violence from heterosexual samples [16, 17]. Of note, male adolescents within exclusively same-sex relationships were less likely than females to report experiencing the violent behaviors. These results underscore the need for early screening and intervention in this population [18].

Challenges in Reporting, Research, and Policy

Studies examining the prevalence and severity of IPV in LGBT relationships are limited by many of the same obstacles of research on heterosexual IPV, particularly small sample populations. Many individuals affected by IPV are reluctant to report IPV for many reasons: fear of retaliation by the abuser, fear of judgment by healthcare providers or law enforcement, fear of further isolation, fear of disrupting family and children, or a desire to protect the abuser by internally diminishing the severity of the violence. Additionally, many individuals suffering from IPV (and the general public at large) are often unaware of what constitutes IPV, either due to denial or lack of education [5]. To overcome this obstacle, many studies based on large samples typically have used nonrandom sampling methods, often with recruitment through gay and lesbian publications, organizations, and activities. The result is that same-sex intimate violence is often studied using nonrepresentative samples.

Setting aside methodological challenges, LGBT relationships face not only increased risk factors for violence, but LGBT survivors also experience identity-specific forms of abuse. The

unique possibilities for extortion make it especially difficult for LGBT individuals to leave or report abusive relationships. These forms of IPV are summarized here:

Internalized guilt Many LGBT individuals choose not to disclose their abuse because they feel that their relationship must appear outwardly "perfect" either to compensate for the stigma of homosexuality/gender nonconformity or not to validate heterosexist bigotry that suggests that LGBT relationships are less valid or "serious" [7]. This is particularly true of younger individuals, who may harbor more conflicted feelings about their sexual identity [19].

Homophobia/biphobia/transphobia Societal oppression of LGBT people has allowed heterosexism to be used as another psychological weapon in the arsenal of a abuser keen on controlling and manipulating his or her partner. For instance, abusive partners of transgender survivors may tell their partners they are not "real" men or women, that no one else would want to be with him or her, or that they would be more unsafe "on the streets" outside the relationship. Other forms of heterosexist abuse may include shaming gender-nonconforming behaviors, telling a partner that the abuser is the only one who understands their sexual identity, or threatening to "out" a partner to his or her family, employer, or community. These behaviors ultimately exploit insecurities concerning the social ramifications of his or her sexual orientation. In addition to psychological trauma, outing may result in the loss of support systems, housing, jobs, or even child custody. Often, individuals affected by may be reluctant to report IPV based on fears of the negative consequences of revealing their true sexual orientation [20].

Children When same-gender couples have children, the abuser may threaten to take the children away. If the abuser is the biological or adoptive parent, this threat could easily be carried out because many states have adoption laws that do not permit same-gender parents to adopt each other's children. In this situation, the non-biological parent has no legal rights to child custody if the couple separates. Similarly, if the abuser is a non-biological parent, he or she may threaten to "out" the biological parent in order to jeopardize the biological parent's custody and transfer the child to a heterosexual household [21].

Lack of support from law enforcement For those LGBT individuals affected by IPV that do seek help, they may encounter a lack of cultural competency from law enforcement that believe that IPV is perpetrated by straight men against straight women. There is often a concomitant misconception that LGBT IPV refers to conditions of mutual combat rather than victimization [22]. According to the 2012 NCAVP report, in nearly a third of the LGBTQ-specific IPV cases reported to the police, the survivor was arrested instead of the aggressor. LGBTQ IPV survivors also experienced other forms of police misconduct including verbal abuse, slurs or bias language, or physical violence. Particularly in the transgender community, half of individuals reported feeling discomfort in seeking assistance from police, and close to a quarter of individuals had experienced police harassment [10]. This mistrust in law enforcement serves to reinforce the degree of isolation transgender individuals experience.

Access to social services Since the reauthorization of the Violence Against Women Act (VAWA) of 2013—which included provisions for LBGT individuals—domestic violence or intimate partner violence is no longer legally defined as violence between straight male aggressors and females. That being said, LGBT individuals may encounter homophobic bias in court should they choose to press charges [21]. Should these individuals reveal their sexual orientation and decide to leave their partners, many have been denied access to social services and safety nets such as shelters. Shelters not only provide safe and stable housing, they also provide other social services such as counseling, legal and employment services, and child

