EXPERIENCES OF INTIMATE PARTNER VIOLENCE

AMONG LGBTQ+ INDIVIDUALS AND THE

PERCEPTIONS OF PROFESSIONAL

SERVICES

by

Kathleen R. Bates, B.S.

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Committee Members:

    Ronald D. Williams, Jr., Chair

    Mary Odum, Co-Chair

    Jeff M. Housman

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DEDICATION

I humbly dedicate this project to all LGBTQ+ survivors of domestic abuse. While our society has made great strides for LGBTQ+ rights, we are falling extremely short in protecting, supporting, and nourishing growth for LGBTQ+ survivors of intimate partner violence.

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I. INTRODUCTION

Introduction

The purpose of this study was to examine the forms of intimate partner violence experienced among sexual minority populations and the pathways associated with the self-efficacy to report victimization. This study was a primary analysis of qualitative interviews with victims of intimate partner violence who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ). Analyses will examine responses from participants who answer questions regarding experiences of intimate partner violence, coping mechanisms, and positive and negative risk factors linked with reporting and seeking services for victims.

Significance of the Problem

Intimate partner violence (IPV) is a complex paradox, a phenomenon built on the contradiction of love and violence that yields over 500,000 injuries requiring medical attention and nearly $4.1 billion in healthcare costs each year (Burge et al., 2014). The World Health Organization (WHO; 2017) defines IPV as physical, sexual or psychological harm against a partner within an intimate relationship. Moreover, IPV includes acts of physical aggression, psychological abuse, controlling behaviors, and sexual coercion (Burelomova, Gulina, & Tikhomandritskaya, 2018). Although psychological acts do not result in bodily harm, it does include behaviors intended to cause harm through threats or insulting and degrading comments that belittle or humiliate the partner (Watkins et al., 2014). Some studies suggest controlling behaviors like restricting mobility and access to friends and family are more frequent than other forms of abuse and often co-occur with other forms of IPV victimization (Burelomova et al.,

2018; Lovestad, Love, Vaez, & Krantz, 2017; Watkins et al., 2014). IPV is also referred to as gender-based violence, relationship violence, domestic violence, and family violence (Satyen, Piedra, Ranganathan, & Golluccio, 2018).

According to a well-established domestic abuse cycle, three distinct phases occur during the abuse, which repeat continuously during the relationship. Throughout phase one (tension building) the couple experiences a buildup of tension from everyday stressors such as finances, jobs or children. The victim will try to control the situation and prevent violent outbursts from the abuser by implementing a variety of means to please the abuser. Phase two (acute battering episode) is commonly triggered by an external event that is uncontrollable. The abuser will direct his/her anger toward their partner through acts of physical, sexual or verbal abuse. Often, the victim will feel numerous emotions that range from shock and disbelief to guilt, shame, and depression. During the final phase (honeymoon phase) the abuser feels temporary guilt and may offer excuses for his/her violent behavior. Common experiences include apologies, gifts, and asking for promises from the victim not to involve law enforcement or to leave. Each time the cycle occurs, an unhealthy bond between the couple strengthens and provides further justification for violent behavior (Walker, 1979).

In the United States, approximately 85% of IPV victims are female and over one third of the female population have experienced physical or sexual violence or stalking by a partner (Bressler, Brink, & Crichton, 2016; Watkins et al., 2014). Additionally, prevalence rates of psychological abuse among women average around 80% (Watkins et al., 2014). The chronic disease burden of IPV victimization is extensive and is a leading contribution to years of life lost among women. Victims in abusive relationships

experience a myriad of physical health issues including, diabetes, frequent headaches, irritable bowel syndrome, chronic pain, and difficulty sleeping. Furthermore, victims report various mental health issues such as anxiety, depression, phobias, and posttraumatic stress disorder (PTSD; Burge et al., 2014). In fact, the prevalence of depression among female victims is 48% while PTSD prevalence rates range from 31% to 84% (Matheson et al., 2015). IPV survivors exhibit increased rates of damaged coping behaviors such as, drug use or heavy drinking, and sexual and reproductive health conditions including miscarriages or sexually transmitted infections (Clark et al., 2018; Kovacs, 2018; Matheson et al., 2015). Children who witness family violence in their homes are more likely to experience or perpetrate IPV as adults (Matheson et al., 2015; Shakya et al., 2016). Moreover, exposure to IPV can cause extensive indirect health effects that may persist into adulthood. Such health effects may include anxiety, withdrawal, attention problems, aggressive behavior, rule-breaking actions, and poor health risk behaviors (Bressler et al., 2016).

IPV not only occurs among married, separated, or single heterosexual relationships, but homosexual relationships as well (Satyen et al., 2018). Reports indicate IPV is more prevalent among sexual minority populations. According to the 2010 National Intimate Partner and Sexual Violence Survey, 44% of lesbian women and 61% of bisexual women reported IPV in their lifetime compared to 35% of heterosexual women (Wong et al., 2017). In a study assessing IPV among men who have sex with men, women, or both, results depicted homosexual men had significantly higher prevalence rates of either victimization or perpetration of IPV compared to heterosexual men. The same study also reported men who had male sex partners were significantly

more likely to be a victim of physical and sexual IPV compared to heterosexual men (Welles, Corbin, Rich, Reed, & Raj, 2011). Those who identify as LGBTQ+ experience a unique set of external social stressors related to prejudice, discrimination and stigma. These stressors can create a sense of burden, shame and guilt due to a persons' self-evaluation of sexual identity. Additionally, people who identify as LGBTQ+ may be reluctant to disclose experiences of IPV or seek support services and healthy coping behaviors (Wong et al., 2017).

IPV prevalence rates differ substantially across gender, race, and sexual orientation, and current research investigating IPV among sexual minority relationships is limited (Bressler et al., 2016; Welles et al., 2011). The 2011 Institute of Medicine Report called for the development and expansion of evidence regarding the health concerns and healthcare needs of sexual minority populations to ensure health equality (Wong et al., 2017). This study focused on adults who are at least 18 years of age and were victims of IPV that occurred within a previous LGTBQ+ relationship. Due to the traumatic and sensitive nature of domestic abuse, this study qualitatively evaluated the personal reflections of IPV victimization.

Research Questions

To explore the styles of IPV among LGBTQ+ relationships and the conduits associated with the self-efficacy to report victimization and seek services, this study examined each participants' lived experiences during the abusive relationship and under what circumstances encouraged or prevented each participant from reporting the abuse and seeking professional help. Additionally, this study examined suggestions for

professionals and organizations to expand and evolve policies and procedures for

LGBTQ+ IPV survivors. Therefore, the following research questions were explored:

1. What are the lived experiences of adults within the U.S. LGBTQ+ community who have experienced IPV in a prior relationship?

2. What circumstances or factors influenced LGBTQ+ IPV survivors' decision whether to report abuse to, or seek assistance from, professional services?

3. How do LGBTQ+ IPV survivors suggest U.S. domestic abuse service agencies respond to, and provide support for, LGBTQ+ people who have experienced IPV?

Assumptions

For this study, it was assumed all participants were at least 18 years old and identified within the LGBTQ+ spectrum. Additionally, it was assumed that all participants experienced IPV in a previous relationship within the United States.

Key Terms

Intimate partner violence: behavior within an intimate relationship that causes or has the potential to cause physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors (Garcia-Moreno et al., 2015, p. 1686)

Intimate partner: a person with whom one has a close personal relationship that may include regular contact, an emotional connectedness, identity as a couple, or ongoing physical contact and/or sexual behavior (CDC, 2018)

Physical violence: the use of physical force like beating, slapping, pushing, kicking, choking, the use of a gun or knife, and threats (Burelomova et al., 2018)

Sexual violence: forcing a partner to have sexual intercourse, unprotected sexual intercourse, harmful acts during sexual intercourse, or conducting any sexual act the victim found degrading or humiliating (WHO, 2013a)

Psychological violence: actions that are offensive, degrading, or humiliating such as restricting access to friends and family, independence, access to information or health services, or verbal abuse like name-calling or threats to beat a woman or children (WHO, 2013a)

Economic abuse: involves tactics of economic control by restricting economic resources such as regulating access to finances, denying access to financial information, or interfering with employment (Adams & Beeble, 2018)

Risk factors: factors that have a measurable association between experiencing different types of intimate partner violence like social norms, gender norms, socioeconomic status, education, or previous experiences of domestic violence (WHO, 2017)

Coping mechanisms: cognitive and behavioral strategies that are used to manage stress such as acceptance, seeking support, denial, substance use, or disengagement (Goldberg-Looney, 2016)

LGBTQ: a persons' sexual orientation that identifies themselves as lesbian, gay, bisexual, transgender, or queer (WHO, 2016)

Cisgender: having a gender identity that matches one's assigned sex (WHO, 2016, p. 3)

Transgender: an umbrella term that includes transsexual people, people who identify as third gender or gender atypical, and those whose sense of gender is different from the sex that was assigned at birth (WHO, 2016)

Homophobia: discrimination of a person that is based off their sexual orientation or gender identity (WHO, 2016)

II. LITERATURE REVIEW

Introduction

Since the 18th century, women have drastically improved gender equality within society. Multiple women's movements including voting and property rights, equal employment and pay, access to higher education and medical professions, and reproductive rights have transformed society's prospects for the female sex (Lin, Sun, Wu, & Liu, 2016). More recently, violence against women, including intimate partner violence (IPV), has gradually gained national attention through feminist scholars, federal legislation, and the Me Too movement (Lin et al., 2016). While believing in gender equality has been connected to lower rates of physical violence, and federal legislation including the Violence Against Women Act has improved public understanding of IPV as a global public health concern, professionals still lack understanding the impact of domestic abuse within various communities (Lin et al., 2016; Lin, Sun, Liu, & Chen, 2018; Russell, 2018). Furthermore, established norms of gender inequality that support domestic abuse increase risks associated with IPV victimization and perpetration (Mannell & Dadswell, 2017).

Intimate partner violence is commonly a form of gender-based violence, which encompasses controlling behaviors, physical aggression, sexual coercion, and psychological abuse (Mannell & Dadswell, 2017). While IPV victimization is also experienced among men, women have increased rates of experiencing coercive behavior and severe injuries including death (World Health Organization, 2013b). Experiencing multiple forms of IPV has been documented at 25% to 54% (Burelomova et al., 2018). Globally, an estimated 24% to 43% of victims have experienced various forms of IPV in

their lifetimes (Rada, 2014). Additionally, one third of all women have experienced physical and/or sexual violence within their romantic relationships (Garcia-Moreno et al., 2013). Furthermore, the national prevalence rate of physical violence has been estimated at 34% and psychological abuse combined with physical violence has been reported at 35% (Lin et al., 2018).

While broader terms of IPV were developed to investigate heterosexual relationships, more attention has recently surrounded terms associated with IPV to investigate occurrences and associations among LGBTQ+ relationships (Finneran & Stephenson, 2013). Research indicates that same-sex couples are more likely to experience domestic abuse compared to heterosexual couples (Edwards, Sylaska, & Neal, 2015; Finneran & Stephenson, 2013; Reuter, Newcomb, Whitton, & Mustanski, 2016). In a longitudinal study investigating IPV experiences among LGBTQ+ couples, female or male-to-female transgender participants were more likely to experience verbal abuse than their male counterparts. Participants who identified as female, male-to-female transgender, or lesbian were more likely to experience physical abuse than their male peers. Lesbian identified participants had an increased risk of experiencing physical abuse compared to gay or bisexual participants. Overall, when gender identification was female, risks for experiencing verbal, physical, and any type of IPV were greater when compared to gay or bisexual (Reuter et al., 2016).

