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| RESEARCH ARTICLE

LGBTQ+ Intimate Partner Violence: A Review of Psychological Crisis Interventions

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| ABSTRACT

Intimate partner violence (IPV), the most prevalent form of violence worldwide, constitutes a public health concern affecting all sexual orientation groups. However, academic circles typically focus more on violence within heterosexual partnerships, with research on intervention measures for LGBTQ+ individuals remaining notably limited. This population often experiences unique stressors such as homophobia and social stigmatization, giving rise to complex psychological crises including identity confusion, major depression, and suicidal ideation. This paper aims to systematically review the experiences and characteristics of intimate partner violence (IPV) among the LGBTQ+ population, the unique manifestations and underlying causes of their psychological crises, and to explore stage-specific psychological crisis intervention techniques for this group. It further urges greater societal attention to the LGBTQ+ community to promote their mental health and well-being.

| KEYWORDS

Intimate partner violence; Psychological crisis; Crisis intervention; LGBTQ+ populations

| ARTICLE INFORMATION

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1.Introduction

1.1 LGBTQ+ populations

Mental health among LGBTQ+ populations has been recognized as a major global public health challenge, with health disparities continuing to widen. The LGBTQ+ community encompasses lesbians, gay men, bisexual individuals, transgender persons, and those who identify as queer or questioning, with each letter representing distinct sexual and gender minority groups whose sexual orientation, gender identity, sexual characteristics, or behaviors differ from those of the majority population (Decker et al., 2018). Such differences, rooted primarily in systemic social discrimination, structural violence, and cultural stigmatization targeting sexual minorities, render LGBTQ+ individuals vulnerable to particularly complex mental health challenges.

Western studies indicate that the prevalence rates of intimate partner violence among same-sex couples are comparable to, or even higher than, those among heterosexual couples (Messinger, 2011; Rollè et al., 2018; Stephenson & Finneran, 2017). However, compared with heterosexual victims, sexual minority victims of IPV have 70% higher odds of depression and 60% higher odds of anxiety (Miller & Irvin, 2017). Moreover, the Human Rights Watch has reported that lesbian, bisexual, and queer (LBQ+) women and non-binary individuals face severe violence and discrimination globally−a reality that not only undermines their quality of life but also exacerbates their health vulnerabilities (Kilbride, 2023). Specifically, LBQ+ individuals frequently experience multiple forms of violence, including physical assault, sexual harassment, and forced marriage, which not only directly impact their mental health but may also elevate the risk of HIV and other sexually transmitted infections.

To date, research on the causes and interventions for same-sex intimate partner violence remains limited compared with studies on heterosexual populations (Santoniccolo et al., 2023). These studies have not only revealed the additional psychological burden borne by LGBTQ+ individuals in the context of intimate partner violence but have also highlighted the severe inadequacies of current support systems in terms of cultural sensitivity and targeted services.

1.2 Intimate Partner Violence

Intimate partner violence (IPV), defined as attempts to harm or control a current or former partner against their will (Chester & DeWall, 2018), is commonly classified into four types (physical violence, psychological aggression, sexual violence, and stalking) and constitutes the most prevalent form of violence worldwide. Existing research has shown that IPV not only results in direct physical injuries to victims but also gives rise to long-term mental health problems, such as depression, anxiety, and post-traumatic stress disorder (PTSD) (World Health Organization [WHO], 2021). The majority of IPV victims are women; globally, approximately 27% of women aged 15 and older have experienced physical or sexual violence by an intimate partner, and in some low-income countries, this rate is as high as 38% (Garcia-Moreno et al., 2021). Furthermore, other marginalized groups experience disproportionately high rates of intimate partner violence. Marginalized populations, including LGBTQ+ individuals, people with disabilities, and ethnic minorities, often have their victimization experiences systematically overlooked due to structural discrimination and the absence of adequate support systems, underscoring the urgent need for more inclusive intervention policies and services.