services. Domestic violence services that are LGBT-specific have been designed primarily for LGBT communities, with providers specializing in work with LGBT individuals and families. But despite LGBT individuals facing higher rates of social isolation, prejudice, and mental illness in daily life, LGBT-specific shelters are rare or nonexistent particularly in rural areas, only compounding the needs of an underserved community. Most domestic violence services have been designed primarily for the heterosexual community—with varying degrees of LGBT acceptance—and providers of these services may not have received training in LGBT domestic violence and usually receive variable amounts of training in LGBT issues. For those individuals who are able to access social services, lack of cultural competency often contributes to the already-present sense of isolation and may actually re-traumatize those affected by IPV, leading them to return to their aggressors or stop seeking support altogether [23]. In fact, many non-LGBT specific shelters that do exist have historically operated under the belief that IPV is a heterosexual phenomenon and did not accept men or trans women. For this reason, while women have the option of going to female-focused shelters, limited resources are available for male and transgender individuals affected by IPV. The recent reauthorization of VAWA, however, now contains a nondiscrimination clause that prohibits LGBT individuals from being turned away from shelters on the basis of sexual orientation or gender identity, so there is hope that more programs will rise to the challenge of providing culturally-competent care to future victims. Despite expanding access for LGBT individuals, however, it must be noted that VAWA came under considerable criticism for the relatively paltry provision of only $4 million to LGBT organizations of its larger $1.6 billion budget. While the reauthorization of VAWA should be applauded as a major step towards legal equality for the LGBT community, disparities in funding only underscore that more work must be done to address the issue of IPV within this vulnerable population.

The Role of Clinicians

Clinicians serve an important role in identifying, supporting, treating, and intervening on behalf of individuals affected by IPV. However, one of the most difficult tasks is screening for IPV, since clinical manifestations of IPV are subtle in all but most obvious cases. Lack of knowledge or training, time limitations, inability to offer lasting solutions or external resources, and fear of offending the patient all contribute to provider-specific barriers that IPV victims face. Compounding the stigma of abuse and violence, classism, racism, homophobia, and transphobia also adds to a culture of inertia and victim-shaming within medicine. Providers must fix this culture through information, trust, empathy, and objectivity.

While signs of trauma (e.g. bruises, burns, scratches to the face, abdomen, and genitals) are thought to be most consistent with IPV, in most cases, abused patients present with either no symptoms at all or may present with non-traumatic diagnoses such as IBS, depression, abdominal pain, anxiety, substance abuse, or STIs. Given this vague constellation of symptoms, it is important for providers to consider IPV as an etiology or even lower thresholds for IPV screening, particularly for gay and transgender patients. Careful history and physical exam skills are essential so that the subtle signs of IPV can be screened for and recognized.

Given that many in the LGBT community feel stigmatized, marginalized, and judged for their sexual orientation, many individuals do not reveal their sexual orientations or gender identity in the clinical setting, complicating the already challenging task of addressing a patient's unique needs and obstacles. As previously mentioned, disclosing one's sexual identity—especially in a setting where trust and rapport have not been established—is a major deterrent for many LGBT victims in seeking help and breaking a cycle of abuse. Establishing rapport with patients tactfully and professionally in a nonjudgmental way is key with any survivor of IPV but is especially paramount in LGBT communities. The first step

is to interview the patient alone in a quiet room and verbally assure them of confidentiality. Then, rather than running through a formal IPV screening questionnaire, it may be more prudent for the provider to open a dialogue with the patient when taking a sexual history ("Are you sexually active?", "Are you in a relationship?", "Do you have sex with men, women, or both?"). Such questions are respectful, relevant, and set up a professional conversation for inquiry about all aspects of sexual and emotional health without appearing voyeuristic or judgmental.

Helpful Hint
After establishing rapport, ask about specific behaviors (hitting, punching, nonconsensual sexual activity, etc.) and try to explore the patient's feelings of fear in the relationship.

By asking pertinent follow-up questions using inclusive, non-heteronormative language, a provider can establish trust with a patient before delving into more sensitive IPV-history questions, such as "Do you feel unsafe in your relationship?" or "Have you been hit, punched, kicked, or physically threatened by your partner or previous partner?". If affirmative, asking "In what context, did these events happen?" and "How have these events affected you?" are good follow-up questions. If a patient discloses how they feel about the violence, it is important to validate and affirm their feelings, particularly given the challenge of discussing IPV with a provider.