Additionally, LGBTQ+ couples are more likely than their heterosexual couple peers to report bidirectional experiences of IPV (Kubicek, McNeeley, & Collins, 2016). Within the past year, young adult gay men reported perpetrating 16.5 acts of physical IPV and experiencing 16 acts of physical IPV. Regarding sexual IPV, young gay men

reportedly perpetrated 10.7 acts and experienced 10.9 acts within the past year. In addition, 27 acts of emotional IPV were perpetrated and 29 acts were received among young adult gay men (Kubicek et al., 2016).

Research has provided insights into socioeconomic risk factors, social and cultural influences, and differences between heterosexual relationships and LGBTQ+ relationships (Murphy, 2013). Furthermore, the longstanding focus on gender-based violence highlights prominent theoretical and empirical explanations of the impact of IPV on healthcare, a victim's wellbeing, and family dynamics.

Impact of IPV on Society and the Individual

The long-term impact of IPV is significant on healthcare and productivity, physical and psychological well-being of victims, and family dynamics including positive parenting strategies. In terms of workplace productivity, IPV impacts an estimated $1.8 billion and equals nearly 32,000 jobs or 8 million paid workdays (Mancera, Mungal, De Santis, & Provencio-Vasquez, 2018).

Healthcare. The American Medical Association (AMA) and World Health Organization (WHO) have coined IPV as healthcare's silent epidemic (Welles, Corbin, Rich, Reed, & Raj, 2011). In the United States, costs associated with IPV range from $1.7 billion to $10 billion per year (Acevedo, Lowe, Griffin, & Botvin, 2013). Documented IPV occurrences associated with assaults, rapes, stalking, and lost productivity costs over $8 billion for morbidity and mortality. An estimated 12% to 25% of women evaluated in emergency rooms are due to IPV related injuries (Cerulli, Poleshuck, Raimondi, Veale, & Chin, 2012). According to Holmes and colleagues (2018), family exposure to IPV imposes a significant burden on healthcare, social services, and lost productivity. In the United

States, individual family exposure to IPV costs the economy nearly $50,000 per family, for a combined total surpassing $55 billion annually.

WHO has emphasized an urgent need to increase education regarding domestic abuse and provide recommendations and education among primary healthcare professionals (Sawyer, Coles, Williams, & Williams, 2016). In the United States, a range of healthcare practitioners including social workers, nurses, physicians, dentists, and medical residents have attended IPV trainings and visited shelters to increase their knowledge of IPV and the skills needed to address domestic violence experienced by their patients (Dyer & Abildso, 2019). Sawyer and colleagues (2016) conducted a systematic review of IPV training among healthcare practitioners and reported a substantial need for non-judgmental and sensitive responses among healthcare professionals when working within the complexities of IPV. Additionally, Turner and colleagues (2017) discovered participation in training programs increased knowledge, attitudes, and clinical competencies for up to a year among healthcare professionals.

Zaher, Keogh, and Ratnapalan (2014) conducted a review of randomized controlled trials of multifaceted approaches to educating physicians about IPV. The authors' research revealed a combination of education, interactive workshops, web-based learning, and experiential training transformed physician behavior. Post-training, physicians provided brochures and posters to patients, accessed IPV support services, and increased reporting rates among patients.

According to the National Home Visiting Resource Center (2017), home visitation has become a primary method to address domestic abuse. Home visitors consist of trained and credentialed employees; however, research has reported numerous home visitors report

feeling a lack in self-efficacy and the skills needed to address IPV victimization among clients (Burton & Carlyle, 2015; Jack et al., 2017). In a study assessing home visitor's perceived barriers to addressing IPV among clients, over 80% reported the victim's partner was present for the visit, while 30.2% reported risking home visitor-client relationships and 25.9% were unsure how to effectively ask questions when addressing IPV experiences (Dyer & Abildso, 2019). Additionally, Sharps and colleagues (2013) reported home visitors feared being a victim of violence or losing their client due to the nature of sensitive and intrusive information shared during home visits. These findings add to the need of continued evidence based IPV trainings to further improve curricula and increase healthcare professionals and practitioners understanding of how to address domestic abuse among clients and patients (Dyer & Abildso, 2019).

Physical and Psychological Wellbeing. Experiences of domestic abuse often result in numerous physical and psychological consequences. The morbidity and mortality associated with IPV present a significant national public health crisis (Cerulli et al., 2012). Psychological symptoms and disorders such as depression, suicidality, anxiety, low self-esteem, paranoia, invasive fear, panic attacks, and posttraumatic stress disorder (PTSD) often occur among IPV victims (Adams & Beeble, 2018; Cerulli et al., 2012; Lin et al., 2018).

In a meta-analysis conducted by Dillon and colleagues (2013), prevalence rates of depression were associated with psychological abuse, PTSD rates were associated with sexual abuse, and suicidal ideation was associated with experiencing both physical and sexual abuse. In a population-based study investigating the health consequences of IPV among married women in Iran, researchers reported numerous mental disorders including

sleep-disorders, self-harm, depression, and PTSD. Results depicted psychological abuse as the most frequently reported type of violence with 67.2% of participants reporting depression and 47% reporting anxiety and insomnia (Soleimani, Ahmadi, & Yosefnezhad, 2017). A cross-sectional study investigating the relationship between economic abuse and psychological wellbeing found a positive association between physical, psychological, and economic abuse and psychological distress. Economic and psychological abuse were the strongest predictors of suicide attempts among the study's participants (Antai, Oke, Braithwaite, & Lopez, 2014). Furthermore, Adams and Beeble (2018) explored the associations between economic abuse and perceptions of quality of life among female IPV survivors. Study results indicated that when economic abuse was high, perceptions of quality of life were low, and vice versa. Additionally, survivors felt an overall weakness about their lives, personal safety, and opportunities for fun, independence, and freedom due to financial insecurities associated with economic abuse.

Physical health consequences include increased risks of brain trauma, poor sexual health, gastrointestinal discomfort and disease, and higher rates of headaches, immune dysfunction, breathing problems, and chronic pain (e.g., back pain, pelvic pain, and abdominal pain; Cerulli et al., 2012; Valera & Kucyi, 2017). Valera and Kucyi (2017) examined associations among IPV victims' brain trauma severity, post-concussive symptoms, cognitive performance, and functional connectivity. Results indicated 75% of the study participants reported multiple brain traumas and 53% reported experiencing multiple post-concussive symptoms. Fifty-three percent reported headaches, 47% reported irritability, frustration, and restlessness, 42% reported poor concentration, and 37% reported forgetfulness, poor memory, and taking longer to think.

Family Dynamics. While IPV occurrences are typically spontaneous, mutual, and influenced by drugs or alcohol, domestic abuse has been linked to the stresses of dysfunctional families and significantly impacts family dynamics (Buzawa & Buzawa, 2013). Each year, 15.5 million children under the age of 18 are exposed to IPV, and over half witness severe forms of IPV that include assault with a weapon (Carlson, Voith, Brown, & Holmes, 2019). Children exposed to IPV are at a greater risk for aggressive behavior and are vulnerable to ineffective parenting (Carlson et al., 2019; Piotrowski & Cameranesi, 2018). A further consequence of IPV is the unavailability or inaccessibility of resources for parents to cope with the demands of parenthood to provide sources of support and safety (Telman et al., 2016). Often, children who grow up in abusive homes experience less attention and low emotional availability, which may lead to insecure attachments and poor self-regulation (Carlson et al., 2019). Positive family relationships and parenting practices are key protective factors for children exposed to IPV. Nurturance, maternal warmth, consistency, responsiveness, and control have been associated with fewer behavioral problems like aggression (Carlson et al., 2019; Piotrowski & Cameranesi, 2018).

In a study assessing the effects of IPV on family functioning and children's post-traumatic stress (PTS) symptoms, more than 50% of the families were positively associated with reporting parenting stress and PTS symptoms among their children (Telman et al., 2016). Piotrowski and Cameranesi (2018) examined exposed siblings' aggressive behavior towards each other to investigate if mother and sibling warmth were protective factors for sibling aggression. Of the siblings exposed to IPV, 73% did not display physical aggression and 62% did not display verbal aggression, while 80% of siblings not exposed to IPV did

not display physical or verbal aggression. Overall, the authors reported warmer sibling relationships were protective factors for aggression. Additionally, the authors reported mother-child warmth played a greater role as a risk factor for aggressive behavior. The authors suggested children exposed to IPV may be sensitive to the perceptions of warmth between the mother and siblings, which may lead to feelings of jealousy or resentment (Piotrowski & Cameranesi, 2018). A cross-sectional study conducted by Rada (2014) inspected opinions of childhood IPV victims related to family environment. Forty-five percent of the participants reported witnessing verbal abuse such as insults, swearing, and humiliation. Roughly 86% of the participants reported their home as a refuge with a welcoming environment, 46.4% reported their family was rarely involved and only intervened during difficult situations, and 6.7% reported their family environment felt like a prison. Those who perceived their family like a prison were more likely to have witnessed IPV between their parents than those who did not.

Risk and Protective Factors

Intimate partner violence occurs across multiple socioecological levels including societal, individual, and interactional, such as community settings, workplaces, families, and intimate relationships (McCarthy, Mehta, & Haberland, 2018). According to Heise (1998), IPV can be characterized through an ecological framework of direct and indirect influences of social, cultural, and socioeconomic risk factors. Theory and research have emphasized a wide variety of contextual factors such as education, race or ethnicity, gender inequalities, and household wealth (Acevedo et al., 2013; Lin et al., 2018; VanderEnde, Yount, Dynes, & Sibley, 2012). Data from national surveys depict couples from racial/ethnic minority groups with low socioeconomic status are at the highest risk

for IPV; however, socio-cultural risk factors including community engagement and social support can buffer IPV victimization (Acevedo et al., 2013).

Socioeconomic Risk Factors. Socioeconomic risk factors such as low income, unemployment, and financial stress are significantly associated with experiencing domestic abuse (Tankard & Iyengar, 2018). According to Buzawa and Buzawa (2013), domestic abuse is disproportionately concentrated in low-income and unemployed populations. Additionally, environmental stressors (e.g., impoverished conditions, violence, or crime in the community) are common in economically disadvantaged communities and have been associated with IPV prevalence rates (Acevedo et al., 2013).

In Dade County, Florida, neighborhoods with concentrated poverty utilized law enforcement for IPV incidents nine times more frequently than economically successful neighborhoods. Similarly, urban Baltimore neighborhoods with low mean per capita income and high unemployment reported increased risks of experiencing IPV compared to neighborhoods with a high mean per capita income and employment (VanderEnde et al., 2012). Additionally, Voith and Brondino (2017) reported disproportionately high rates of domestic abuse occurred among persons living in disadvantaged neighborhoods with reduced access to resources. Furthermore, Heise and Kotsdam (2015) reported rates of gross domestic product (GDP) among 44 countries and found GDP was significantly associated with all forms of IPV victimization. Economically disadvantaged families who experience IPV are more likely to report a variety of physical and mental health issues, and survivors often lack feelings of social efficacy (Buzawa & Buzawa, 2013). Additionally, Lin and colleagues (2018) reported higher socioeconomic status (SES)

lowered women's risk of experiencing IPV and signified a woman's financial independence, which enabled self-empowerment.

WHO reports lower SES is indicative of lower levels of education and has been consistently reported across numerous studies as influencing domestic abuse (Reichel, 2017). In a study investigating education as a risk and protective factor, Acevedo and colleagues (2013) reported the following education levels among the study's participants, 11% received less than a high school education, 55.2% received a high school education or equivalent, and 33.8% received some college education or higher. Results depicted participants with less than a high school education were more likely to report experiencing IPV than participants with a high school education or higher.