Although early research predominantly focused on heterosexual relationships, growing evidence in recent years has indicated that LGBTQ+ populations face equal or even higher risks of IPV. Data from the National Intimate Partner and Sexual Violence Survey (NISVS) show that the lifetime prevalence of IPV among bisexual women is as high as 61.1%, substantially exceeding the 35.0% rate among heterosexual women (Walters et al., 2013). The IPV prevalence rates among gay and bisexual men (ranging from 26.0% to 37.3%) are also significantly higher than conventionally recognized (Finneran & Stephenson, 2013). Transgender populations exhibit particularly pronounced IPV risks, with a lifetime prevalence reaching 54%, and this is frequently accompanied by structural violence, including medical discrimination and police inaction (James et al., 2016).

These studies reveal that the vulnerability of LGBTQ+ populations to IPV risk stems not only from individual relationship factors but is also closely associated with systemic social exclusion. Future intervention strategies should aim to build a genuinely inclusive violence response system through legislative reform, professional training, and the development of community support networks.

2.Psychological Crisis Intervention

2.1 Psychological Crisis

Crisis generally refers to an individual's acute reaction to sudden, unexpected events, representing a natural phenomenon that continually alters or disrupts a state of equilibrium. It not only manifests as the failure of individual psychological defense mechanisms, giving rise to cognitive confusion and emotional distress, but may also be expressed as physiological dysfunction (Zhou, 2021). Psychological crisis, in turn, denotes an internal psychological state caused by various psychological conflicts (Zhou & Li, 2023), characterized by the breakdown of habitual coping mechanisms, disruption of cognitive and emotional functioning, and a temporary collapse of social adaptability.

In the context of intimate partner violence (IPV), crisis manifests as the victim's decompensatory reaction to sustained violent oppression. When the threat of violence exceeds the individual's psychological tolerance threshold, it triggers intense feelings of loss of control, despair, and existential fear. This crisis state essentially represents a comprehensive collapse of the individual's safety system. Specifically, when violence persistently erodes basic survival needs such as bodily autonomy and emotional bonds, the victim becomes trapped in a vicious cycle of traumatic entrapment, in which physiological hypervigilance and behavioral learned helplessness mutually reinforce each other, ultimately resulting in paralysis of adaptive functioning (Langhinrichsen-Rohling & Turner, 2012).

2.2 Psychological Crisis Intervention

Psychological crisis intervention refers to the process in which crisis intervenors adopt appropriate psychological crisis intervention strategies promptly and effectively after the occurrence of a crisis to help individuals resolve the crisis and restore their psychological equilibrium as quickly as possible (Cong, 2020). LGBTQ+ individuals constitute a relatively small proportion of the population and occupy a marginalized position in terms of sexual orientation. When faced with psychological crises, they lack relevant experience and psychological recovery skills, and there are few targeted psychological crisis intervention support resources available in society. Moreover, for this population, when they encounter psychological issues related to their sexual orientation, they may also find it difficult to adapt within a short period of time, because once they seek help, they face the risk of identity disclosure (Potter et al., 2012).

Common psychological responses to IPV among LGBTQ+ individuals include disbelief, fear of the truth, fear of being alone, worry about recurrence of violence, and sleep disturbances (Worden, 2018). Understanding the characteristics of different crisis phases facilitates the implementation of targeted interventions. For instance, in the survival safety phase, sexual minority individuals may exhibit symptoms such as helplessness, fear, and anxiety, along with disorganized language functioning and distrust toward anyone around them during communication (Keating & Muller, 2020). In the mid-phase, individuals often experience a dual burden: on one hand, they suffer from intrusive recollections of violent scenes; on the other hand, they engage in self-blame due to social stigma, which in turn triggers social avoidance behaviors (Ong et al., 2025). The stable recovery phase,

however, presents challenges in restructuring relationship patterns, manifesting as either hypervigilance toward intimate relationships or repetition of hazardous relationship dynamics (Pain, 2018).