Inquiring about specific IPV experiences rather than asking about a more general "history of domestic violence" is beneficial for two reasons: First, IPV often goes unacknowledged not only on an institutional level, but also on a cultural level, even within the LGBT community [24]. Many individuals affected by IPV do not have the knowledge to label their experiences as abusive or violent—particularly in cases of sexual assault or emotional/psychological abuse—so inquiring and correctly identifying IPV fulfills a much-needed educational role for these patients. Second, identifying specific violent or abusive experiences may aid in furthering dialogue, educating the patient, guiding the physical exam, and developing a treatment plan that suits a patient's specific needs. Once providers are able to obtain a proper history of IPV and trauma, they can then extend their screening and physical exam to include physical injury, substance abuse, depression, anxiety, HIV and other STIs, the prevalence of which is much higher in individuals affected by IPV.

Helpful Hint
Remember to validate and affirm a patients feelings and experiences to maintain rapport and trust.

Physical Exam

Patterns of injury that might be suspicious for abuse include multiple injuries in various stages of healing, cuts, scratches, or bruises on the face, abdomen, and genitalia, or any acute injury that does not have a clear cause. The presence of STIs or signs of self-harm and substance abuse, while not direct signs of IPV, should prompt discussions about emotional health and relationship history. As previously mentioned, however, most individuals affected by IPV present without any overt signs of trauma.

A Brief Note on Documentation

The role of clear and accurate medical records cannot be understated. Medical documentation is readily admissible in court as evidence that can substantiate a individual's assertion of harm, even when a victim is unable to testify against his or her aggressor. Correct documentation also enables providers to effectively communicate amongst each other about a patient's history of IPV, permitting more individualized patient care in the future. Whenever possible, the patient's own words should be documented in the chart, and the

relationship of the aggressor and indivdual abused be stated along with supporting photographs and descriptions from the physical exam. Areas of tenderness or concern, even without visual evidence of trauma, should be documented on a body map, along with descriptions of the symptoms.

IPV Intervention

After listening to the patient, affirming their experiences, and conducting a thorough history and physical exam, the next step in IPV intervention is ensuring patient safety. Patient safety can be addressed on several fronts. The first is to ask the patient if he or she subjectively feels safe going home at all, and, if not, if he or she has a safe place to stay. Another key step may be determining whether there are firearms in the household, or if the aggressor has access to firearms or other weapons. Not only will this allow one to make appropriate referrals to social services, it can also give the provider better insight into the volatility of the domestic situation. It is also crucial to note if children are present in the home and if their safety is also jeopardized. The physician should alert the patient of their legal protections, and that restraining orders and civil protection orders are available in the United States. These protections may even mandate temporary child custody and mandate rent or mortgage payments by the aggressor.

Creating a personalized safety plan is simple and powerful tool for patients who feel endangered. Patients should be advised to take measures to establish independence and security. Such activities may include ensuring that important phone numbers are available at all times, rehearsing realistic escape routes from their homes, workplaces, or anywhere partners may threaten them, developing outside contacts, seeking support regularly from friends, colleagues, or professionals, and keeping a list of secure places to seek refuge if their safety is imminently threatened. Keeping change for phone calls, opening separate bank accounts, and leaving extra money, car keys, clothes, or copies of important papers with a friend or in a safe place serves as a way for an individual affected by IPV to discreetly build their independence without a possibly dangerous confrontation with their abuser [25].

Different interventions may be appropriate if the patient is a minor. Almost half of LGBT youth and adolescents report feeling abused in at least one past relationship; therefore, screening and intervention is especially crucial in this vulnerable demographic [26]. More specifically, males reporting exclusively same-sex relationships are less likely than females to report experiencing violence [18]. If the patient's safety is imminently jeopardized, it may be advisable to discuss the situation with the patient's parents. In the pediatric population, referring to social work may also provide an important role in managing complex social dynamics in the home or at school.

A host of health risks are associated with IPV and have been outlined in Table 10.2. Chronic pain, gastrointestinal distress, and frank physical injuries are all physical findings important to document and address with the appropriate medical management and pharmacotherapy. Sexually transmitted infections and psychiatric illness such as depression, anxiety, and post-traumatic stress disorder are far more prevalent in abusive relationships, and individuals affected by IPV are often not empowered to seek treatment. Therefore, the clinical encounter should also include STD screening, depression and anxiety screening (including assessing risk of suicidal ideation), and discussion of safe sex practices [23]. Particularly

Table 10.2 The impact of IPV on health

Intimate partner violence in heterosexual and LGBT all victims of IPV is associated with increased health risks of the following:
• Substance use disorders
• Trauma and stress related disorders (ex. PTSD)
• Depression, suicidal ideation and attempts
• Sexually transmitted diseases
• Unplanned or early pregnancy and pregnancy complications
• Eating disorders
• Gastrointestinal disorders
• Chronic pain disorders
• Psychosomatic symptoms

in pediatric and adolescent populations, physicians should initiate frank discussions about safe sex, STDs, and consent. Substance abuse in particular has been found consistently to correlate with IPV in both heterosexual and LGBT populations, so the clinician should explore the patient's coping mechanisms and evaluate the patient for substance dependence [27].