Socio-Cultural Risk Factors. According to Walby (2013), a complex relationship between economic inequality and domestic violence exists in relation to social inequality and the ability to create positive social relations. Men who perceive a higher peer or community prevalence and acceptance of IPV are more likely to perpetrate IPV themselves (McCarthy, Mehta, & Haberland, 2018). Coupled with expectations and aggression, violent behaviors are modeled by fathers, peers, characters on television, movies, video games, and playing or watching sports (Mancera et al., 2018).

Salazar and colleagues (2019) examined a web-based sexual violence prevention program among college men, which assessed for mediating effects of sexual violence perpetration. The results indicated that hostility toward women, patriarchal ideology, and date rape attitudes significantly mediated the effect of the prevention program on sexual violence perpetration. Some studies that have focused on positive social aspects of communities (e.g., social support groups, religious groups) in relation to IPV have

reported higher levels of a socially collective efficacy, which has been linked to lower risks of experiencing IPV, social isolation, and PTSD (Acevedo et al., 2013; VanderEnde et al., 2012). According to Wilkins and colleagues (2014), changing socially accepted rules and norms about gender inequality may decrease risk factors associated with experiencing IPV victimization.

Culture is defined as a set of social rules and norms that a specific group of people from the same country, religion or ethnicity upholds (White & Satyen, 2015). Regardless of economic context or level of development, domestic abuse occurs in all cultures and countries in the world (Rivas, Bonilla, & Vazquez, 2018). While there are significant differences regarding the acceptance of gender-based violence and ideologies, various types of IPV are experienced across demographic and cultural groups (Lin et al., 2018). Additionally, gender inequality varies between communities within the same culture or country (VanderEnde et al., 2012). Examining cultural factors that influence domestic abuse is crucial since cultural ideologies can empower and oppress women (White & Satyen, 2015).

Feminist theorists and empirical studies have identified patriarchal ideology as a primary cause of IPV against women. This ideology endorses male dominance and inequitable gender roles (Lin et al., 2018). In a systematic review of gender, power, and violence, McCarthy, Mehta, and Haberland (2018) reported 56% of male IPV perpetration accepted violence against women, 40% perpetrated IPV based on views of gender roles and norms, and 29% perpetrated IPV to establish and maintain power and control within the relationship. In a study conducted among Bangladeshi men, 59.6% reported perpetrating physical or sexual abuse against their wife, and 36% endorsed

attitudes justifying spousal abuse (Islam et al., 2017). Furthermore, the acceptance of male dominance, toleration of violence, gender roles and norms, and inequality among women significantly increased their risks of experiencing various forms of domestic abuse (Ali et al., 2011; Islam et al., 2017; Karakurt & Cumbie, 2012).

Demographic Risk Factors. Research studies consistently demonstrate that a vast majority of IPV survivors are women of reproductive age (Kastello et al., 2016). Intimate partner violence prevalence rates during pregnancy ranges from 3.4% to 11.0% in middle to high-income countries and from 3.8% to 31.7% in developing countries (Khaironisak, Zaridah, Hasanain, & Zaleha, 2017). In the United States, prevalence rates range from 0.9% to 36% and as high as 81% in some rural locations (Kastello et al., 2016). Reports indicate that domestic violence continues during pregnancy due to patriarchal attitudes and the normalization of controlling behavior (Khaironisak et al., 2017; Lewis, 2018). Domestic abuse against women becomes more crucial when any form of IPV victimization involves pregnancy, as it is associated with numerous health complications for both the mother and fetus (Khaironisak et al., 2017; Lewis, 2018). Health complications may include infections, preterm labor, low birth weight, premature rupture of membranes, fetal injury, stillbirth, and spontaneous abortion (Lewis, 2018; Souza, Ranjani, Fernandes, Noronha, & Anitha, 2018). Additionally, IPV victimization during pregnancy impacts adequate prenatal care and unplanned pregnancies (Khaironisak et al., 2017).

According to Lewis (2018), domestic violence during pregnancy is associated with numerous risk factors including low educational levels, unemployment, financial distress, history of experiencing domestic violence, marital status, and unplanned

pregnancies. In a meta-analysis investigating IPV risk factors among pregnant women, IPV occurrences were 2.1 times higher among mothers with low educational levels; however, unplanned pregnancies were not significantly associated with IPV (Alebel et al., 2018). According to Khairondisak et al. (2017), significant risk factors associated with experiencing emotional abuse or sexual abuse were marital status and a history of IPV experiences. Similarly, low household income was associated with experiencing emotional abuse. Moreover, numerous studies have identified drug and alcohol use as a risk factor associated with IPV victimization among pregnant women (Alan et al., 2015; Khaironisak et al., 2017; Salvi, Pardeshi, & Chandanwale, 2014). Wilson and colleagues (2019) reported pregnant women were nine times more likely to experience physical violence if their significant others misused or abused alcohol. Additionally, Alebel and colleagues (2018) reported pregnant women were 11.4 times more likely to experience domestic violence if their abuser consumed alcohol.

Research suggests bidirectional occurrences of IPV are more evident among African American and Hispanic young adult couples than their peers (Grest, Lee, Gilreath, & Unger, 2018). African Americans experience a disproportionate prevalence of IPV compared to Hispanic and Caucasian groups (Al'Uqdah, Maxwell, & Hill, 2016). While nearly 28% of American women have reported IPV victimization, the risks are heightened for African American women, with 4 in 10 experiencing physical IPV by their significant other (Lacey, Sears, Matusko, & Jackson, 2015). Additionally, female IPV survivors within the African American community have an increased risk for eating disorders such as bulimia and binge eating (Lacey et al., 2015). Furthermore, African American men are 62% more likely to experience IPV victimization compared to

Caucasian men (Al'Uqdah et al., 2016). When comparing IPV prevalence rates among Hispanic couples to Caucasian couples, Cummings et al. (2013), reported higher violence rates among Hispanic couples at 14% and 6% respectively. Additionally, Hispanics have higher repeat occurrences of IPV (59%) compared to African Americans (52%) and Caucasians (37%; Mancera et al., 2018). In a longitudinal study assessing IPV victimization and perpetration among Hispanic young adults, 33% reported IPV victimization and 26% endorsed violence perpetration. The study also reported 30-day heavy drinking in high school predicted psychological bidirectional IPV as a young adult and 30-day marijuana use in high school predicted sexual bidirectional IPV as a young adult (Grest et al., 2018).

When assessing risk factors for IPV amongst African Americans and Hispanics, significant differences occur when compared to Caucasians (Al'Uqdah et al., 2016; Mancera et al., 2018). Raiford and colleagues (2012) reported African American relationships are often mutually combative with bidirectional rates of two to 2.7 times higher than rates among Caucasians. Additionally, short-term and long-term effects of domestic abuse may be greater for African American women due to social conditions and external factors that can increase chances for poorer outcomes (Lacey et al., 2015). Speculation of IPV susceptibility among the Hispanic community suggests *Machismo* (i.e., Mexican/Latino men who engage in risky behavior such as violence, adultery, and drunkenness) and acculturation may increase domestic violence (Mancera, Dorgo, & Provencio-Vasquez, 2015; Mancera et al., 2018). However, recent studies have reported cultural adaptation as a protective factor in reducing IPV experiences (Grest, Amaro, & Unger, 2017; Grest, Lee, Gilreath, & Unger, 2018). Essentially, social views and factors

such as living in disadvantaged neighborhoods, low SES, historical remnants of racism, and experiences of racism, stigma or stereotypes may contribute to heightened IPV prevalence rates among the African American and Hispanic community (Al'Uqdah et al., 2016; Mancera et al., 2018).

Research has also established that LGBT couples are at an increased risk for IPV compared to heterosexual couples (Kubicek, McNeeley, & Collins, 2016). IPV among lesbian women occur at rates equal to or higher than heterosexual women. Prevalence estimates of physical abuse and perpetration are 15% and 12%, respectively (Lewis, Mason, Winstead, & Kelley, 2017). Additionally, sexual IPV has been reported among 3% of homosexual men compared to 0.2% of heterosexual men, while physical IPV has been reported among 25% of homosexual men compared to 8% of heterosexual men (Messinger, 2011). According to Wall and colleagues (2014), past year experiences of physical abuse and sexual abuse for gay men were 5.8% and 4.5% respectively.

When comparing relationship experiences of LGBT couples and heterosexual couples, different characteristics occur such as internalized stigma, "outness" of one or both individuals, and the lack of same-sex couple role models (Reuter, Newcomb, Whitton, & Mustanski, 2016). When assessing risk factors for increased prevalence rates of IPV victimization and perpetration among this community, numerous studies have reported a positive association between stigma, discrimination, and internalized homophobia (Kubicek, McNeeley, & Collins, 2016; Logie et al., 2019; Reuter, Newcomb, Whitton, & Mustanski, 2016). These oppressive risk factors are thought to cause minority stress, which refers to any additional stressors a person within this community may encounter as a direct result of experiencing stigmatization and

discrimination (Head & Milton, 2012). Issues related to societal discrimination, including marriage laws and stereotypes as well as internalized homophobia, contribute to stress related occurrences of IPV among young gay men (Kubicek, McNeeley, & Collins, 2015). Studies investigating college students who identified as LGBT and perceived a societal or internalized homophobia were also more likely to experience IPV victimization and perpetration (Edwards & Sylaska, 2013; Gillum & DiFulvio, 2012; Kubicek et al., 2015). According to Lewis and colleagues (2016), lifetime discrimination was associated with emotional IPV perpetration among lesbian and bisexual women. Further, internalized homophobia was associated with physical or sexual IPV perpetration as well.

Impact of IPV on the LGBTQ+ Community

Stigma, discrimination, and violence targeting the LGBTQ+ community is a global health and human rights issue (Logie et al., 2019). Countries outside the United States have criminalized same-sex practices (Carroll, 2016) and have reported increased levels of harassment, violence, stigma, discrimination from health care and law enforcement services, and rejections from family and friends (Baral, Grosso, Adams, Kennedy, & Hurley, 2012). Stigma is publicly acknowledged as a key social driver in limiting access to prevention, support, and treatment services (Logie et al., 2019). Domestic abuse victimization among homosexual relationships is commonly shaped by power imbalances, jealousy, alcohol and drugs, and threats to masculinity (Finneran & Stephenson, 2014). In the United States, nearly all IPV services do not serve men and most states do not provide civil protections for survivors from same-sex relationships (Wall, Sullivan, Kleinbaum, & Stephenson, 2014). Transgender persons experience

public, education, and workplace harassment, discrimination within government assisted programs, inadequate public facilities, social ostracism, and hate crimes (Barrett & Sheridan, 2017).

Physical and Psychological Wellbeing. While female victims of heterosexual IPV include a myriad of associated adverse health consequences, same-sex relationships are not excluded (Buller, Devries, Howard, & Bacchus, 2014). Research indicates that lesbian women who were survivors of domestic abuse did not differ from their counterparts in perceived mental health outcomes (Coston, 2018). Same-sex IPV victims may experience eating disorders, depression, anxiety, PTSD, and sexual and reproductive health complications as well (Buller et al., 2014). In a systematic review of IPV among LGB couples, Edwards and colleagues (2015) reported 18.4% of LGB adults who experienced physical IPV conveyed anxiety and fear for the safety of their lives. Survivors of emotional abuse from same-sex partners have also reported depression symptoms and a decrease in self-esteem (Longares, Escartin, & Rodriguez-Carbelleira, 2016; Longares, Saldana, Escartin, Barrientos, & Rodriguez-Carballeira, 2018). Additionally, Buller et al. (2014) reported gay men who were exposed to any type of IPV had increased odds of reporting depression symptoms. Numerous studies have reported significant trends in poorer quality of life and higher levels of stress, anxiety and depression among same-sex couples who experience IPV victimization (Friedman et al., 2019; Wathen, MacGregor, Tanaka, & MacQuarrie, 2018; Wong et al., 2017).