3. Types of IPV Related to LGBTQ+ Populations

3.1 Psychological Violence

Psychological violence, also referred to as mental abuse, refers to acts that cause psychological harm to others through non-physical means, which may include humiliation, controlling others, concealing information, isolating victims from their friends and family, or threatening victims with economic resources. This type of IPV may also include stalking, a repetitive behavior that causes victims to experience heightened fear. Psychological violence is one of the most common forms of violence among LGBTQ+ partners. It can occur in various types of relationships, including dating, marital, and domestic partnerships (Messinger, 2018), and may be influenced by factors such as social prejudice and discrimination, which can exacerbate stress and tension within the relationship (Barros et al., 2019).

Multiple studies have revealed the pervasiveness of psychological violence among diverse sexual minority populations and its extensive negative impacts on health. In the United States, research focusing on Black gay and bisexual men has found that experiencing psychological IPV is significantly associated with poorer HIV prevention and care outcomes, as well as other physical and mental health problems (Wirtz et al., 2022). Similarly, among adolescents and young adults assigned female at birth, psychological IPV has also been identified as a critical issue that severely undermines individuals' self-esteem and life satisfaction (Whitton et al., 2019). Among LGBTQ+ college students in the United States, psychological violence from intimate partners has been linked to a history of parental abuse, interpersonal conflict, and microaggressions (Taylor & Neppl, 2020). Furthermore, one study identified four patterns of intimate partner violence victimization and perpetration among sexual minority women, revealing the ways in which experiences across different social spaces are associated with heterosexual norms (Sutter et al., 2019). Regarding differences in violence patterns, a study focusing on young sexual minorities found that transgender men reported particularly elevated rates of psychological violence (Stults et al., 2022).

The above studies indicate that psychological violence within intimate relationships among LGBTQ+ populations constitutes a significant concern, exerting adverse effects on their physical and mental health.

3.2 Physical Violence

Physical violence refers to physical attacks explicitly directed at the victim's body with the intent to cause harm or pain, encompassing a spectrum of behaviors ranging from relatively minor acts (such as pushing or grabbing the arm) to extremely severe ones (such as beating to unconsciousness or threatening or attacking with weapons). It represents the most directly visible and highly dangerous form of violence in intimate relationships. In intimate relationships among LGBTQ+ populations, the manifestations of physical violence include both general physical aggression and forms that are distinctly identity-targeted. For example, bisexual individuals may be subjected to coercive acts intended to prove their sexual orientation. In addition, violence perpetrated through identity-based threats, such as threatening to disclose one's sexual orientation or gender identity, is particularly prominent. These forms of violence often intersect with other types of abuse and may pose fatal risks at the time of relationship dissolution.

Physical violence is typically part of a broader pattern of abusive and coercive behavior, rather than an isolated event. Research has indicated that risk factors for physical violence victimization among LGBTQ+ individuals include prior experiences of victimization or perpetration, heterosexual experiences (Silva et al., 2022), racial stigma (Swann et al., 2022), history of bullying victimization (Folayan et al., 2022), experiences of isolation (Ogunbajo et al., 2022), exposure to controlling behaviors (Raghavan et al., 2019), and suicidal behaviors (Nydegger et al., 2020). Furthermore, the likelihood of engaging in physical aggression is positively correlated with partner discrimination, alcohol consumption, and anxiety symptoms, while negatively correlated with emotional intimacy, partner dedication, social support, and relationship adjustment (Do et al., 2022).

3.3 Sexual Violence

Sexual violence refers to any sexual act or coercive sexual behavior carried out without explicit, voluntary consent, essentially constituting sexual assault perpetrated through violence, threats, coercion, deception, power oppression, or exploitation of the victim's inability to resist. Sexual violence within IPV is a serious and often neglected issue for LGBTQ+ populations. Its complexity far exceeds that of similar violence in heterosexual relationships, involving unique power dynamics, social stigmatization, and systemic barriers. The rates of intimate partner sexual violence observed among LGBTQ+ individuals are higher than those among heterosexual individuals. In particular, transgender and gender non-conforming individuals face a higher risk of sexual harassment and violence compared with cisgender heterosexual individuals, and gender non-conforming individuals who have experienced sexual IPV tend to have elevated anxiety levels.