Many individuals affected by IPV remain in abusive relationships for a number of reasons, be they emotional, physical, or financial, and the process of extricating themselves from the relationship often takes a long time. Even so, many individuals who have been abused may refuse help altogether. Particularly in these situations, the most essential advice for the clinician is to patiently listen, providing accessibility, support, and frequent and regular follow-up both during the abusive relationship and after the relationship has been terminated [23]. Identifying IPV allows the provider to educate his or her patients and advocate for their wellbeing. Physicians should reaffirm that intimate partner violence is a crime and inform their patients that there is help available should he or she be willing to receive it.

Below is a list of domestic violence resources organized by region, reproduced from the 2007 National Resource Center on Domestic Violence Information & Resource Guide [28].

Gay Men's Domestic Violence Project (GMDVP)
955 Massachusetts Avenue, PMB 131
Cambridge, MA 02139
Telephone: 800-832-1901
Email: Support@gmdvp.org
Web: http://www.gmdvp.org/

Founded as a non-profit organization by a survivor of domestic violence in 1994, The Gay Men's Domestic Violence Project (GMDVP) provides community education and direct services to gay, bisexual, and transgender male victims and survivors of domestic violence. It now has a growing pool of volunteers and speakers, and four staff members. GMDVP relies on the grassroots support of survivors, its volunteer base, the LGBT community, and other allies.

Lambda GLBT Community Services
216 South Ochoa Street
El Paso, TX 79901
Telephone: 208-246-2292
Fax: 208-246-2292
Email: admin@lambda.org
Web: http://www.lambda.org/

LAMBDA has led the effort to create an awareness of homophobia and its effects, becoming a major source of information for decision makers and news media. LAMBDA has also worked to protect gays and lesbians from discrimination and violence in homes, businesses, and schools through educational campaigns, non-discrimination leadership, and anti-violence efforts. LAMBDA's Anti-Violence Project (AVP) provides victim services to survivors of hate crimes, domestic violence, sexual assault, and other crimes. AVP's services include crime prevention and education, a 24-h bilingual (English-Spanish) hotline, peer-to-peer support groups, and accompaniment to and advocacy with police, the courts, and other service providers.

The National Coalition of Anti-Violence Programs (NCAVP)
240 West 35th Street, Suite 200
New York, NY 10001
Telephone: 212-714-1184
TTY: 212-714-1134
Web: http://www.ncavp.org

The National Coalition of Anti-Violence Programs (NCAVP) is a coalition of over 20 lesbian, gay, bisexual, and transgender victim advocacy and documentation programs located throughout the United States. Before officially forming in 1995, NCAVP members collaborated with one another and with the National Gay and Lesbian Task Force (NGLTF) for over a decade to create a coordinated response to violence against LGBT communities. NCAVP member organizations have increasingly adapted their missions and their services to respond to violence within the community. The first annual domestic violence report was released in October of 1997.

Arizona

Wingspan Anti-Violence Project
300 East Sixth Street
Tucson, AZ 85705
Telephone: 520-624-1779
Fax: 520-624-0364
TDD: 520-884-0450
Email: wingspan@wingspan.org
Web: http://www.wingspanaz.org/content/WAVP.php

The Wingspan Anti-Violence Project is a social change and social service program that works to address and end violence in the lives of lesbian, gay, bisexual, and transgender (LGBT) people. WAVP provides free and confidential 24-h crisis intervention, information, support, referrals, emergency shelter, and advocacy to LGBT victim/survivors of violence. Additionally, the project offers extensive outreach and education programs.