Interactions between domestic abuse and HIV infections have been shown to be significant among gay and bisexual men. HIV infection among this population is usually obtained through forced sexual contact or reduced ability to negotiate safe sex practices.

In addition, HIV infection has been associated with discrimination, which can detrimentally decrease overall psychological wellbeing (Siemieniuk et al., 2013). Stephenson and Finneran (2017) investigated condom usage among gay couples who reported IPV experiences. Of the 46.1% who reported experiencing any type of domestic abuse and 33.6% who reported perpetrating the abuse, 55.1% of the participants reported condomless anal sex at their last sexual encounter. Stephenson, Freeland, and Finneran (2016) conducted a study among gay and bisexual men and reported 49.1% of participants not only experienced IPV, but also reported feeling significantly less likely to negotiate condom use. Additionally, Stephenson and Finneran (2013) investigated HIV-related IPV (e.g., lying about HIV status, omitting HIV status before intercourse, intentionally transmitting HIV) and reported 10.5% of participants experienced HIV-related IPV and 6.2% perpetrated HIV-related IPV. These findings suggest domestic violence may be a substantial risk factor for HIV transmission and acquisition among gay and bisexual men (Stephenson, Freeland, & Finneran, 2016).

Coping Strategies. Coping strategies influence how an experience impacts an individual, and depending on the type of strategies utilized, overall health and other outcomes can be significantly impacted (Goldberg-Looney, Perrin, Snipes, & Calton, 2016). According to Holahan and Moos (1987), coping styles among IPV victims include engagement/active strategies and disengagement/avoidance strategies. Active strategies are behaviors that directly address violent circumstances and may include positive reframing, seeking emotional and instrumental support services, or addressing the issue with the perpetrator. Avoidance strategies are defined as passive attempts to avoid or disengage with the violent situation. Examples of disengagement coping include denial,

substance use, and self-distraction (Goldberg-Looney et al., 2016; Holahan & Moos, 1987).

Freeland and colleagues (2018) qualitatively examined formal (e.g., counseling services, IPV organizations, law enforcement) and informal (e.g., support from friends and family, ignoring the violence, substance use) coping strategies among gay and bisexual men. Participants frequently reported utilizing counseling services and seeking support from their family and friends. Substance use was also identified as a coping strategy, though most participants considered this strategy to be a last resort. Additionally, Buller et al. (2014) reported substance use as a coping strategy among homosexual men. Conversely, Reuter and colleagues (2016) reported substance use was not associated with IPV experiences for gay men. When examining the relationship between bidirectional IPV and alcohol use among lesbian women, Lewis and colleagues (2015) reported alcohol use as a coping strategy for emotional distress. Goldberg-Looney et al. (2016) reported denial and disengagement were positively associated with experiencing sexual, physical, and emotional IPV among gay men. In addition, White Hughto et al. (2017) reported avoidant coping was positively associated with transgender IPV survivors. Empirical findings examining copings strategies among LGBTQ+ IPV survivors remains in its infancy. Of the limited research, results indicate dynamic coping strategies and a need for tailored interventions that meet the specific needs for the LGBTQ+ community should be a focus for IPV related professions (Freeland et al., 2018).

Perceived Barriers to Reporting IPV. Many survivors of domestic abuse seek informal and formal support, which include friends, IPV organizations, health

professionals, and the criminal justice system. The decision to seek help is a complex and iterative process that is influenced by individual, interpersonal, and cultural factors (Calton, Cattaneo, & Gebhard, 2016). Due to the discrimination and stigma faced within the LGBTQ+ community, IPV victimization is widely thought to be underreported (Langenderfer-Magruder, Whitfield, Walls, Kattari, & Ramos, 2016). Members within this community often face challenges within their cultural context (e.g., homophobia, history of police violence) that make IPV experiences difficult to identify, report and seek help (Langenderfer-Magruder et al., 2016).

Research recognizes that men who experience domestic abuse often report negative experiences with IPV services as well as societal perceptions of masculinity regardless of sexual identity (Freeland, Goldenberg, & Stephenson, 2018). Historically, emergency shelters have not provided services to male or female LGBTQ+ IPV survivors. Lesbian women and transgender persons have reported fear of rejection from staff and shelter residents as a significant barrier to seeking services when needed (Calton et al., 2016). Freeland and colleagues (2018) investigated perceived barriers for seeking support services from IPV focused organizations among gay and bisexual men and reported most participants did not seek assistance due to the belief of being viewed as a perpetrator. Additionally, the stigma and shame of being a male IPV survivor mediated seeking services among several participants. Those who did seek support services reported that service providers assumed the type of assistance that was needed and referred them to other agencies that were inappropriate for the type of aid that was required.

Furman and colleagues (2017) conducted qualitative research investigating service providers' opinions regarding support services for LGBTQ+ IPV survivors and identified three common themes including direct service provision, organizational transformation, and organizational principles and values. Service providers included professionals who were affiliated with community programs, shelters, or counseling services with an IPV focus. Participant feedback regarding direct services identified a client-centered approach that overtly identified as LGBTQ+ inclusive, nonjudgmental support base, training, and gender inclusive language when discussing the client's partner was necessary to provide comprehensive counseling. Participants expressed organizational transformation should occur through policies, practices, structures, and hiring diverse staff who self-identified as LGBTQ+. Lastly, participants described their organizations were based on feminist ideologies and only served women. A common conclusion among participants identified the need to understand how feminist definitions related to IPV translate into the unintentional exclusion of LGBTQ+ individuals as well as the importance of incorporating comprehensive theories of IPV ideologies within the Violence Against Women sector (Furman et al., 2017).

Healthcare related support services and screening tools have been validated for heterosexual couples and do not have well-established psychometric soundness for use among LGBTQ+ IPV survivors (Wall et al., 2014). Healthcare policies and practitioners assume that couples are heterosexual and cisgender, resulting in most system-level responses as ambivalent or helpless (Calton, Cattaneo, & Gebhard, 2016).

While literature suggests LGBTQ+ survivors experience significant barriers to seeking support services, literature also suggests dynamic barriers exist when utilizing the

justice system to report abuse. LGBTQ+ survivors of domestic abuse are often discouraged due to the heterosexual nature of policies and discrimination among the court system and within law enforcement (Calton et al., 2016). Police responses to IPV are usually influenced by personal and contextual factors of the survivor and perpetrator as well as prior knowledge and beliefs about IPV and gender-based stereotypes. Additionally, the criminal justice system tends to share the same gender-related beliefs, which significantly predicts how the law enforcement system will respond to incidents of domestic abuse (Russell, 2018).

Russell and Kraus (2016) assessed the relationship between perceptions of partner violence and criminal justice decisions and reported masculine offenders were perceived as more likely to perpetrate physical violence resulting in bodily harm. A study conducted among gay and bisexual men by Freeland et al. (2018) reported a negative perception of the civil court and law enforcement. While at court, one participant reported perceptions of embarrassment as the judge did not take him seriously and dismissed his case. Regarding law enforcement, participants distrusted the police due to previous experiences, perceptions of their homophobic nature, and the difficulty police have in identifying which partner was the perpetrator. The National Coalition of Anti-Violence Programs (2013) reported 29% of transgender IPV survivors were hesitant to seek law enforcement services due to experiences of harassment, discrimination, and police brutality. Additionally, 12% of the participants reported that the police were violent while intervening in domestic violence. However, Langenderfer-Magruder and colleagues (2016) did not find significant differences in IPV reporting between transgender and cisgender participants who experienced domestic abuse.

Summary

      While the public health approach is to prevent and promote evidence-based prevention strategies, the dominant approach to domestic abuse has not occurred upstream. Rather, IPV prevention occurs at the later stage of community and policy change when trying to keep survivors from drowning downstream (Carlson et al., 2019). A shift in societal awareness and readiness must occur if IPV gender-based stereotypes are to halt (Bates, Kaye, Pennington, & Hamlin, 2018). Training and support services should generate discussions that raise public awareness about domestic abuse. Prevention advocates, activists, and researchers must increase awareness among policy makers. Additionally, policy that guarantees services for all survivors of sexual orientation and gender identity must be adopted (Calton, Cattaneo, & Gebhard, 2016).

      As the LGBTQ+ community continues to fight for inclusion within all aspects of society, public health professionals must ensure the various models of practice are reflective of the dynamic and unique needs of LGBTQ+ persons who have experienced IPV victimization (Barrett & Sheridan, 2017). These survivors face significant barriers to receiving help; therefore, continued research must explore how prior knowledge of domestic abuse and gender norms affects perceptions of IPV in the LGBTQ+ community (Calton, Cattaneo, & Gebhard, 2016; Russell, 2018). Furthermore, this understudied phenomenon must expand knowledge regarding the unique aspects of LGBTQ+ relationships and scrutinize the power and control tactics that are specific to sexual orientation and gender identity (Calton, Cattaneo, & Gebhard, 2016).

III. METHODOLOGY

IRB Approval

This study was approved by the Texas State University IRB on April 11, 2019 with IRB reference number 6445.

Purpose of Study

The purpose of this study was to examine the forms of intimate partner violence (IPV) experienced by LGBTQ+ individuals and the circumstances that influenced the decision whether to report victimization or seek assistance from professional services. The information gathered within this study will contribute to the current knowledge used for organizations and professionals who work within the LGBTQ+ community. Additionally, the information collected will contribute to future practice by identifying the specific needs of survivors of IPV who identify as LGBTQ+. Such findings will aid organizations and professionals working within medical care, law enforcement, and public health education to assess if their services and skill sets are appropriate and efficient when providing aid to LGBTQ+ persons who have experienced domestic abuse.

Research Design

Due to the traumatic and sensitive nature of IPV and limited knowledge of LGBTQ+ IPV survivors, this study qualitatively evaluated the personal reflections of persons who experienced IPV victimization through dense interviews. This qualitative approach was used to identify descriptive, in-depth insights into the phenomenon, and uncover root motivations and factors that influenced decision making when the abuse occurred. Additionally, a qualitative research design was selected because of its ability

to explore participant perspectives of various built environments and policies surrounding LGBTQ+ individuals and IPV survivors to provide a deeper insight to contribute to the field of social and behavioral sciences (Jeanfreau & Jack, 2010; Watkins, 2012).

Sampling Procedures

To participate in this study, an individual must have identified as LGBTQ+, reported experiencing intimate partner violence victimization in a prior relationship, reported not being involved in an abusive relationship at the time of the interview, have been at least 18 years of age, and had resided in the United States when the IPV occurred. The anticipated number of research participants (20-25) was approximated on predicted saturation of information collected during each interview; however, only eight participants volunteered for the study, and seven participated in an in-depth interview.

Studies focused on sensitive topics or minority populations often face unique challenges when recruiting participants (Dichter et al., 2019; Treweek et al., 2013). Discussing traumatic experiences, concerns regarding emotional distress, stigma, or potential retaliation can cause hesitation resulting in difficulty to recruit and retain participants (Dichter et al., 2019). To access the target population, two rounds of recruitment efforts occurred. Initially, participants were recruited through e-mail invitations, social media advertisements, and through snowball sampling. Recruitment emails were sent to LGBTQ+ student organizations including Allies programs (e.g., programs that aim to help LGBTQ+ students, staff, and faculty feel safe, supported, and able to develop) as well as student diversity and inclusion programs with a request to

distribute study information among their members. A recruitment flyer was posted on various social media sites with the contact information of the primary investigator. Additionally, the primary researcher provided study details and contact information to participants to share with their friends and acquaintances who may be interested in participating. After four months of recruitment, which resulted in one participant, a second round of recruitment efforts was implemented when funding was approved to provide incentives for participation.

