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Barriers to Help Seeking for Lesbian, Gay, Bisexual, Transgender, and Queer Survivors of Intimate Partner Violence

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Abstract

Intimate partner violence (IPV) is a pervasive and devastating social problem that is estimated to occur in one of every four opposite-sex relationships and at least one of every five same-sex romantic relationships. These estimates may not represent violence against those who identify as transgender or genderqueer, and very little comprehensive research has been conducted on IPV within these populations. One statewide study on IPV found rates of IPV were as high as one of every two transgender individuals. In order to cope with the effects of abuse or leave an abusive partner, many lesbian, gay, bisexual, transgender, and genderqueer (LGBTQ) IPV survivors seek support from others. However, LGBTQ IPV survivors may experience unique difficulties related to their sexual orientation and gender identity when seeking assistance. This article reviews the literature on LGBTQ IPV and suggests three major barriers to help-seeking exist for LGBTQ IPV survivors: a limited understanding of the problem of LGBTQ IPV, stigma, and systemic inequities. The significance and consequences of each barrier are discussed, and suggestions for future research, policy, and practice are provided.

Keywords

intimate partner violence, LGBTQ, same-sex, help seeking, stigma

Intimate partner violence (IPV) occurs in same-sex and opposite-sex romantic relationships (Centers for Disease Control and Prevention [CDC], 2010; Tjaden & Thoennes, 2000; Turell, 2000), as well as in relationships in which one or both partners identify as transgender or genderqueer (National Coalition of Anti-Violence Programs [NCAVP], 2012). An emerging literature endeavors to describe all IPV survivors' experiences, but much work needs to be done before research and practice are truly inclusive of all survivors. This review contributes to that work by describing barriers to help seeking within a particularly vulnerable population: lesbian, gay, bisexual, transgender, and genderqueer (LGBTQ) survivors. We begin by describing the context within which those barriers exist and the vocabulary necessary to understand it.

The Context of Barriers to Help Seeking for LGBTQ IPV Survivors

Defining Terms

We use several terms common in the LGBTQ community and only recently appearing in the broader literature. First, we use "trans*" to describe identities across the diversity of the gender spectrum, including transgender, transsexual, genderqueer, and two-spirit (e.g., J. R. Johnson, 2013). "Trans*" describes anyone whose gender identity is different from the gender they/she/he were assigned at birth. Second, those whose gender identity and assigned-at-birth gender are consistent are described as "cisgender." Third, "queer" refers to a rejection of fixed identity categories (Halberstam, 2011). For example, those who identify as "genderqueer" reject the notion that a person must be one of the two fixed categories—male or female. To better represent the gender spectrum, we use generic pronouns, such as "they." Finally, the term sexual minority refers to individuals whose sexual orientation differs from the heterosexual majority of the population.

Many researchers use the term same-sex IPV to refer to any physical, psychological, or sexual abuse between two intimate partners of the same gender or sex (e.g., Murray, Mobley, Buford, & Seaman-DeJohn, 2007). However, same-sex IPV and its counterpart, opposite-sex IPV, exclude individuals who (a) do not identify within the gender binary, (b) identify as transgender, and/or (c) identify as genderqueer in addition to, or instead of, identifying as lesbian, gay, or bisexual. As such, we will use the term LGBTQ IPV to describe any IPV in which

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one or both partners identify as LGBTQ. We use the term cisgender opposite-sex IPV (COSIPV) to describe IPV in which partners identify as cisgender, straight, or heterosexual.

The Prevalence of LGBTQ IPV

In a recent report based on a national data set, the CDC found that sexual minority respondents reported rates of IPV equal to or higher than sexual majority respondents (Walters, Chen, & Breidig, 2013). Specifically, 44% of lesbian women, 61% of bisexual women, and 35% of straight women reported having experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.[1] Twenty-six percent of gay men, 37% of bisexual men, and 29% of straight men reported having experienced rape, physical violence, and/or stalking by an intimate partner at some point in their lifetime (Walters et al., 2013). Researchers, including the CDC, often exclude trans* individuals from their analyses or offer only binary gender identity categories. However, two large studies have shown significantly greater risk of IPV among trans* and genderqueer people (e.g., 51.7% trans* vs. 34.2% cisgender in Langenderfer-Magruder et al., 2014; NCAVP, 2012). Results of these studies suggest IPV is a widespread problem, and LGBTQ individuals may be at an increased risk of IPV, making it especially important for help to be available to them.