Research indicates that bisexual men and bisexual women are more likely than gay men and lesbians to report having experienced sexual violence (Kiekens et al., 2022), and that younger women are more likely than men to be victims of this type of violence (Williams Jr. & Gutierrez, 2022). In addition, heterosexual aggression and discrimination are positively correlated with

sexual IPV perpetration and victimization. Other related factors include older age, childhood sexual abuse, smoking (Wong et al., 2021), and engaging in commercial sex with men and being diagnosed with sexually transmitted infections (Liu et al., 2018).

In summary, these findings highlight that IPV among LGBTQ+ populations is influenced by multiple social and personal factors, underscoring an urgent need for targeted interventions and ongoing research grounded in an intersectional perspective to reduce risks and strengthen protective mechanisms.

4. Psychological Crisis Intervention Pathways for LGBTQ+ Populations

LGBTQ+ populations experience disproportionately higher rates of family and societal violence compared with the general population, due to their sexual orientation or gender identity. The trauma resulting from such violence is characterized by its long-term and complex nature, underscoring the urgent need for targeted, phase-specific psychological crisis intervention strategies. This paper focuses on three key phases following the cessation of violence, exploring the corresponding core intervention techniques and their applications.

4.1 Survival Safety Phase (Immediate Post-Violence Phase)

The core tasks of the survival safety phase include establishing physical and psychological safety, meeting basic survival needs, managing acute stress responses, and preliminarily addressing identity-related trauma. In this phase, individuals have just escaped the violent environment; physical safety is undoubtedly the absolute priority, often accompanied by intense acute stress reactions as well as profound identity-related shame and self-doubt.

First, intervention efforts should begin with a thorough safety assessment and planning. This requires close collaboration with social workers and legal advisors to ensure that shelters or temporary housing are not only genuinely safe but also LGBTQ+ affirming, such as respecting individuals' pronouns and providing accommodation arrangements consistent with their gender identity. At the same time, it is essential to assess additional risks that may arise from the disclosure of one's LGBTQ+ identity and to develop practical safety plans accordingly, such as applying for protective orders or changing contact information.

Subsequently, providing non-intrusive psychological first aid (PFA) is a critical step in stabilizing the individual. This process enhances the individual's sense of control through listening, unconditional acceptance, and offering practical resource information. Meanwhile, intervenors guide the individual to mentally construct an inner safe space or container to temporarily hold overwhelming emotions that cannot yet be processed; to employ the "5-4-3-2-1" grounding exercise to help return from flashbacks or dissociative states to the present reality; and to practice deep diaphragmatic breathing to regulate an over-aroused autonomic nervous system. At this stage, intervenors must consistently use affirming language, unconditionally accept the individual's identity, and clearly attribute the violence to the perpetrator's prejudice rather than to the victim's identity itself.

In parallel, efficiently connecting individuals with LGBTQ+-affirming resources to address their most pressing survival needs is another core task. This includes ensuring access to safe shelter, food, and necessary medical care, with particular attention to the potential interruption of hormone therapy that transgender individuals may face. These are essential prerequisites for stabilizing the individual's foundation and ensuring survival.

After establishing a basic sense of safety, intervention can gradually shift to preliminarily addressing identity-related trauma. At this point, intervenors may gently explore the core negative beliefs that the individual has formed through experiences of violence. By employing affirmation techniques to validate the legitimacy and authenticity of their experiences and painful feelings, intervenors can begin to help the individual challenge internalized homophobia. This process necessitates emphasizing the healthiness and legitimacy of LGBTQ+ identities and introducing relevant community resources, thereby instilling hope and laying a foundation for subsequent recovery.