Reflexivity

To ensure credibility of findings, the study authors participated in reflexive practices by identifying discomfort, vulnerability, projection, and unconscious reactions towards each participant through self-reflection and self-criticism, which was captured through audit trails and journaling. The maintenance of a reflexive journal ensured all items were considered equally important as well as analyses of the researcher's emotional response to each interview as one investigator a part of the research team is a survivor of IPV as well. Additionally, members of the research team met continuously to evaluate participant responses, interviewer-interviewee dynamics, and the research process after traumatic interviews such as sexual abuse. The research team meetings provided emotional support for the primary investigator who listened to and processed the traumatic stories shared by participants. Additionally, each meeting discussed how to record emotional responses in the reflexive journal as part of transparency during data analysis (Probst & Berenson, 2014).

During the second participant interview, the lead graduate researcher discovered participants had trouble understanding interview question nine (Appendix A) due to the

question wording. Originally, the question asked "What advice do you have for organizations or professionals (law enforcement, medical care, health educators) who serve LGBTQ+ survivors experiencing abuse. What do they need to know or do to ensure they have appropriate and effective services for those who identify as LGBTQ+?" The first two participants seemed confused and paused for reflection before asking the question to be repeated, and then asked follow-up questions before responding. The lead investigator, with guidance from a faculty co-investigator, reworded the question to improve clarity. The question was changed to, "If you were going in and reporting abuse to someone in victim services, law enforcement, counseling, what to you would be an ideal way for that provider to communicate to you, that you matter. What would be some things they could say or do that would make you feel like you're comfortable talking to them?" Participants 3-7 did not seem confused, they did not ask for this question to be repeated, nor did they have follow-up questions, indicating the change effectively improved clarity. At the end of the interview, each participant was provided a referral flyer of counseling services for survivors of intimate partner violence.

Data Collection

Data collection occurred through individual direct interviews to gain an understanding and elicit information about personal experiences and perspectives. Participants were asked to participate in a one-time interview (interview protocol in Appendix A), to complete a demographic questionnaire (Appendix B), and to participate in a member check to ensure the accuracy of the research team's interpretation of their data. Interview questions were semi-structured and open-ended to

encourage participants to openly sharing their personal experiences of domestic abuse. Upon the conclusion of the second participant interview, the lead researcher identified the need to include additional questions regarding the impact of the LGBTQ+ community in relation to "coming out," and question number three was added to the interview script (Appendix A). Each interview was audio-recorded with a digital recorder, with participant consent.

Participants were given the option to be interviewed via Zoom, an online meeting room, or in a private room at Texas State University within the department of Health and Human Performance. Interviews were scheduled based on participant availability and occurred between May through October 2019. Prior to the interview, each potential participant received the informed consent document via email for review (Appendix D), which discussed the study purpose and procedures. At the start of each interview, each participant provided verbal consent to participate in the interview and to be audio recorded.

To ensure the protection of participant identities, recordings were uploaded via a USB cord to the university's password protected server and audio files were transcribed with pseudonyms rather than participant names. Additionally, written field notes taken during interviews, demographic questionnaires, and member checks were kept in a locked cabinet. Furthermore, all data collected from audio recordings, transcribed Word documents, and NVivo files were classified as confidential and accessible only by the members of the research team directly involved in data collection and analysis. Before data analysis and dissemination, all data were de-identified to protect participant identities.

Data Analysis

      Transcriptions. Two graduate trained researchers transcribed audio recordings with cleaned speech (Riessman, 1993). One graduate researcher was trained by the lead graduate researcher to identify any discrepancies within the transcripts. The lead graduate researcher conducted continual evaluations of participant responses, transcriptions, and analysis to ensure ongoing reflection throughout the transcription process (Probst & Berenson, 2014). Individual codes and a codebook were developed from transcripts, interview notes, demographic questionnaires, and member checks to identify common phrases, main ideas, and categories.

      Investigator Triangulation. To ascertain confirmation of findings and differences in perspectives, several investigators collected and analyzed the data (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014). The lead graduate researcher conducted participant interviews and took descriptive field notes (e.g., nonverbal behaviors or actions of participant), reflective audit trails (e.g., personal reflections or questions that arose during the interview) as well as conducted member checks to solicit accurate feedback on preliminary findings (Merriam & Tisdell, 2015) from all seven participant interviews. The two graduate researchers independently analyzed each participant interview prior to comparing and finalizing findings.

      Thematic Analysis. Two graduate trained researchers conducted analysis under the supervision of a faculty mentor experienced in qualitative methodology to thematically examine transcripts, audio recordings, and field notes to increase the effectiveness of data analysis (Tessier, 2012). The lead graduate researcher regularly met with the faculty mentor throughout the data collection and analysis process to

discuss best practices for data examination. During this time, two graduate researchers independently reviewed participant transcripts and coded each transcript in NVivo. To identify thematic coding from all participant transcripts and create a codebook, the two graduate researchers met four times within five weeks.

Each data analysis meeting reviewed new participant transcriptions and codes and compared possible themes among previous participant transcripts to draft a codebook. The lead graduate investigator met twice with the faculty mentor and graduate researcher to discuss updating the codebook. Three versions of the codebook were created based on the emergence of new concepts that were identified during the coding process. Each updated codebook was used to re-analyze and re-code previous transcripts to create a final codebook. Version one of the codebook was utilized to transcribe participant interviews 1-3. The second version of the codebook was utilized to code participant interviews four and five as well as re-code transcriptions 1-5. The final codebook was utilized for coding participant interviews six and seven.

To identify commonly shared problems and problem solving among each participant, a constant comparative method of data analysis occurred through grounded theory. Utilizing grounded theory provided the primary graduate investigator answers to the research questions, which were based on the identification of categories and themes found within the demographic questionnaire, audio recordings, interview notes, and member checks (Merriam & Tisdell, 2015). Once coding was completed through NVivo, the research team generated hypotheses based on systematically classifying data to interpret and infer answers to the research questions.

One element that emerged during grounded analysis was the Social Cognitive Theory (SCT). According to Kazemi et al. (2019), SCT provides a framework when examining the influence of domestic abuse on human behavior such as coping mechanisms and the ability to seek IPV-related services. Perceptions to seek professional help is connected to Bandura's (2001) SCT and concept of self-efficacy, which identifies personal judgements of how well a person can execute a course of action. Based on the construct of self-efficacy, the research team concluded answers to the research questions by determining participant beliefs and perceptions regarding their capability to cope with the abuse that was experienced.

IV. RESULTS

Participants

Eight participants volunteered to participate in the study. However, due to difficulty in confirming one participant, seven consented to participate in the study. One volunteer requested to reschedule the interview twice, and never confirmed the final reschedule. Follow up communication occurred once more to offer the opportunity to participate in the study, but the potential participant did not respond.

The lead investigator offered each participant the option to choose their interview location through the online meeting app Zoom or in person in a private room located within the Department of Health and Human Performance. Six participants elected to participate in an interview through Zoom and one participant elected to participate in person. All seven participants verbally consented to being audio recorded and completed the demographic questionnaire at the time of their interview.

Descriptive analysis of demographic questionnaire responses revealed four participants identified as female and three identified as male, four identified as white, two as Hispanic or Latino, and one as multi-racial. The majority (71.4%) of participants were 25-34 years old, and identified as being single, never married (71.4%). Approximately two-fifths had earned a bachelor's degree (42.8%). Regarding sexual orientation, three identified as gay, two as bisexual, and two as lesbian. Table 1 depicts further participant characteristics.

Thematic Analysis

Five overarching themes emerged during thematic analysis: 1) experiences identifying as LGBTQ+, 2) experiences of domestic abuse, 3) coping mechanisms, 4)

experiences seeking professional help, and 5) suggestions for professionals. Three

subthemes within experiences identifying as LGBTQ+ included historical reference,

judgement or discrimination, and support. Four subthemes within experiencing domestic

abuse included childhood abuse, intimate partner violence, multiple abusive relationships,

and health complications. Two subthemes within coping mechanisms included positive

and negative coping skills. Three subthemes within seeking professional help included

barriers, positive experiences, and negative experiences. All participants were coded with

pseudonyms to protect participant identities. Descriptions of themes with illustrative

quotes follow.

Theme 1: Experiences Identifying as LGBTQ+. As participants recalled their

lived experiences identifying as LGBTQ+, 85.7% of participants reported positive

experiences. However, researchers discovered participants who identified as 45 years old

and older described "coming out" differently due to the LGBTQ+ landscape from 30

years ago:

> ln the early-mid 90's, [I] was still living down there in the border [of Texas and
>
> Mexico] where everyone was Catholic and you couldn't be out and gay…and
>
> there was a club we would go to [but] it didn't have a sign to protect us…and it
>
> was off the main street, kind of in the back um, so that's where we would go. So,
>
> that's the place where we felt safe inside. Outside…no, people would do drive-
>
> byes, or like throw bricks at us, or like really harass um transgendered [sic]
>
> people…My group of friends, most of them had been thrown out by their parents
>
> for being gay. Um, they tried to arrest me twice for holding hands with a girl.
>
> Yeah, it sucked, it's not like 2019 at all…So, you always had to have, like, your

dukes up, you know, be on guard. [At] the mall, I was holding hands with my

girlfriend and a cop walks straight over and said if we didn't stop that he was

going to have to arrest us because it was illegal. Then another time I had gone on

a date with a girl and we were kissing by the car and a cop pulls over and I

happened to know him from church; it was so embarrassing. I was kind of like a

deer in the headlights. We never spoke again, so it broke up that friendship,

Melissa.

In contrast, most participants (57.1%) remarked supportive experiences from friends and

family members when "coming out," as the following quote highlights:

[I] came out to friends…at 14…they were very, very supportive, um… we were

all just flamboyant. Like guys that liked Lady Gaga, and I wouldn't say feminine,

just flamboyant. We were out there; we were um to quote one classmate of mine

"a trip". So, I had a blast in high school! But I told my parents on my 20th

birthday. We all went to Peter Piper Pizza…and uh I had told them. They were

like, "alright." So, that was really cool. I always knew they were probably going

to be supportive, but…I know my dad has always kind of had a…I know

sometimes he gets uncomfortable with me being [feminine], but you know times

have changed and my parents are progressive people and they realized that as

time changed [you] constantly have to reevaluate how you think of certain things.

So that's a gift for sure…I never got anything other than, you know, support,

Anthony.