However, recent literature suggests LGBTQ survivors face significant barriers to receiving that help. The aim of this review is 2-fold to provide researchers, service providers, and activists with a cohesive understanding of those obstacles and to make recommendations for research, practice, and policy that will address them. We begin with an overview of help seeking for IPV and then draw from the broader IPV literature to describe three barriers to LGBTQ IPV survivors attaining support: (a) limited understanding of the problem of LGBTQ IPV, (b) stigma, and (c) systemic inequities. We conclude with recommendations to increase effective and accessible support for this population.

IPV Survivor Help Seeking

In order to protect themselves from abuse, many IPV survivors seek informal and formal support. Common informal support includes asking others for a safe place to stay, help with child care, financial assistance, or emotional support. Friends are the most common source of informal support (Du Mont et al., 2005; Goodman, Dutton, Weinfurt, & Cook, 2003). Many IPV survivors also seek assistance from formal sources, especially as violence escalates, including domestic abuse networks, health professionals, and the criminal justice system (Duterte et al., 2008; Goodman et al., 2003). Goodman, Dutton, Weinfurt, and Cook (2003) found that survivors who seek formal help are most likely to do so by contacting civil and criminal court systems.

Despite the existence of resources, many IPV survivors do not report abuse (Hennings & Klesges, 2002), or make only partial use of a help source by dropping a court case (Rhodes, Cerulli, Kothari, Dichter, & Marcus, 2011) or not following up on referrals. Decision making about help seeking is a complex and iterative process that depends on individual, interpersonal, contextual, and cultural factors (Liang, Goodman, Tummala-Narra, & Weinstraub, 2005). However, positive encounters with sources of help are vital, as a negative experience can stymie future efforts, and a positive one can establish a pathway that may be revisited (Cattaneo & Goodman, 2010). A body of scholarship evaluates interactions between survivors and sources of help to try and maximize the utility of each encounter. This article adds to that scholarship by reviewing obstacles to successful interactions for a particularly vulnerable subgroup of IPV survivors.

Barriers to Help Seeking

To develop an understanding of scholarship relevant to LGBTQ IPV and help seeking, we used the following search engines: PsychNet, EBSCO host, and Google Scholar. We used the following sets of terms to locate articles: (a) IPV terms, such as domestic violence (DV), IPV, and abuse; (b) LGBTQ terms, such as lesbian, gay, transgender, and same-sex; and (c) help seeking terms, such as help seeking and support. We then used the reference sections of the initial pool of articles to locate additional sources relevant to the review.

This review yields three major barriers to help seeking for LGBTQ survivors. Table 1 depicts key sources related to each barrier. Two caveats are in order: First, this list is not exhaustive, as many obstacles could be profitably addressed. However, there is clear consensus in the literature that these barriers are key for LGBTQ IPV survivors in particular, and addressing them is a good starting place. Second, these barriers overlap and interact in complex ways. We list them separately here to ease comprehension. The first barrier, in particular, frames the rest. We describe it first to set the stage.

Barrier 1: Limited Understanding of the Problem of LGBTQ IPV

We have a limited understanding of the problem for two reasons: (a) research on the topic is lacking and is constrained by methodological limitations and (b) cohesive and user-friendly theory about the development and maintenance of LGBTQ IPV is lacking.

Understudied phenomenon. First and foremost, our limited understanding comes from a dearth of research about LGBTQ IPV (Fortunata & Kohn, 2003). It is clear that abusive partners use forms of physical and psychological abuse to exert power and control over their romantic partners across identities, and thus some research findings on COSIPV likely generalize. However, certain aspects of LGBTQ IPV are believed to be unique to LGBTQ relationships and deserve special scrutiny.

LGBTQ IPV can include power and control tactics that are specific to minority sexual orientation or gender identity, including threats of disclosure and the use of homophobia,

Table 1. Key Sources Related to Barriers to Help Seeking for LGBTQ IPV Survivors.