California

Community United Against Violence (CUAV)
60 14th Street
San Francisco, CA 94103
Business Telephone: 415-777-5500
24-h Support Line: 415-333-HELP
Fax: 415-777-5565
Web: http://www.cuav.org/

Community United Against Violence (CUAV) is a 20-year old multicultural organization working to end violence against and within lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) communities. Believing that in order for homophobia and heterosexism to end, CUAV must fight all forms of oppression, including racism, sexism, ageism, classism and ableism. CUAV offers a 24-h confidential, multilingual support line, free counseling, legal advocacy, and emergency assistance (hotel, food, and transportation vouchers) to survivors of domestic violence, hate violence, and sexual assault. CUAV uses education as a violence prevention tool through the speakers bureau, the youth program, and the domestic violence prevention program.

Los Angeles Gay & Lesbian Center/STOP Partner Abuse/Domestic Violence Program
1625 North Schrader Boulevard
Los Angeles, CA 90028
Telephone: 323-860-5806 (clients)
Fax: 323-993-7699
E-mail: domesticviolence@laglc.org
Website: http://www.laglc.org/domesticviolence

The L.A. Gay & Lesbian Center's STOP Partner Abuse/Domestic Violence Program provides a comprehensive continuum of partner abuse and domestic violence services designed to address the specific and unique needs of the lesbian, gay, bisexual and transgender communities.

San Diego Lesbian, Gay, Bisexual, Transgender Community Center
3909 Centre Street
San Diego, CA 92103
Telephone: 619-692-2077
Fax: 619-260-3092
Web: http://www.thecentersd.org/

Group and individual counseling offered to both victims and offenders struggling with relationship violence. This program is also probation/court-certified for court-ordered clients. Lesbian, gay, bisexual and transgender youth are also served. [The Relationship Violence Treatment & Intervention Program] is targeted towards victims and offenders of same-sex relationships.

Colorado

Colorado Anti-Violence Program
P.O. Box 181085
Denver, CO 80218
Telephone: 303-852-5094; or 303-839-5204
Crisis Line: 888-557-4441
Fax: 303-839-5205
E-mail: coavp@hotmail.com
Web: www.coavp.org

The Colorado Anti-Violence Program is dedicated to eliminating violence within and against the lesbian, gay, bisexual, and transgender (LGBT) communities in Colorado. CAVP provides direct client services including crisis intervention, information, and referrals for LGBT victims of violence 24 h a day and also provides technical assistance, training, and education for community organizations, law enforcement, and mainstream service providers on violence issues affecting the LGBT community.

Illinois

Center on Halsted Horizons Anti-Violence Project
961 W. Montana, 2nd Floor
Chicago, IL 60614
Telephone: 773-472-6469
Fax: 773-472-6643
TTY: 773-472-1277
E-mail: mail@centeronhalsted.org
Web: http://www.centeronhalsted.org/coh/calendar/home.cfm

The Center on Halsted Anti-Violence Project (AVP) has assisted thousands of victims of anti-lesbian, gay, bisexual, or transgender (LGBT) hate crimes, domestic violence, sexual assault, discrimination, and police misconduct. Staff and trained volunteers counsel, support, and advocate for all victims and survivors of such violence. All AVP victim services are free and confidential.

Massachusetts

Fenway Community Health Violence Recovery Program
7 Haviland Street
Boston, MA 02115
Telephone: 617-267-0900
Toll-free: 888-242-0900
Spanish information: 617-927-6460
TTY: 617-859-1256
Web: http://www.fenwayhealth.org/services/violence.htm

The Violence Recovery Program (VRP) at Fenway Community Health provides counseling, support groups, advocacy, and referral services to Gay, Lesbian, Bisexual and Transgender (GLBT) victims of bias crime, domestic violence, sexual assault and police misconduct. VRP staff members frequently present at trainings for police, court personnel and human service providers on GLBT crime survivor issues. Other services include a support group for GLBT domestic violence survivors, the region's only support group for male survivors of rape and sexual assault, advocacy with the courts and police, and assistance with victim compensation. VRP provides short-term counseling to survivors and their families, and referrals to longer-term counseling through their mental health department.

The Network/La Red
P.O. Box 6011
Boston, MA 02114
Telephone (V/TTY): 617-695-0877
Fax: 617-423-5651
E-mail: info@thenetworklared.org
Web: http://www.biresource.org

The Network/La Red was formed to address battering in lesbian, bisexual women's, and transgender communities. Through (a) the formation of a community-based multi-cultural organization in which battered/formerly battered lesbians, bisexual women, and transgender folks hold leadership roles; (b) community organizing, education, and the provision of support services; and (c) coalition-building with other movements for social change and social justice, the Network/LaRed seeks to create a culture in which domination, coercion, and control are no longer accepted and operative social norms. Agency services include a Hotline, Safe Home program, Advocacy program, and Organizing/Outreach program. All services are bilingual and wheelchair and TTY-accessible. ASL interpreters, air filters, and reimbursement for childcare are available as needed.