Furthermore, support from the LGBTQ+ community was mentioned by the majority

(57.1%) as another positive experience during their "coming out" period:

I just love uh…I love the culture of it. I love the…like my mom…asked why drag queens are so vulgar or why the gay club [or] why everything is so hyper-sexual, and I was, like, just because we can be! [laughing] I don't know how to express it, but there's just…You know when your gay and you finally come out, like that's hardest thing you'll ever say. So, it just breaks down filters like for the rest of your life, *Jonathan.*

Analysis revealed all participants (n=7) expressed multiple positive experiences related to being LGBTQ+ and all but one (n=6) reported multiple negative experiences. Support or judgement and discrimination were reported as common experiences as an identified member of the LGBTQ+ community. Three participants reported judgement and discrimination were experienced within familial relationships:

The relationship that I have with my mother has deteriorated. It was never really great, so [my coming out] just kind of made it worse. [When I first] thought that I was, you know, not straight my mom basically put me in therapy to try to [make me straight]. Yeah, so that's what really kicked off everything. She claims it wasn't for that, but, yeah, *Michelle.*

Currently, only two people in my family even know and it was not very positively accepted. It was more like "we don't understand, and we think it's wrong, but we're not going to not love you" type thing. It wasn't hatred, but I still don't feel comfortable talking to them about the female relationships that I have. It has to be male or it just can't be brought up. The very first time I tried I was 13 and I tried to come out to my family, and it was not received well. They said I was sick, that I was going through a phase, that I needed to pray more,

that I needed to go to church. That kind of made me lock it down and not tell

anybody anything for a few years. There are actually a couple of cousins and

aunts that have come out as gay that I can never get a hold of. They were cut out

of the family when I was younger so being anything other than straight is just

not accepted in my family, *Ashley.*

Similarly, another participant noted religion as a substantial factor in

experiencing judgement and discrimination:

I grew up Mormon, which is hugely relevant to my identity, um, specifically in

tandem with being gay because, like, when I first discovered I was gay, sort of

realized it to myself, um, I was, like, 11 or so. I didn't really…I didn't judge

myself. Like, I genuinely…it was almost matter of fact to be, like, oh okay I

guess I'm gay and I was cool with that and it wasn't until, like, maybe a year

later when I turned 12. When you turn 12 in the Mormon church is when you

start getting special roles and you receive like the priesthood and power of God,

to put it simply. That's when sort of the religious implications came into play

and that was an internal struggle for years that ultimately led up to this sort of

black and white turning point of being like the closest thing I ever had to a

suicide attempt, [which] was when I was about 17, *Jonathan.*

Additionally, three participants identified negative experiences related to social

judgement and discrimination. For example, Jesus discussed experiences of

being bullied in middle and high school for being gay, and Anthony reported

being mugged. Furthermore, Rachel discoursed the existence of homophobia:

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"It's going to be everywhere. I'm aware of that, but sometimes it is a little bit hard knowing people are judging me."

While each participant reported varied negative experiences identifying as LGBTQ+, six participants also reported positive experiences. The main subtheme that emerged from this category was the identification of a supportive network. While four participants identified family and friends were supportive, four participants also reported finding comfort and security within the LGBTQ+ community, as addressed by the following statement:

> I like to involve myself with the gay community. Just because it's where I fit…I have lots of friends that are gay, bi, trans, everything. So, I definitely go to them for a lot of stuff. I would definitely say that's where I fit in, where I go to, *Rachel*.

Theme 2: Experiences of Domestic Abuse. Participants detailed experiencing various types of IPV during the abusive relationship. Occurrences of physical and psychological abuse were the most commonly reported types of abuse evident in the testimonies shared by participants. Nearly all participants reported being physically (n=6) or psychological (n=6) abused by an intimate partner. Two participant narratives included occurrences of sexual abuse by an intimate partner, and two shared stories about being economically abused.

Those who reported experiences of physical abuse identified physical force that included beating, slapping, punching, or having items thrown at them. One participant recalled an experience after returning back to her abuser, "I ended up forgiving her and going back to her house and she beat the shit out of

me. She pulled me…and she threw me [on the mattress], and she whipped me

with those old phone cords that you would plug into the wall… She was very,

very violent and scary," *Melissa*.

Participants who reported experiencing sexual abuse described forceful

intercourse and oral sex as well as unprotected sexual intercourse. One

participant indicated being involved in a polyamorous relationship and

experiencing multiple occurrences of rape by both partners, "we would all go

drink and, on a few occasions, I suspected of being drugged, but they would just

keep me drinking until I was unable to resist," *Ashley*.

Numerous participants reported experiences of psychological abuse,

which consisted of degrading or humiliating name-calling, threats to commit

suicide or to "out" them to family, restricting access to friends and family, and

controlling behaviors. A theme of controlling physical appearances emerged

among three participants, as this quote exemplifies:

It got to the point where my partner would basically force me to sit and have her

put makeup on me before going anywhere. I couldn't wear my hair up when we

went out…that kind of thing. That was the complete opposite of what I wanted.

I didn't want to wear makeup or women's clothing, *Michelle.*

Another participant compared two separate abusers who had threatened to kill

themselves if the relationship had ended:

I tried to break up with him and said I can't really be around you

anymore and   he quickly ran across the room, grabbed a pair of scissors out of

the drawer and said I'm going to kill myself right here and now if you do

this…there was someone I was talking to a few months ago who did something similar as to what I would consider as emotional hostage. He mentioned to me that because I couldn't be with him he was essentially going to stop taking his HIV medication, *Jonathan*.

Two participants reported experiencing economic abuse such as restricting economic resources and interfering with employment. One participant reported, "I was promised work, and he never followed through on that, never gave me work, never paid me a cent," *Anthony*.

Three additional subthemes related to experiences of domestic violence included, experiences of multiple abusive relationships (57.1%), health complications as a result of the abuse (42.8%), and childhood abuse (28.5%). Three participants discussed various health complications such as PTSD, panic and fear, and brain trauma:

> The one thing that's really difficult for me is that I have a lot of issues with my memory. Yeah, you know going to therapy they always call it trauma brain…So, it's like somehow my brain is like, any abuse nope, don't want to remember it," *Michelle*.

> Even now, I'm still working through being touched by people. Like even just hugs there's this sense of paranoia that comes out when I'm touched by anybody. It's just an immediate knee jerk reaction. I have residual feelings. [I would] do things like jump every time I heard the front door open, or every person I saw that remotely looked like him or her and not get upset and panic. Even now and then, something will happen where I will freeze or panic, *Ashley*.

I had blocked all of this out until recently, like within the past 3 years where I

could talk about it, and not feel ashamed or PTSD again just from talking about

it. Like I wouldn't even say her name. I just didn't want to go there, because I

didn't know what was going to happen, but I got help, thank God, *Melissa*.

Theme 3: Coping Mechanisms. Numerous healthy and unhealthy

coping strategies emerged during participant interviews. For example,

participants commented on recognizing "red flags" during the abusive

relationship but being torn about how to deal with competing emotions. Rachel

stated, "I was like, 'red flag! This is not healthy, normal!'…It was a lot of

mixed emotions. I really didn't know what to do or how to even think about it

for a while."

Six participants reported utilizing several positive coping skills including

seeking social support (n=6), acceptance (n=4), and seeking professional

support (n=2). For instance, one participant specified seeking social support

from friends: "I did have my friends. I would get out of the house and talk to

them, and tell them, you know, this is going on, this and that, and I was like and

I don't know what to do anymore," *Jesus*. Similarly, another participant reported

seeking support from a teacher, "it was during finals and I actually came down

and cried in [her] office before one of my finals. She, like, closed her door and

let me sit in there and cry for, like, a good 10 minutes and I was, like, 'okay, I'm

good'," *Michelle*.

In contrast, several of the same participants (n=6) also reported multiple

negative coping skills including denial (n=5), substance use (n=3), ignoring

(n=3), and disengagement (n=1). Denial through justification of love was commonly discussed by several participants, "it was like, oh she just wants me to be, you know, better looking for whatever. She just loves me so much that she just wants me to look my best," *Michelle*. Another participant expressed, "I had it in my mind at the time that this guy was my cosmic complement, this sort of soulmate type situation. It was like this is literally the person I have to like work through…I have to stay in this relationship, I have to make it work," *Jonathan*. Additionally, Rachel reported, "I guess when you love somebody you're like, maybe it won't happen again."

Participants who conveyed substance use as a coping strategy reported using alcohol (n=3), marijuana (n=2), and LSD (n=1). One participant outlined using all three substances to help her cope:

> I drank a lot…I found myself reaching for it more and more and finding ways to get it because I wasn't 21, but I did have bars I could get into. So, I was going to these bars more and more often and, um, just trying to cope, I guess…I was going out way too much and trying to do things to help me forget about it. So, I was drinking, [smoking weed, doing LSD] ...doing everything I could to not think about it basically, *Ashley*.

Theme 4: Experiences Seeking Professional Help. Five participants specified seeking multiple professional assistance from counselors (n=4), law enforcement (n=3), and legal services (n=1) during the abusive relationship as well as afterwards. The stories shared about seeking professional assistance

contained common subthemes of barriers, positive experiences, and negative

experiences.

Participants identified fear of retaliation (n=2) and financial issues (n=1)

as barriers to seeking support. Moreover, three participants stated experiencing

internalized fear, judgement, and homophobia as barriers to seeking professional

help, as stated by the following participant:

> I was abused by a teacher at 9 and that also lead to the shame of not wanting to
>
> reach out because I was like, I can't believe I'm being abused again. I was
>
> abused as a kid and I can't believe I'm abused as an adult I must be doing
>
> something that draws these people towards me, so I thought it'd be my fault,
>
> *Ashley*.

Comparably, all three participants testified being fearful that professionals

would not believe their abuser was female:

> There was the fear that nobody would believe that it happened because
>
> these women were much smaller than me. I was just like, "oh how could
>
> she have done that to you," you know that kind of thing. That was the
>
> fear of that, *Michelle*.
>
> Nobody believes that a woman can rape another woman, *Ashley*.
>
> The main reason why I didn't call the police was because in our
>
> relationship I was the more masculine one and she was the feminine one
>
> and I just felt insecure that they wouldn't believe me because of the way
>
> I dress or the way I look and they would take her word over mine,
>
> *Rachel*.

While personal barriers to seek assistance existed, several of the same participants reported both positive and negative experiences when seeking professional help. Three participants informed the lead investigator of experiencing four negative occurrences when searching for aid from counselors (n=2), law enforcement (n=1), and legal services (n=1):

> I talked to the woman there, the psychiatrist on campus or whatever, and instead of her saying something along the lines of yes, this is an unhealthy relationship, you should get out of this, you need help, it's not okay, her tactic, almost immediately, instead of addressing the real issue she tried to like relationship counsel this. She was like, alright well how can we get through this together, *Jonathan.*

> The way he would approach some of the questions, it's not, this isn't an issue, you know what I'm saying. He'd focus exclusively on my feelings about being bisexual, my experiences of being bisexual, which is important, but most of my experiences had to with the heterosexual partners that led me into it and that's what I was trying to focus on, *Ashley.*

> So, I decided one night, you know, enough is enough. I will call the cops. So, I did, and I was told, where did this happen? And then I said, oh over here by whatever, and like oh you're going to want blah blah blah county. I was like ok. So, that was nighttime, so the next day I called, and for the life of me I can't remember what excuse they used, but they kind of passed the butt to the sheriff's office and all these agencies just were bull shitting me. That was so much harder than anything I had experienced about [the abuse]. When it came to

this system failing me in the way I expected it probably would, I was faced with a reality that frankly I wasn't ready to face. I think they didn't want to deal with me because I was gay…I really just don't know what happened with the [legal services for] students. They just, the one I was assigned just ghosted me. I was like you're my last resort, like what's going on? And I called bosses and I called cell phones, ok we'll pass along the message…nothing, *Anthony*.

Two participants reported four positive experiences when searching for professional help including counselors (n=2), medical (n=1), and law enforcement (n=1) personnel. The statements below explain experiences a participant had with counselors and a medical physician:

[When] my therapy first started, I had a very awesome lady. She was like "no, this is not [normal], nothing that has been happening to you is your fault" and then she recommended me to a specialist who specializes in LGBT patients and she was really good, [but then] she stopped practicing. Then I met this girl and I've been with her for 6 years and she does text me and call me for quick mini sessions, so she's phenomenal. She made me feel like I wasn't any different for liking men and women or anything like that. You know, she was really good at making me feel comfortable.