Source	Focal Population	Type of Source	Barrier 1	Barrier 2	Barrier 3
Basow and Thompson (2012)	IPV service providers	Quantitative study	X		
Cruz and Firestone (1998)	Gay men	Qualitative study	X	X	
Fountain and Skolnik (2007)	LGBTQ individuals	Annual report	X		
Grant et al. (2011)	Transgender and gender nonconforming individuals	Executive summary		X	X
Hendricks and Testa (2012)	Transgender and gender nonconforming individuals	Literature review		X	
Herek (2002)	Heterosexual men and women	Quantitative study		X	
Herek (2004)	LGB individuals	Review article		X	
Jablow (2000)	LGBT individuals	Review article			X
Merrill and Wolfe (2000)	Gay and bisexual men	Quantitative study	X	X	X
NCAVP (2012, 2013)	LGBT individuals	Organization report			X
Potocznick, Mourot, Crosbie-Burnett, and Potocznick (2003)	Same-sex couples				X
Renzetti (1996)	IPV service providers	Quantitative study			X
Turrell and Cornell-Swanson (2005)	LGBT individuals	Quantitative study			X
Walters (2011)	Lesbian women	Qualitative study	X		X
West (1992)	Lesbian women	Review article		X	

Note. These sources are frequently cited in the Barriers sections. A full table of key sources is available upon request. "X" indicates that the source supports the barrier. LGBT = lesbian, gay, bisexual, and transgender; IPV = intimate partner violence; LGB = lesbian, gay, and bisexual; LGBTQ = lesbian, gay, bisexual, transgender, and genderqueer.

heterosexism, transphobia, or transmisogyny[2] against a partner. For example, LGBTQ partners may experience conflict related to the disclosure of their same-sex relationship or one partner's sexual orientation or gender identity, and one partner may threaten to "out"[3] the other partner (Kulkin, Williams, Borne, de la Bretonne, & Laurendine, 2007). An abusive partner may threaten to tell his or her partner's co-custodial parent, employer, family, friends, or landlord about their same-sex relationship, resulting in fear of loss of children, employment, relationships with family and friends, or housing (Ristock, 2002, 2005). Similarly, if a partner contracts HIV via a same-sex relationship, then an abusive partner may also threaten to tell others about their (or the survivor's) medical condition (Fountain & Skolnik, 2007). An abusive partner may also threaten to out a trans* partner's trans* identity and/or history, given that trans* individuals may live "stealth"[4] in certain environments, such as their workplace, due to fear of discrimination and distress (Brewster, Velez, DeBlaere, & Moradi, 2012; Budge, Tebee, & Howard, 2010). In such cases, being outed is a significant fear with potentially devastating and very real consequences.

An abusive partner may also use homo/bi/transphobia against a partner by suggesting that others will not believe that the relationship or violence is real (West, 1998) or that potential helpers will discriminate against them once they find out that they are involved in an LGBTQ relationship (Fountain & Skolnik, 2007). An abusive partner may levy homo/bi/transphobia, asserting that their partner's sexual orientation, gender presentation, or gender identity makes them unattractive. For example, one straight transgender woman recounted some of the power and control tactics her ex-boyfriend used against her, saying "After [the abuse occurred], he would tell me that no one would ever want a freak like me, that I am not a real woman, and that I am worthless" (Fountain & Skolnik, 2007, p. 12). Although prior literature has identified some of these dynamics, they are not well understood, and therefore cannot easily inform intervention.

In addition to the small amount of research on these topics, there are two specific gaps in our knowledge. First, we have little information on how the aspects of IPV that are unique to same-sex relationships affect LGBTQ survivors' mental and physical health. For example, research suggests LGBTQ IPV survivors are often isolated and experience difficulty completing day-to-day activities, such as working or attending school (Merrill & Wolfe, 2000), and their mental health is adversely impacted by IPV (Houston & McKirnan, 2007). However, the extent to which unique LGBTQ IPV dynamics moderate and mediate these important outcomes is unclear. Second, much of the research on IPV dynamics in LGBTQ populations is on gay and lesbian IPV survivors. It is possible that bisexual, trans*, and genderqueer populations may be even more vulnerable to LGBTQ-specific IPV tactics. It is also possible that there are differences in consequences of IPV based on identity. For example, some researchers have suggested that rates of injury among gay survivors of IPV are particularly high (e.g., Merrill & Wolfe, 2000), but we have limited knowledge of the factors contributing to these higher levels of injury. If researchers ignore these differences in identities, they risk masking more fine-grained effects.