4.2 Trauma Stabilization Phase (1-3 Months Post-Violence)

The hallmark of the trauma stabilization phase is that the individual's basic survival needs have been preliminarily met, and acute stress symptoms may have somewhat subsided. However, trauma responses such as intrusive memories, nightmares, marked mood swings, and avoidance behaviors remain prominently present. Given the characteristics of this phase, the core objectives of intervention focus on stabilizing emotions, processing traumatic memories, rebuilding a sense of safety and control, deepening identity-related repair work, and enhancing the individual's overall coping skills.

First, intervention efforts should begin with systematic psychoeducation. It is crucial to clearly explain to the individual the psychosomatic mechanisms underlying trauma responses, which helps them understand that current symptoms are normal reactions following trauma, thereby effectively reducing self-stigma. Concurrently, it is necessary to deepen the application of techniques previously introduced, such as the safe container and grounding exercises, so that they serve as secure vessels for processing traumatic memories. Importantly, intervenors should help the individual recognize that the roots of their distress lie not only in isolated events but also in societal prejudice.

Based on this foundation, cognitive restructuring techniques become the core intervention approach at this phase. The aim is to help individuals identify and challenge the core negative beliefs that have been shaped by experiences of violence and internalized social prejudice. The key to intervention lies in guiding individuals to replace these harmful cognitions with more realistic and balanced beliefs. This work particularly needs to focus on internalized homophobia and transphobia, utilizing

positive role models from LGBTQ+ communities to mount compelling counterarguments, thereby strengthening positive identity formation.

Subsequently, under the condition of ensuring a highly safe and supportive environment, Narrative Exposure Therapy (NET) or its modified approaches can be introduced. This technique guides individuals to chronologically narrate their life experiences along a timeline, with particular focus on traumatic events. Through this process, the goal is to help individuals integrate fragmented memories into a more coherent life narrative, clearly distinguishing between past and present states, with special attention to how key identity-development events—such as coming out or seeking medical care—intertwine with violent experiences. Ultimately, this facilitates the strengthening of individuals' agency to resist oppression and enhances their sense of belonging.

In parallel, emotion regulation skills training is indispensable, including teaching mindfulness, which cultivates a non-judgmental awareness of present-moment experiences; learning distress tolerance, which involves techniques for enduring painful emotions without worsening the situation; and enhancing emotion regulation, which entails identifying emotional triggers, reducing emotional vulnerability, and increasing positive emotional experiences. It is important to guide individuals in practicing the application of these skills in specific contexts that may trigger identity-related anxiety.

Finally, on the condition of carefully assessing the individual's psychological readiness and the safety of the group environment, consideration may be given to introducing homogeneous supportive or psychoeducational groups led by professionals with LGBTQ+ cultural competence. Such groups aim to provide valuable peer support, significantly reduce feelings of isolation, allow members to learn effective coping experiences from others, and practice social interactions in a safe environment.

4.3 Functional Recovery Phase (3-6 Months Post-Violence)

The functional recovery phase marks a critical transition for the individual, moving from mere survival toward a state of living. At this point, traumatic symptoms have significantly diminished and emotions have become relatively stabilized; however, new challenges emerge, including rebuilding healthy interpersonal relationships, restoring academic or occupational functioning, achieving economic independence, deepening positive self-identity and pride, processing residual grief and anger, and practicing identity expression in broader social contexts. In response to this transition, the core objectives of intervention center on promoting social functional recovery and independent living skills, consolidating positive identity and sense of empowerment, supporting the individual in setting and pursuing life goals that align with their authentic self, and, optionally, enhancing community connectedness and social advocacy awareness.

The primary step involves systematically advancing social functional reconstruction. First, social skills training: guide individuals to identify safe interpersonal relationships, establish healthy boundaries, effectively express their needs, and specifically practice strategies for coping with daily discrimination and microaggressions. Second, academic and vocational support: assist in formulating practical educational or career plans by assessing abilities and interests, connect with LGBTQ+ affirming resources, and specifically address practical challenges such as coming out in the workplace and responding to discrimination. Third, life management skills development: teach budgeting, independent living skills, and the establishment of a healthy lifestyle. Throughout this process, particular emphasis should be placed on the strategic significance of economic independence in enabling a complete departure from violent environments, and opportunities for social interaction within LGBTQ+ communities may be provided to expand support networks.