The doctor I had shortly after my miscarriage was a new doctor and he saw trauma from the rape, and he was approachable about it. He didn't really say anything, but he gave me a card on my way out for a counselor like discretely gave it to me, which helped fuel the initial decision to leave. I'm actually still his patient now! I appreciate him doing that too because all these things were

adding up that made me think all these people are seeing signs that something is

not right, and I thought I was hiding it, *Ashley*.

Another participant discussed her experiences with a counselor and police

officers:

> I started seeing a therapist on campus and I would go talk to her to learn how to
>
> talk about experiences in my life because I wouldn't tell anybody anything.
>
> Everything was so private. I didn't learn how to like trust people with my life.
>
> And I learned how to do that [with her]. She made me feel like I was her friend
>
> and that I could depend on her. Like I could really trust her, and she didn't
>
> condescend or be therapy. She was like a friend that was concerned about me,
>
> and that always felt really good.
>
> I would get locked into the apartment and couldn't get out, at all for days. I
>
> remember [when the police arrived] being calm, I didn't feel rushed. They
>
> weren't asking me a ton of questions; they just came to do their job. He just
>
> came to help. I remember they were nice; it wasn't scary, it wasn't
>
> embarrassing. I just felt like relieved and grateful that they were being nice and
>
> friendly and everything, *Melissa*.

Theme 5: Suggestions for Professionals. During data analysis, each

participant addressed a variety of ideas and suggestions for professionals who

work with the LGBTQ+ community and survivors of intimate partner violence.

First, professionals who work with the LGBTQ+ community should focus on

increasing awareness about increased rates of abuse within LGBTQ+

relationships. By normalizing the conversation and providing easily accessible

information and resources, domestic abuse among the LGBTQ+ community may not seem as taboo. "I feel like a lot of the stuff people go through doesn't get talked about. To make it less taboo, just maybe [create] anything that promotes awareness," *Rachel*. Also, "statistics, statistics, statistics! Tangible items that people can see and hold and take home. Or, lifelines, like innovative little business cards [or flyers] where you can just tear [off] the number [and dial] the number, [which] will lead to [a support line]," *Anthony*.

Second, participants in the current study recommended professionals who work with LGBTQ+ survivors of abuse as they would their heterosexual counterparts. The most commonly deliberated topic among participants was the notion of equality, of wanting to be treated for the abuse that was experienced instead of their sexual identity. One participant passionately commented, "What if I was in danger, and since I never got a protective order, or emergency order, something like that, I was severely attacked or even went missing," *Anthony*. Whether it was counseling services, law enforcement, or medical personnel, participants identified the importance of listening to what is happening in the story, as expressed in the following statement, "I would much rather have someone treat me as if I was in a straight relationship. I don't view my abuse as something different because it was with a woman," *Michelle*.

The third recommendation participants shared is professionals should be aware of their tone of voice and demeanor when a LGBTQ+ survivor of abuse is sharing their story, "refrain from certain language. I know cops and things like that they're used to asking bullet point questions, I understand that, but it's all

about phrasing and the tone. I get that they have a job to do, but if you are trained to handle sensitive situations, changing the way a question is asked can make all the difference," *Ashley.*

Finally, participants suggested professionals who provide services to survivors of domestic abuse to identify as an ally. Participants expressed the importance of feeling comfortable and safe prior to reaching out for support, so prominently identifying a LGBTQ+ resource, employee or ally provides an opportunity to connect to that organization or professional:

Maybe cops should be wearing rainbow stickers, you know? Just let us know we shouldn't be scared of you. Because you always feel like it's going to be you getting in trouble or whatever. There's just like this fear, but most cops are open and loving and helpful, and I think if they just let us know somehow. Or wear ally stickers or pink pins or something, that would make people feel safe, *Melissa.*

V. DISCUSSION

This study sought to understand the lived experiences of LGBTQ+ survivors of intimate partner violence. A qualitative method approach was utilized to explore those lived experiences, including internal and external factors that influenced the self-efficacy to seek support services or report victimization. Additionally, the study sought to provide suggestions for IPV professionals by presenting "best practices" for helping LGBTQ+ survivors of domestic abuse. Such information is useful because, historically, domestic abuse has been framed as a heterosexual and cisgender issue (Furman et al., 2017). However, this perspective is misleading, as previous research examining domestic abuse among LGBTQ+ suggested these individuals are at an equal or increased risk of IPV victimization compared with their heterosexual counterparts (Langenderfer-Magruder et al., 2016). Furthermore, literature reflects little research on sexual orientation, experiences of IPV, and the ability to report among this community (Calton et al., 2016). Therefore, the results of this study fill an important gap in the literature by identifying the specific needs LGBTQ+ survivors of IPV require to encourage seeking services, reporting victimization, and beginning a healing process.

The current study found specific beliefs regarding normalizing conversations about IPV victimization within the LGBTQ+ community. Participants felt a main priority should be the use of digital platforms that connect them to heterosexual survivors of domestic abuse as well as professional services. This finding contributes to the literature by adding the importance of social media as an essential resource or communications tool when trying to normalize conversations surrounding domestic abuse within the LGBTQ+ community. This finding is congruent with a previous study that

reported the use of Twitter as a tool to collect IPV narratives to foster further conversation and understanding of stigmatized issues (Weathers, Sanderson, Neal, & Gramlich, 2016).

Additionally, the current study found three key findings. First, participants expressed feelings of discomfort in seeking professional services. The most common influence to seek or not seek help was internalized barriers like discrimination, fear, and judgement, which were connected to experiences of "coming out" or identifying as a LGBTQ+ person. Reported experiences of these internalized barriers are consistent with other research investigating LGBTQ+ survivors of IPV and barriers for seeking professional assistance (Calton et al., 2016; Edwards & Skylaska, 2013; Langenderfer-Magruder et al., 2016; Martin-Storey, 2015). It is imperative to examine these types of barriers as they relate to internalized homophobia or threats of disclosure and the use of homophobia. Furthermore, understanding minority stressors related to internalized stigma provides opportunity for professionals to better inform interventions.

The second key finding draws attention to the inconsistency in services provided among certain professional services. Participants in the study recalled interactions with domestic abuse professionals that were both positive and negative. For example, four positive interactions and four negative interactions were conveyed by the participants who discussed utilizing IPV-related services. These findings are comparable to a similar study that reported both positive and negative encounters for LGBTQ+ survivors of IPV when searching for professional assistance (Sylaska & Edwards, 2015). Participants in the current study shared the desire to be heard, believed, and treated with respect by IPV service professionals: "just be open and to listen to what is actually happening and to hear

both sides of the story," *Rachel*, furthermore, "be careful, shut your mouth, listen, and don't say anything that is not true. You better know exactly what to say, because you're dealing with something that has a… a horrendous history," *Anthony*. These conclusions coincide with Furman and colleagues' (2017) conclusion that cultural competency training for service providers enhanced their efforts to support diverse clients.

The last key finding highlights the marginalization of LGBTQ+ survivors of domestic abuse from society and professionals. Participants in the current study shared the necessity for counseling professionals to focus on their experiences of IPV instead of their sexual orientation and gender identity. This finding is unique to this study, as a recent review of literature demonstrated same-sex couples motivations for use of violence was different compared to their heterosexual counterparts (Buttell & Starr, 2013), which may impact treatment options (Cannon & Buttell, 2015), rather than equal treatment. One possible explanation for participants who reported sexual identity focused treatment is that IPV professionals treat with an emphasis on the feminist or patriarchal theory, which is based on a binary gender framework. Despite the small sample size for this study, similar responses were identified among participants regarding lived experiences of domestic abuse, factors that influenced seeking services as well as interactions experienced with counselors, medical professionals, and law enforcement.

Implications for Future Research

This study's overall discoveries revealed interesting perceptions that can be pragmatic to future research and practice. Perhaps the most thought-provoking implication for future research is the creation of a social platform or movement to increase awareness that domestic abuse occurs within the LGBTQ+ community as well.

Participants from the study discussed the importance of normalizing the conversation about domestic violence in LGBTQ+ relationships through social media, community forums, and LGBTQ+ organizations and programs currently in existence. Ortega and Busch-Armendariz (2013) specifically point out that the expansion of legislation (e.g., Violence Against Women Act) to protect LGBTQ+ survivors of IPV are momentous, but if communities are unaware of its' pervasiveness, policies and programs that address the needs of LGBTQ+ survivors of domestic abuse will not be sustained.

Consider the "Me Too" movement, which has sought empowerment through empathy for sexual assault survivors since 2006. Liberations via #MeToo challenged harassment, discrimination, and assault through transformative empathy. By promoting practices of listening and self-reflexivity, survivors gained power as individuals to feel whole again through the support of a transnational community (Prasad, 2018; Rodino-Colocino, 2018). Normalizing the conversation about domestic abuse among LGBTQ+ relationships may be sparked through an all-inclusive movement such as, Us Too:

> #MeToo it applies to me, but it wasn't, like, specific to who I am really, and it felt like gays were excluded in a way, [but], like, Us Too and just use that and say this is for us, the rest of us, *Melissa*.

Regarding research, investigating the impact of a social movement similar to Me Too should be conducted in relation to social cognitive theory. Patterns in self-efficacy beliefs and outcome expectancies provide extensive variance for how victims of IPV decide to report or seek professional services as well as stay or leave the relationship. Analyzing beliefs and outcome expectancies within a larger perspective provides a

relative responsiveness of social systems that not only predicts human behavior, but also guides social change within governing systems (Steinmetz & Gray, 2018).

Participants in this study were provided the option to conduct their interview in an in-person setting or through the online meeting space Zoom. While each participant reported experiencing multiple types of IPV during the abusive relationship, comfortability of the interview setting influenced a participant's ability to provide in-depth details. The reflective audit trails revealed most participants disclosed feeling anxious or nervous prior to the interview beginning; however, these feelings of discomfort dissipated for those who chose to interview from home or their own personal space. For the participant who chose to interview face to face, feelings of discomfort remained. The lead investigator noted asking several follow up questions to encourage the participant to provide further details as well as to ensure the participant felt calm answering each question. Perhaps, such differences between in-person and online interviews warrants further investigation for qualitative research.

Limitations

While the results of this study provide insight into lived experiences of domestic abuse among LGBTQ+ survivors, limitations should be noted. Due to the nature of qualitative research, the findings of this study are limited by time and context and are thus not generalizable to other populations. Additionally, the traumatic nature of the research topic as well as the marginalized targeted population may have served as recruitment barriers. The lead graduate investigator contacted numerous organizations and offered an incentive for participation, but participation was low, which may contribute to incomplete results. However, despite the relatively low number of

participants in the current study, the in-depth interviews provided rich descriptions of the lived experiences of a marginalized, hard-to-reach population. Additionally, member checks suggested the plausibility of researcher interpretations.

Participation was not limited to the amount of time a participant had not been involved with the individual who perpetrated the abuse. Depending on the timeframe of the prior abusive relationship, the ability to recall lived experiences and factors that influenced reporting or seeking victim services may have varied among participants. Additionally, the information obtained from this study was self-reported by the participants. While the face to face interview technique allowed the interviewer to prompt participants and clarify responses through follow up questions, success was dependent upon self-reporting, which may have impacted theme and subtheme identifications (Devries et al., 2014).

According to Barr and colleagues' (2017), knowledge regarding factors that are associated with self-disclosure of abuse during in-person interviews versus anonymous reporting is limited. Understanding these factors may modify efforts to improve interview protocols to obtain more accurate prevalence rates. Furthermore, the lead graduate investigator was experienced with semi-structured interviewing techniques, which may have positively impacted probing questions during the interviews.