Methodological limitations. The research that does exist on LGBTQ IPV is difficult to interpret and generalize due to the variability in methodologies used to assess LGBTQ IPV and

the difficulties researchers often have recruiting samples that are representative of the LGBTQ population. The variability in methodologies may explain the large range in prevalence rate that recent reviews indicate (17–52% of same-sex relationships; Murray & Mobley, 2009; Ristock, 2005). For example, the items researchers have used to assess sexual orientation and gender identity include "Have you ever cohabitated with a same-sex partner?" (e.g., Tjaden & Thoennes, 2000), "Have you ever had a same-sex sexual experience?" (e.g., Greenwood et al., 2002), and "Do you identify as LGBTQ?" (e.g., Walters, 2011). As a result, researchers may be sampling distinct groups (Cruz & Firestone, 1998; Renzetti, 1997). Researchers may also assume IPV was perpetrated by an LGBTQ partner, when in fact a perpetrator may have been cisgender or heterosexual, particularly for bisexual, trans*, and genderqueer survivors.

Similarly, many studies assume gender identity based on items that assess sexual orientation, but this assumption is problematic. It is possible, for example, for someone to identify as genderqueer and to be engaged in a heterosexual relationship. As a result, especially little is known about prevalence of IPV and patterns of help seeking in the trans* and genderqueer communities.

Researchers also use different measures to assess abuse, ranging from one or two yes/no items (e.g., Carvalho, Lewis, Derlega, Winstead, & Viggiano, 2011) to multi-item instruments (e.g., Revised Conflict Tactics Scales [CTS2]; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). The time frames that researchers use to assess victimization also differ, ranging from past year to lifetime victimization, producing vastly different estimates. These issues are endemic to IPV research in general (e.g., Follingstad & Rogers, 2013) but appear to be particularly ripe in this area. According to Murray and Mobley's methodological review (2009), in over half of the studies conducted on same-sex IPV between 1995 and 2006, researchers either did not report instruments' psychometric properties or reported that instruments were psychometrically inadequate. Further, critiques of the CTS2, the most widely used measure in the IPV field, highlight the fact that it does not capture the context of violence (DeKeseredy & Schwartz, 2001). This measurement shortcoming is particularly important when considering the diversity of abusive tactics and dynamics likely present in LGBTQ IPV relationships. Combined, these methodological issues make LGBTQ IPV prevalence rates difficult to interpret.

Additionally, most research uses small samples of LGBTQ IPV survivors. Although such data can offer great in-depth insight, findings may not be generalizable to the LGBTQ population. Difficulties in recruiting large representative samples stem from at least two sources. First, Murray and Mobley (2009) suggest that federal and state government funding agencies favor research on COSIPV, limiting the resources available to LGBTQ IPV researchers. Second, LGBTQ and IPV stigma may limit the appeal of participation (Owen & Burke, 2004; Walters, 2011). Even the survivors that might ordinarily feel comfortable answering questions about their LGBTQ IPV experiences may refuse to participate in a context they perceive to be stigmatizing, such as a courthouse. Trans* and genderqueer survivors in particular may not expect that their identities will be seen or understood by the researchers, or they might believe that the research is not about them. For example, individuals who identify as genderqueer may not participate when research is billed as focusing on "same-sex" IPV.

Feminist theories and gender-specific narratives. In addition to these empirical research limitations, the field's understanding of LGBTQ IPV is constrained by theoretical limitations. The theories that many people use to conceptualize the development and maintenance of IPV center on COSIPV and are not easily applied to LGBTQ IPV. This gap is not due to a lack of relevant theory, as multiple feminist and gender-role theories are relevant to explaining the evolution and maintenance of violence in relationships. However, the field lacks a cohesive theory about the way in which LGBTQ IPV develops and differs from COSIPV. The lack of cohesive theory makes it difficult to produce practice-friendly explanations for violence that can be used to address LGBTQ IPV.

Relevant theories exist. The feminist movement played a major role in raising awareness about violence against women (Goodman & Epstein, 2008). As a result of these historical roots, many antiviolence activists and scholars have conceptualized IPV using feminist theories, which posit that systems of patriarchy cause and maintain violence in intimate relationships (A. Hattery, 2009). Because men have more social, political, and economic power than women, these theories suggest that there is a cultural belief in American society that it is acceptable for men to have power and control over women in romantic relationships. In other words, the broader power structure in society that favors males is enacted within relationships.