Michigan

Triangle Foundation
19641 West Seven Mile Road
Detroit, MI 48219-2721
Telephone: 313-537-7000
Fax: 313-537-3379
Web: http://www.tri.org/ Triangle Foundation is Michigan's leading organization serving the gay, lesbian, bisexual, transgender (GLBT) and allied communities. The Triangle Foundation Anti-Violence Program is a social change and social service program that works to address and end violence in the lives of GLBT people. We provide free and confidential intervention, information, support, attorney referrals, emergency shelter referrals, and advocacy to GLBT victim/survivors of violence. Additionally, we offer extensive outreach and education programs.

Minnesota

OutFront Minnesota
310 East 38th Street, Suite 204 Minneapolis, MN 55409

Telephone: 612-824-8434 [Hotline]
Telephone: 612-822-0127
Toll-free: 800-800-0350
E-mail: info@outfront.org
Web: http://www.outfront.org
OutFront Minnesota offers direct services to victims of domestic violence and offers training concerning same-sex domestic abuse to DV service providers.

Missouri

Anti-Violence Advocacy Project of the St. Louis region
P.O. Box 63255
St. Louis, MO 63163
Telephone: 314-503-2050
Web: http://www.avap-stl.org/
The mission of the Anti-Violence Advocacy Project (AVAP) of the St. Louis Region is to provide education and advocacy that addresses intimate violence and sociopolitical oppression based on sexual orientation and/or gender identity. This project addresses all forms of violence that affect the lesbian, gay, bisexual, transgender, queer community, including (but not limited to) domestic violence, sexual violence, anti-gay harassment and hate crimes.

Kansas City Anti-Violence Project
PO Box 411211
Kansas City, MO 64141-1211
Telephone: 816-561-0550
Email: info@kcavp.org Web: http://www.kcavp.org
KCAVP was created to provide information, support, referrals, advocacy and other services to LGBT survivors of violence including domestic violence, sexual assault, and bias crimes, focusing these services within the Kansas City metropolitan area. KCAVP also educates the community at large through training and outreach programs.

New York

Gay Alliance of the Genesee Valley
Rochester, NY 14605
Telephone: 585-244-8640
Fax: 585-244-8246
Web: http://www.gayalliance.org/ The Gay Alliance of the Genesee Valley is dedicated to cultivating a healthy, inclusive environment where individuals of all sexual orientations and gender expressions are safe, thriving, and enjoy full civil rights.

In Our Own Voices
245 Lark Street
Albany, NY 12210
Telephone: 518-432-4188
Fax: 518-432-4123
Email: info@inourownvoices.org
Web: http://www.inourownvoices.org
In Our Own Voices is an autonomous organization dedicated to addressing the many needs of the LGBT community. The purpose of [the Capital District LGBT Anti-Violence Project] is to improve domestic violence services for lesbian, gay, bisexual and transgender people, particularly people of color, in the Capital District.

Long Island Gay and Lesbian Youth
34 Park Avenue
Bay Shore, NY 11706-7309
Telephone: 361-655-2300
Fax: 631-655-7874
Web: http://www.ligaly.org
Long Island Gay and Lesbian Youth (LIGALY) is a not-for-profit organization providing education, advocacy, and social support services to Long Island's gay, lesbian, bisexual, and transgender (GLBT) youth and young adults, and all youth, young adults, and their families for whom sexuality, sexual identity, gender identity, and HIV/AIDS are an issue. Our goals are to empower GLBT youth, advocate for their diverse interests, and to educate society about them. [The Long Island Gay and Lesbian Youth Anti-Violence Project] will serve GLBT and HIV-positive victims of violence, and others affected by violence, by providing free and confidential services enabling them to regain their sense of control, identify and evaluate their options and assert their rights. In particular, the Project will assist survivors of hate-motivated violence, domestic violence and sexual assault.