Finally, this study was limited to those who volunteered to participate (i.e., bisexual, gay, and lesbian individuals) but did not include representative from all areas of the LGBTQ+ spectrum (e.g., transgender, queer, asexual). Results may differ if a more representative sample of persons identifying as LGBTQ+ shared their lived experiences. Future research should explore experiences interacting with IPV professionals and the

association between experiences identifying as LGBTQ+ and internalized barriers to reporting or seeking professional services among this community. Additionally, suggestions for IPV professionals should be investigated to identify "best practices;" however, this study may increase awareness of these issues and provide a template for future researchers to prompt uncovering such suggestions.

Conclusion

The purpose of this study was to build on the limited literature investigating experiences of LGBTQ+ survivors of IPV victimization. Additionally, examining recommendations for future best practices is crucial to re-evaluate current policies and practices professionals utilize when treating or working with IPV survivors who identify as LGBTQ+. Throughout this study, participants identified several key topics that influenced their decision to report abuse or utilize IPV-related services. Participants discussed internalized fear of homophobia, changing organizational policies and procedures to be more inclusive, and utilizing social platforms to increase awareness as important factors to contribute to the gap in literature within the field of public health education and promotion.

Furthermore, researchers and professionals within the field of public health education and promotion are charged with the reckoning of breaking down barriers and stimulating forums to ensure communities are working together to protect its fellow members no matter their sexual orientation and gender identity. It is imperative to capitalize on social readiness regarding certain health topics such as intimate partner violence to show survivors from the LGBTQ+ community that they are not alone,

professionals do want to help them recover, and will provide support when these

survivors are ready to speak up (Prasad, 2018).

APPENDIX SECTION

Appendix A: Interview Guide

Investigator will collect consent forms.

"Thank you for agreeing to speak with me today."

"The purpose of this interview is to hear about your experiences of intimate partner violence to assist professionals who work in the public health field or with the LGBTQ+ community to provide resources and services for victims of domestic abuse. Specifically, we want to understand how you were able to cope with traumatic experiences of abuse. We want to understand what occurrences prevented or helped you in reporting and seeking support and what barriers you encountered when reporting or seeking services for victims of intimate partner violence."

"The underlying assumption that we are working with is that victim services are limited to heterosexual victims of intimate partner violence. Additionally, professionals in law enforcement, medical care, and public health education lack necessary training and skills when working with LGBTQ+ victims of domestic abuse. We want to hear from you what you believe to be common barriers that LGBTQ+ victims of abuse experience when reporting and seeking help. We want to know if and how you were able to overcome those barriers. Someone like you has a better understanding of what those barriers are and that is why we are talking with you."

"We'd like to remind you that to protect the privacy of your interview, all transcripts will be coded with pseudonyms and we ask that you not discuss what is discussed in the interview with anyone else."

"The interview will last about 30-60 minutes and we will audiotape the discussion to make sure that it is recorded accurately. Do you consent to the recording of today's interview?"

"Do you have any questions for us before we begin?"

1. The first question is related to your preferred pronoun and preferred description of your sexual orientation, so when I am addressing your interview within my writing and data analysis it is in a way that you find respectful. Is there a pronoun you would prefer me to use when addressing you and referring to your interview questions?

2. I'd like to start off by getting to know you and understanding what your experiences have been like identifying as _____?

3. Tell me a little bit about what your experiences were like coming out?

4. Tell me about what you experienced during the abusive relationship. If you were in multiple abusive relationships, you can focus on the most recent one.
    a. How often did the abuse occur? What type(s) of abuse did you experience?
    b. How would you describe the relationship between you and the abuser before the relationship became abusive?
    c. When did you first realize the relationship was abusive?
    d. What feelings would you use to describe the moment you realized the relationship was abusive?
    e. How long did you experience the abuse for?
    f. Tell me about the moment you decided to leave the abusive relationship. What prompted you to leave? What support (if any) did you have? How long ago did you leave?
5. How did you cope during your experiences of abuse?
    a. Did you have a support network (friends, family, colleagues, counseling services, etc.)?
    b. Did you ever ignore the abuse or hide it from others? If yes, why? If not, why?
    c. What behaviors or actions would you use to describe how you coped during the abuse?
6. Did you ever tell anyone about the abuse (friends, family, victim services, law enforcement, doctor/nurse)? If yes, who did you tell?
    If yes, ask the following questions for each person identified:
    a. Tell me about the moment you decided to confide in _____.
    b. What was the experience like when you told _____ about the abuse? What barriers (if any) did you encounter? What supports (if any) did you encounter?
    c. How did _____ respond to you?
7. Did you, a neighbor, or a friend/family member ever contact the police during an incident?
    a. If so, what was the experience like having the police respond to the incident? Was their presence positive or negative? Did you file a police report?
    b. If not, why weren't they called?

8. What advice do you have for professionals who work with the LGBTQ+ community about raising awareness about abusive relationships?

   a. How can professionals provide better support for the LGBTQ+ community?

9. What advice do you have for organizations or professionals (law enforcement, medical care, health educators) who serve LGBTQ+ survivors experiencing abuse? What do they need to know or do to ensure they have appropriate and effective services for those who identify as LGBTQ+?

   a. If you were going in and reporting abuse to someone in victim services, law enforcement, counseling, etc., what to you would be an ideal way for that provider to communicate to you that you matter? What would be some things they could say or could do that would make you feel comfortable talking to them about the abuse?

Appendix B: Demographic Questionnaire

1. What is your age?
   - 18-24 years old
   - 25-34 years old
   - 35-44 years old
   - 45-54 years old
   - 55-64 years old
   - 65-74 years old
   - 75 years or older

2. What is your gender identity?
   - Female
   - Male
   - Nonbinary or genderqueer
   - Transgender
   - Other: (please specify)_____

3. With what sexual orientation(s) do you identify? Select all that apply.
   - Asexual
   - Bisexual
   - Gay (homosexual)
   - Lesbian
   - Queer
   - Straight (heterosexual)
   - Other: (please specify)_____

4. Please specify your race/ethnicity. Select all that apply.
   - White
   - Hispanic or Latino
   - Black or African American
   - Native American or American Indian
   - Asian or Pacific Islander
   - Other: (please specify)_____

5. What is the highest degree or level of school you have completed?
   - Less than a high school diploma
   - High school diploma or GED
   - Some college or trade/technical/vocational classes
   - Associate degree
   - Bachelor's degree
   - Master's degree or higher

6. What is your marital status?
   - Single, never married
   - Married or domestic partnership
   - Widowed
   - Divorced
   - Separated

Appendix C: Informed Consent

This consent form will give you the information you will need to understand why this research study is being done and why you are being invited to participate. It will also describe what you will need to do to participate as well as any known risks, inconveniences or discomforts that you may have while participating. We encourage you to ask questions at any time. If you decide to participate, you will be asked to verbally confirm, and it will be audio recorded as documentation of your agreement to participate. You will be given a copy of this form to keep.

PURPOSE AND BACKGROUND
You are invited to participate in a research study to learn more about the experiences of intimate partner violence, or domestic abuse, and reasons for reporting or not reporting and seeking or not seeking services. The information gathered will be used to understand specific needs of victims of domestic abuse who identify as LGBTQ. This information will help organizations who serve victims of abuse to assess if their services are providing the correct form of help for LGBTQ victims of intimate partner violence. You are being asked to participate because you have experienced intimate partner violence and have identified as LGBTQ.

PROCEDURES
If you agree to be in the study, you will be asked to participate in one brief interview at a time convenient for you. The interview will last approximately 30-60 minutes. During the interview, you will be asked to share your experiences of intimate partner violence, your coping strategies, if you reached out to someone or an organization for help, if you encountered anything that prevented you from seeking help, and what suggestions you have for organizations, hospitals, doctors, or law enforcement to provide helpful services for LGBTQ victims of intimate partner violence. The interview will be audio-recorded, and the researcher may take notes as well, to ensure your thoughts are accurately recorded.

RISKS/DISCOMFORTS
The interview will include questions about the traumatic nature of experiencing domestic abuse, which may cause extreme discomfort when sharing those memories. We will make every effort to protect participants' confidentiality. However, if you are uncomfortable answering any of these questions, you may choose not to answer. In the event that some of the interview questions make you uncomfortable or upset, you are always free to decline to answer or to stop your participation at any time. Should you feel discomfort after participating and you are a Texas State University student, you may contact the University Health Services for counseling services at 512-245-2161. They are located at the Student Health Center at 298 Student Center Drive or 1347 Thorpe Lane in San Marcos. If you are a student at the Round Rock campus, they are located in Nursing Building #116 at 1555 University Blvd.

If you are a Texas State University employee, you may contact Bobcat Balance for counseling services at 855-884-7224.

If you are non-Texas State student or employee, you may contact the National Domestic Violence hotline for counseling services at 1-800-799-7233.

BENEFITS/ALTERNATIVES
There will be no direct benefit to you from participating in this study. However, the information that you provide will benefit professionals and organizations within this field to increase their knowledge and help create and provide specific resources and counseling services for LGBTQ victims of intimate partner violence.

EXTENT OF CONFIDENTIALITY
Reasonable efforts will be made to keep the personal information in your research record private and confidential. Any identifiable information obtained in connection with this study will remain confidential and will be disclosed only with your permission or as required by law. The members of the research team and the Texas State University Office of Research Compliance (ORC) may access the data. The ORC monitors research studies to protect the rights and welfare of research participants.

Your name will not be used in any written reports or publications which result from this research. Data will be kept for three years (per federal regulations) after the study is completed and then destroyed.

PAYMENT/COMPENSATION
You will receive an electronic $50 gift card to be used at Target for your time.

PARTICIPATION IS VOLUNTARY
You do not have to be in this study if you do not want to. You may also refuse to answer any questions you do not want to answer. If you volunteer to be in this study, you may withdraw from it at any time without consequences of any kind or loss of benefits to which you are otherwise entitled.

QUESTIONS
If you have any questions or concerns about your participation in this study, you may contact the Principal Investigator, Kathleen Bates: 832-863-9001 or k_b277@txstate.edu; or the faculty advisor, Mary Odum: 512-245-8304 or modum@txstate.edu.

This project was approved by the Texas State IRB on April 11, 2019. Pertinent questions or concerns about the research, research participants' rights, and/or research-related injuries to participants should be directed to the IRB Chair, Dr. Denise Gobert 512-716-2652 – (dgobert@txstate.edu) or to Monica Gonzales, IRB Regulatory Manager 512-245-2334 - (meg201@txstate.edu).

In responding to interview questions, you agree to participate
Your consent will be verbally confirmed, and audio recorded as documentation
You have the option to not have your responses to interview questions recorded

Table 1. Demographic Characteristics of Participants (N=7)

Participant Name	Age	Gender Identity	Sexual Orientation	Race/Ethnicity	Education	Marital Status
Michelle	18-24	F	Lesbian	White	Bachelor's	Single, never married
Johnathan	25-34	M	Gay	White	Some college or trade school	Married or domestic partnership
Ashley	25-34	F	Bisexual	White	Master's or higher	Single, never married
Melissa	45-54	F	Bisexual	Multi-Racial	Bachelor's	Married or domestic partnership
Jesus	25-34	M	Gay	Hispanic/Latino	Some college or trade school	Single, never married
Anthony	25-34	M	Gay	White, Hispanic/Latino	Bachelor's	Single, never married
Rachel	25-34	F	Lesbian	White	High school diploma or GED	Single, never married

*Participant names are pseudonyms to protect participant identities.

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