As the feminist movement progressed, many activists and scholars expanded their understanding of patriarchal violence to include any violence in which a person uses coercive measures to control a less powerful individual (Hooks, 2000). IPV is intimately connected to male dominance and sexism even if an abuser is not male, because IPV occurs within a culture, created by men, that condones violence as a strategy for dominant people to control subordinate people. Building on that supposition, specific theories have articulated ways in which power dynamics operate in relationships. For example, coercive control theory suggests that the goal of IPV is power and control and that the field should understand abuse as an ongoing pattern of strategies to that end, highlighting the deprivation of autonomy, rather than focusing on discrete physical events (Stark, 2007). Further, "the coercive control model views the dynamics in abusive relationships from the vantage of the historical struggle for women's liberation and men's efforts to preserve their traditional privileges in personal life in the face of this struggle" (Stark, 2009, p. 2). In a more fine-grained analysis of relationship dynamics, positioning theory focuses on how people position themselves in relation to each other (Harré & van Langenhove, 1999). In the context of IPV, a broad spectrum of behaviors can serve as mechanisms for achieving a

superior position from accusing a partner of wrongdoing to active threats (e.g., Ofreneo & Montiel, 2010). Such theories draw our attention to the ways in which systems of oppression can be reflected in relationships, and while theorists tend not to make this link, they are clearly relevant to LGBTQ relationships as well as cisgender opposite-sex (COS) relationships.

Additional feminist theories highlight the fact that while relevant theory may exist, encompassing the experiences of the full population of survivors necessitates a deep understanding of social identities. Crenshaw (1991) argued that multiple aspects of identity intersect and impact violence against women, and she coined the term "intersectionality" to reflect the intersections of identities. Although Crenshaw was focused on the experiences of Black female survivors, her perspective suggests the lived experience of LGBTQ individuals' gender identities and sexual orientations must be considered together to fully understand the causes and experiences of LGBTQ IPV. For example, many LGBTQ individuals experience homophobia and transphobia and internalize these prejudices.[5] Internalized homophobia or transphobia may motivate violence between LGBTQ partners, when this negative social regard for LGBTQ identity is projected on to a partner.

Cohesive and easily applicable theory is lacking. Feminist theories articulate the idea that IPV is based in larger systems of oppression and that IPV differs according to the identities and experiences of perpetrators and survivors. However, pulling these theories together in a practice-friendly way is challenging.

Many people continue to use a gender-specific narrative to explain IPV, where heterosexual men are the primary agents reproducing patriarchy through their violence and heterosexual women are the survivors.[6] Traditional gender roles are a part of this narrative. They indicate that women should be nice, nurture others, defer to men, and be submissive (Mahalik et al., 2005). Alternately, men should not be feminine in any way, show no weakness, and seek adventure, even if violence is a necessary part of that adventure (Connell, 1995; Mahalik et al., 2003). An unmasculine man would be conciliatory and peaceful, rather than dominating and violent (Connell, 1995). In addition, women are presumed, particularly by males, unable to meaningfully contribute to exchanges of physical violence (Connell, 1995).

The dominance of this narrative is an obstacle to the awareness and acceptance of other types of IPV perpetrators and survivors, both among those experiencing violence and those providing formal and informal assistance (Donnelly, Cook, Ausdale, & Foley, 2005; Walters et al., 2013). In a recent study, Walters (2011) found the narrative framing men as batterers and women as survivors is so strong that even trained victim advocates may be blind to signs of LGBTQ IPV. One lesbian survivor who was also an advocate said it was hard for her to realize she was in a violent relationship because, in addition to adopting the societal belief that women are nonviolent, she had received formal employee training at a DV shelter that reinforced the notion that IPV requires a male batterer. Another survivor reported, "My mom didn't believe me—when I told her she didn't believe that she—her reaction was that doesn't happen with other women" (Walters, 2011, p. 259). This attitude may disempower a lesbian IPV survivor and discourage her from seeking further support. Similarly, Basow and Thompson (2012) found DV service providers were significantly more likely to identify a woman as a survivor of nonphysical/emotional abuse if her relationship was presented as heterosexual than if it was presented as lesbian.