The New York City Gay & Lesbian Anti-Violence Project
240 West 35th Street, Suite 200
New York, NY 10001
Telephone: 212-714-1141 [Hotline]
Telephone : 212-714-1184 TTY: 212-714-1134 [Hotline]
Fax: 212-714-2627
E-mail: clientservices@avp.org
Web: http://www.avp.org
The New York City Gay & Lesbian Anti-Violence Project serves lesbian, gay, transgender, bisexual and HIV-positive victims of violence, and others affected by violence, by providing free and confidential services. The Project assists survivors of hate-motivated violence (including HIV-motivated violence), domestic violence, and sexual assault, by providing therapeutic counseling and advocacy within the criminal justice system and victim support agencies, information for self-help, referrals to practicing professionals, and other sources of assistance. The larger community is also served through public education about violence directed at or within LGBT communities and through action to reform government policies and practices affecting lesbian, gay, transgender, bisexual, HIV-positive and other survivors of violence.

North Carolina

North Carolina Coalition Against Domestic Violence (NCCADV)
115 Market Street, Suite 400
Durham, NC 27701
Telephone: 919-956-9124
Fax: 919-682-1449
Web: http://www.nccadv.org
Project Rainbow Net, an initiative of the North Carolina Coalition Against Domestic Violence (NCCADV) addresses issues related to domestic violence in lesbian, gay, bisexual and transgender relationships. The initiative is a grassroots effort based on the insight of an advisory council made up of lesbian, gay, bisexual and transgender people who have an understanding of domestic violence in LGBT relationships and a desire to end it. Project Rainbow Net provides training to LGBT community groups and domestic violence service providers in North Carolina, in an effort to improve the state's response to LGBT survivors of domestic violence. This website, as well as the NCCADV website (www.nccadv.org) contains information about domestic violence in LGBT relationships, tools for domestic violence service providers, tips on helping a friend experiencing domestic violence, and links to other online resources.

Ohio

Buckeye Region Anti-Violence Program (BRAVO)
PO Box 82068
Columbus, OH 43202
Telephone: 614-268-9622
E-mail: bravoavp@earthlink.net
Toll-free: 866-86-BRAVO [Hotline]
Web: http://www.bravo-ohio.org
BRAVO works to eliminate violence perpetrated on the basis of sexual orientation and/or gender identification, domestic violence and sexual assault through prevention, education, advocacy, violence documentation and survivor services, both within and on behalf of the Lesbian, Gay, Bisexual and Transgender communities.

The Lesbian Gay Community Center of Greater Cleveland
6600 Detroit Avenue
Cleveland, OH 44102
Telephone: 216-651-LGBT (651-5428)
Toll-free: 888-GAY-8761 (429-8761)
E-mail: info@lgcsc.org
Web: http://www.lgcsc.org/
The Center works toward a society free of homophobia and gender oppression by advancing the respect, human rights and dignity of the lesbian, gay male, bisexual and transgender communities. The Center is a non-profit organization that provides direct service, social support, community-building and programs to empower lesbian, gay, bisexual, transgender and intersex people. Core program areas are Education, Health and Wellness and Youth Services.

Ontario
The 519 Anti-Violence Programme
519 Church Street
Toronto, ON M4Y 2C9
Canada
Telephone: 416-392-6877 [Hotline]
E-mail: avp@the519.org
Web: http://www.the519.org
The 519 Anti-Violence Programme provides support to and advocacy for people who have experienced same-sex partner abuse or hate motivated violence or harassment, works with the LGBTQ Communities in Toronto to provide education on responding to and preventing violence, works with other service providers to ensure that their services are accessible and appropriate for LGBTQ people and works with other agencies to develop new services to address service gaps.

Oregon
Survivor Project
P.O. Box 40664
Portland, OR 97240
Telephone: 503-288-3191
Email: info@survivorproject.org
Web: http://www.survivorproject.org/defbarresp.html
Survivor Project is a non-profit organization dedicated to addressing the needs of intersex and trans survivors of domestic and sexual violence through caring action, education and expanding access to resources and to opportunities for action. Since 1997, Survivor Project has provided presentations, workshops, consultation, materials, information and referrals to many anti-violence organizations and universities across the country, as well as gathered information about issues faced by intersex and trans survivors of domestic and sexual violence.

Pennsylvania
Equality Advocates
1211 Chestnut Street, Suite 605
Philadelphia, PA 19107
Telephone: 215-731-1447
Toll Free: 866-LGBT-LAW (866-542-8529) [Hotline, available within PA only.]
Email: info@equalitypa.org
Web: http://www.equalitypa.org
Equality Advocates' mission is to advocate equality for lesbian, gay, bisexual, and transgender individuals in Pennsylvania through direct legal services, education, and policy reform.