Based on this foundation, intervention deepens to the level of affirmative counseling and identity integration. This entails moving beyond trauma repair toward positive identity development: exploring the meaning of one's personal identity, inner strengths, and sense of pride; integrating sexual orientation, gender identity, and other social identities; supporting the setting of life goals that are congruent with one's authentic self; assisting in addressing unresolved grief related to one's family of origin; and actively exploring the possibility of building a chosen family. It is important to encourage participation in LGBTQ+ community cultural activities to strengthen a sense of belonging, while always respecting the individual's autonomous choices regarding identity expression and degree of community involvement.

Subsequently, relationship-focused intervention should be undertaken. Its core lies in helping individuals explore patterns for building and maintaining healthy intimate relationships and friendships, addressing deep-seated trust issues and intimacy fears stemming from past trauma, and teaching practical communication skills and conflict resolution strategies. In addition, it is essential to specifically address issues unique to LGBTQ+ relationships, such as discrepancies in the degree of outness between partners, negotiation of consensually non-monogamous relationships, and approaches to managing both partners' potential traumatic experiences within the relationship.

Meanwhile, values clarification and meaning reconstruction represent a critical component in promoting long-term psychological resilience. Techniques such as Acceptance and Commitment Therapy (ACT) may be utilized to guide individuals in identifying the core values that truly matter to them following traumatic experiences. By encouraging individuals to take action guided by these values rather than by fear, intervenors help them pursue a meaningful life, integrating traumatic experiences as part of their life narrative rather than allowing them to define the whole. If the individual is receptive, intervenors may also assist

in connecting their personal identity with broader LGBTQ+ advocacy or social justice values, thereby enhancing their sense of meaning and purpose.

Finally, with regard to family intervention, it may be cautiously considered only under the strict conditions that the individual is fully prepared, that the safety of the environment has been professionally assessed and confirmed, and that the family members demonstrate genuine willingness to change. The limited objectives are to facilitate family members' understanding of the survivor's identity, to assist in establishing inviolable healthy boundaries, and to address residual emotional pain. It must always be emphasized that the core principle of any intervention is the absolute protection of the survivor's safety and well-being, and the intervention should be led by experienced and affirmatively oriented therapists. Throughout the process, family members should be educated about scientific facts regarding sexual orientation and gender identity, while resolutely avoiding any form of forced contact or pressure toward reconciliation.

5. Conclusion and Future Directions

The effectiveness of interventions is critically dependent on professionals' profound understanding of the diversity of sexual orientations and gender identities, as well as their familiarity with the history, culture, terminology, and systemic oppression faced by LGBTQ+ communities. Intervenors must continuously reflect on their own biases, use affirming language, and create absolutely safe and non-judgmental spaces. The work should be guided by a systemic perspective: at the individual level, implementing phase-specific techniques; at the relational and family level, cautiously assessing the possibility of family intervention while actively supporting chosen families; at the community level, actively connecting with LGBTQ+ community resources and support groups, leveraging the power of peer support and belonging; and at the social policy level, advocating for anti-discrimination legislation, equal rights, accessible gender marker changes, safety protections, and access to gender-affirming medical care, as improvements in the social environment are fundamental to preventing violence and facilitating recovery.

Currently, the field faces challenges such as insufficient resources, multiple intersecting forms of discrimination, and inadequate cultural competence among intervenors. Future efforts should prioritize strengthening professional training, developing evidence-based intervention models tailored to LGBTQ+ subgroups, and continuously advancing social policy reforms to address the root causes of violence. Only by building a truly inclusive, equitable, and respectful social environment that embraces diverse genders and sexual orientations can we provide a safe ground for LGBTQ+ individuals to flourish freely.

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