Furthermore, when physical violence occurs between two females, a helper may presume it is merely a "cat fight" and is not serious or dangerous (Walters, 2011). One lesbian IPV survivor recalled, "It's almost like there's this belief that IPV can only happen if there is physical power; there's a physical power difference. It has to be that someone is more physically able to control the other one, which isn't the case" (Walters, 2011, p. 258). Consequently, loved ones who are aware of female-to-female IPV may not intervene in the same way that they would if the abusive partner was male.

Within relationships between gay males, violence is also made less visible by stereotypes about gender roles. According to Connell (1995), "patriarchal culture has a simple interpretation of gay men: they lack masculinity" (p. 143). If individuals do not characterize gay males as traditionally masculine, they may not believe gay males are capable of violence, or they may believe that the societal pressure to behave in a traditionally masculine way does not affect them. To the contrary, the need to prove masculinity can be a motivator for violence in relationships. Cruz and Firestone (1998) conducted qualitative interviews about violence in gay male relationships, and one man reported:

> Men are conditioned to be the ones who are in charge of a relationship and the ones who make all the calls. And so when you get two men in a relationship together, they both expect that power and I think a lot of men don't know any other way to get that power except to hit whomever they're with. Too much testosterone!

Finally, among trans* and genderqueer survivors whose experiences and identities do not fit in a binary gender model of cismen and ciswomen, the way gender role theories are applied is particularly problematic. Without the stereotypically masculine aggressor and stereotypically feminine victim easily identifiable, both the survivor and the potential helpers may not recognize abuse and may miss ways in which societal expectations about gender roles actually do influence both partners. For example, gay male partners may internalize the notion that men are more valuable than women in society, and violence may be motivated by one person enacting too feminine of a role in particular settings. The gender specificity of the dominant theory used to describe and understand IPV is a barrier to recognizing these complex dynamics, and consequently to providing effective assistance.

Barrier 2: Stigma

Stigma serves as a two-way barrier to help seeking for many LGBTQ IPV survivors, by preventing survivors from seeking

support (Cruz & Firestone, 1998) and by preventing potential helpers from offering support. While the experience of stigma is common among LGBTQ people in general, specific subpopulations experience a particularly high level of discrimination and pernicious effects. The following sections describe the nature of the stigma these groups experience, and the ways they are an obstacle to help seeking.

The Nature of Stigma for Populations Under the LGBTQ Umbrella

LGBTQ stigma. "LGBTQ stigma" refers to society's negative regard for identities, relations, or communities that are not heterosexual or cisgender (see Hendricks & Testa, 2012; Herek, 2004; Norton & Herek, 2012). Stigma can be experienced explicitly, when one encounters negative regard through statements or policies, or implicitly, when one perceives negative regard in more subtle ways. Both forms of stigma are pervasive. LGBTQ individuals are twice as likely as straight people to experience a life event characterized by prejudice (Mays & Cochran, 2001). For example, much of the research on explicit discrimination against LGBTQ individuals has focused on the workplace, and approximately 68% of LGBTQ individuals report experiencing employment discrimination (Fassinger, 2007).

Research has shown that bisexual and trans* individuals face a particularly difficult landscape in this regard. People who are bisexual may experience additional marginalization for not being straight or LG (Rust, 2000). Research on binegativity, or negative attitudes against bisexual individuals, suggests that both heterosexual and homosexual individuals perceive bisexual identity more negatively than gay or lesbian identity (Herek, 2002; Mohr & Rochlen, 1999). Similarly, research suggests that the prevalence of these negative attitudes (Norton & Herek, 2012) and harassment and violence (Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012) is higher in the trans* population than it is within the LGB population. One survey of approximately 6,450 transgender and gender nonconforming people found 63% of participants had experienced discrimination as a result of bias toward their gender identity, including the loss of a job, bullying, and physical and sexual assault (Grant et al., 2011). Stotzer's (2009) recent review of the literature on the prevalence of violence against transgender individuals indicated 48–69% of trans* respondents had been harassed, and 20–86% had been physically assaulted or beaten as a result of their gender identity or gender expression.

LGBTQ individuals react to stigma in a variety of ways. For example, they protect themselves by hiding their identity in order to avoid harm (D'Augelli & Grossman, 2001). LGBTQ individuals may also internalize stigma, which is associated with a host of negative outcomes, such as depression, anxiety, and substance abuse disorders (Hendricks & Testa, 2012; Williamson, 2000). In addition to its direct effects on mental health, in all stigmatized groups, internalized stigma likely makes resilience in the face of negative events and coping with external stressors difficult (Hendricks & Testa, 2012).