Texas
Montrose Counseling Center, Inc. (MCC)
701 Richmond Avenue
Houston, TX 77006-5511
Telephone: 713-529-3211 [Hotline]
Toll Free: 800-699-0504 [Hotline: Regional Toll-Free]
Telephone: 713-529-3590 [Youth Line]
Telephone: 713-529-0037
Fax: 713-526-4367
E-mail: avp@montrosecounselingcenter.org Web: http://www.montrosecounselingcenter.org
MCC, a Joint Commission on Accreditation of Healthcare Organizations facility, provides comprehensive behavioral health and social services for the Gay, Lesbian, Bisexual, Transgender and Questioning communities in and around metropolitan Houston. Anti-violence services include 24-h hotline, advocacy/case management, safety planning, medical, legal and court accompaniment, professional and peer counseling, assistance with Crime Victim's Compensation applications, Victim Impact Statements and protective orders, and legal advocacy for bias/hate crimes, domestic violence and sexual assault. Emergency shelter and transitional housing is also available for domestic violence survivors. Other services available include licensed outpatient substance abuse treatment and GLBTQ youth enrichment programs.

Resource Center of Dallas
P.O. Box 190869
Dallas, TX 75219-0869
Telephone: 214-528-0144
Fax: 214-522-4604
The Resource Center's Family Violence Program promotes self-autonomy, safety and long-term independence for gay, lesbian, bisexual and transgender individuals involved in family violence.

Vermont
Safespace
PO Box 158
Burlington, VT 05402
Telephone: 802-863-0003
Toll-free hotline: 866-869-7341
E-mail: Info@SafeSpaceVT.org
Web: http://www.SafeSpaceVT.org
SafeSpace is a social change and social service organization working to end physical, sexual, and emotional violence in the lives of lesbian, gay, bisexual, transgender, queer and questioning (LGBTQQ) people. SafeSpace provides direct services to survivors of violence through its Support Line, and provides education/outreach to the community about issues of violence in the LGBTQQ community. The organization provides information, support, referrals, and advocacy to LGBTQQ survivors of domestic, sexual and hate violence/discrimination. Advocates work with survivors, helping them access legal, medical, financial, housing, and other community resources. Finally, SafeSpace provides education, training and professional consultation to individuals, groups, schools, and organizations about the issues of violence in the LGBTQQ community.

Virginia
Equality Virginia
403 North Robinson Street
Richmond, VA 23220
Telephone: 804-643-4816
Fax: 804-643-1554
E-mail: va4justice@aol.com
Web: http://www.equalityvirginia.org/
Equality Virginia is a statewide, non-partisan, lobbying, education and support network for the gay, lesbian, bisexual, transgender, and straight allied (GLBT) communities in Virginia. The Anti-Violence Project is an Equality Virginia Education Fund-based program that works to address and end violence in the lives of lesbian, gay, bisexual, transgender, queer and HIV-affected people across the Commonwealth.

Washington
The Northwest Network of Bi, Trans, Lesbian and Gay Survivors of Abuse
PO Box 20398
Seattle, WA 98102
Telephone: 206-568-7777
TTY message: 206- 517-9670
E-mail: info@nwnetwork.org
Web: http://www.nwnetwork.org/about.html
The Northwest Network acts to increase its communities' ability to support the self-determination and safety of bisexual, transgender, lesbian, and gay survivors of abuse through education, organizing and advocacy. The Northwest Network works within a broad liberation movement dedicated to social and economic justice, equality and respect for all people and the creation of loving, inclusive and accountable communities. Services are free and confidential and include support groups, individual counseling, legal advocacy, shelter referrals, safety planning, basic needs assistance, community education and community organizing.

Wisconsin
Milwaukee LGBT Community Center
315 West Court Street
Milwaukee, WI 53212
Telephone: 414-271-2656 [For AVP program, dial extension 111]
Fax: 414-271-2161
Web: http://www.mkelgbt.org
The Milwaukee LGBT Community Center's mission is to improve the quality of life for people in the Metro Milwaukee area who identify as LGBT by providing a home for the birth, nurture and celebration of LGBT organizations, culture and diversity; initiating, implementing and advocating for programs and services that meet the needs of LGBT communities; educating the public and LGBT communities to encourage positive changes in systems affecting the lives of people identifying as LGBT; empowering individuals and groups, who identify as LGBT to achieve their fullest potential; and cultivating a culture of diversity and inclusion in all phases of the project.

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