Stigma as a barrier to reaching out for help. Stigma may keep LGBTQ IPV survivors from reaching out for help for two primary reasons. First, experiences with stigma in the rest of their lives may lead them to believe that they will be met with discrimination from helpers, especially for bisexual and trans* individuals, who may fear stigmatization from lesbian women and gay men, as well. Second, LGBTQ survivors may not reach out for help because they are afraid of being outed (West, 1998). Many LGBTQ individuals carefully manage who knows about their sexual orientation and/or gender identity because they fear the stigma described earlier (Budge et al., 2010; Herek, 2004; Mohr, Jackson, & Sheets, in press). LGBTQ IPV survivors may be especially reluctant to seek support if their loved ones are not aware of their sexual orientation and/or gender identity, thereby reducing their potential support (Carvalho et al., 2011). LGBTQ IPV survivors' fears that their loved ones will abandon them, that they will lose their job, or that they will experience discrimination if they disclose their sexual orientation or gender identity (Renzetti, 1997; Russo, 1999) may be so strong that they would rather stay in the abusive relationship than risk being "outed" when seeking support.

Although the development of transgender identity and the process of coming out differ across people (Bockting & Coleman, 2007), there are two distinct points that many trans* individuals come out: pre and post change in their gender role (Zimman, 2009). Trans* people may identify as trans* with a partner without coming out publicly or privately (Nuttbrock et al., 2009), and they might fear being outed to others before they are ready to disclose their identity or before they make associated changes, such as using preferred pronouns, using a preferred name, changing outward appearance or expression, and undergoing any physical procedures or hormonal therapies. Trans* survivors may also be hesitant to seek help later in their transition if they are living publicly and passing as their/her/his preferred gender and fear that seeking help will force them to disclose their trans* history.

In addition to experiencing sexual orientation and gender identity stigma, LGBTQ survivors may not to seek help due to IPV stigma. IPV survivors are often reluctant to seek support because they feel ashamed and embarrassed about the abuse (Simmons, Farrar, Frazer, & Thompson, 2011). For LGBTQ survivors, the shame, embarrassment, and guilt surrounding IPV may be compounded by LGBTQ stigma, making it even harder to seek safety and support.

Stigma as a barrier to providing help. Although interpersonal discrimination in the context of IPV support services has not been empirically explored to date, several studies suggest this phenomenon occurs. Perhaps the clearest evidence comes from one study by Renzetti (1996) in which participants were asked to report on the helpfulness of DV service providers. Participants reported that providers who were the least helpful were unhelpful because they acted as if LGBT people were invisible, or responded to them in a homophobic way. Although this study is outdated and should be replicated to determine its current applicability, it gives researchers and advocates a sense of the

problems that they should look for, and it is a prime example of the issues that tend to occur without policy change and vigilance. While there have been shifts in policy and awareness in some places (discussed in Barrier 3 and the Recommendations sections), researchers and advocates do not know whether they are ameliorating survivors' concerns.[7] Turrell and Cornell-Swanson's (2005) more recent review of the help-seeking literature indicated LGBTQ IPV survivors were broadly dissatisfied with formal support services, including DV agencies, shelters, crisis lines, police, attorneys, and clergy (e.g., Merrill & Wolfe, 2000). Although it is unclear why LGBTQ survivors were dissatisfied across studies, it is possible that interpersonal interactions that occurred while survivors were seeking help from various agencies were wrought with discrimination or invalidation, as suggested by Renzetti's (1996) results.

Research on discrimination in other contexts suggests prejudice occurs. The National Transgender Discrimination Survey found that 19% of respondents were refused care by medical providers due to their gender identity, 28% experienced harassment in a medical setting, and 28% postponed medical care due to discrimination (Grant et al., 2011). Research also suggests that therapists may treat LGB clients differently based on their sexual orientation, leading clients to terminate therapy or perceive therapists as unhelpful (Liddle, 1996; Mohr, Weiner, Chopp, & Wong, 2009). If this type of discrimination exists more generally, it likely exists in organizations devoted to addressing IPV. Homophobic, transphobic, or heterosexist attitudes could cause a potential helper to refuse to help an LGBTQ IPV survivor, ignore an LGBTQ IPV survivor's requests for assistance, or treat an LGBTQ IPV survivor differently than they/she/he would treat a heterosexual IPV survivor. Moreover, the systems within which these interactions occur (Barrier 3) can present their own obstacles to survivors.

Barrier 3: Systemic Inequities

The interactions between help providers and recipients that are discussed in the previous section take place within a larger institutional structure, and there is evidence that stigma is manifested at this system level. In the United States, the legal landscape for same-sex couples is shifting. While at the time of this writing 37 states and the District of Columbia have legalized gay marriage (Freedom to Marry, 2015), many policies favor or assume that couples are opposite sex and that both partners are cisgender. As a result, most system-level responses to LGBTQ survivors are ambivalent at best, feeding survivors' reluctance to use them (Russo, 1999).

If LGBTQ IPV survivors do not feel comfortable seeking support from an institution or system, they may not reach out for help or suffer when they do, even if they are not afraid of interpersonal discrimination from individuals that work within that system. In other words, even if an LGBTQ IPV survivor does not fear discrimination from a help provider (as described in Barrier 2), such as a victim advocate, he or she may not seek help from the organization that the provider works for if the system is not set up to help LGBTQ individuals. These issues are likely apparent across support systems but two stand out as key access points to help for survivors: the justice system and emergency shelters.

The Justice System

Civil court. Many IPV survivors petition for protection orders (POs), but the state-specific statutes underlying the orders make it difficult for LGBTQ survivors to obtain them. For example, in Montana and South Carolina, LGBT individuals are specifically omitted from PO statutes (American Bar Association, 2008), so they are unable to apply for protection. In most states, PO statutes are unclear on whether LGBTQ individuals are included in the provision, allowing local authorities to decide how to proceed on a case-by-case basis and many judges to use their own discretion, which is open to personal bias and likely results in inconsistent decisions and unclear policies (Potocznick, Mourot, Crosbie-Burnett, & Potocznick, 2003). For instance, although Virginia's statute is unclear on whether POs can be granted to LGBTQ survivors, in recent years the vast majority of PO requests against a same-sex partner have been denied (American Bar Association, 2008). A recent study compared the amount of POs requested to the number of POs granted in 14 states and two Canadian cities that have gender-neutral PO statutes (NCAVP, 2010). They found that approximately 55% of LGBTQ survivors' PO requests were denied. LGBTQ IPV survivors may be discouraged from seeking support from the justice system because they are aware of such statutes and believe the chances of actually obtaining a PO are slim.

Additionally, in some states, the threshold for obtaining the order differs depending on sexual orientation. For example, in Kansas and Nevada, judges may request that same-sex IPV survivors prove they were cohabitating when the violence occurred in order for a judge to grant a PO. As a result of these stipulations, straight survivors who were not cohabitating at the time of abuse may get protection from the court, but LGBTQ petitioners may not.

Law enforcement. Law enforcement officers may also discriminate against LGBTQ survivors. Renzetti (1992) found a sample of lesbian IPV survivors rated police and attorneys as most unhelpful out of a list of helpers. One lesbian woman recalled the following experiences with law enforcement after being physically abused by her girlfriend:

> The police came out three or four times. It was always a neighbor who called. They would just tell us to behave and that, you know, that we needed to act like ladies. They didn't even ask for an explanation. They just told us to go and you know, whenever they would come they would just say you guys need to be quiet. When she was hitting me outside and they came and I was physically bruised she—she didn't even try and explain it away at all. She just kind of stood there and then the police left. (Walters, 2011, p. 261)

Such experiences may decrease the likelihood a survivor will contact the police in the future. In addition, when the police

arrest a partner, they may have difficulty assessing batterer from survivor and arrest the survivor. In all LGBTQ-specific cases that were reported to police in 2012, the police arrested the survivor 29.7% of the time (NCAVP, 2013). Although there is evidence of the police erroneously arresting the survivor in OSIPV cases as well (e.g., Menard, Anderson, & Godbolt, 2009), results of a nationwide survey of trans* individuals showed that 46% feel uncomfortable seeking police assistance (Grant et al., 2011). Their hesitance is likely related to their experiences of harassment or discrimination by police (29% in the same survey) and police brutality. In one study, nearly 12% of transgender individuals reported that the police were violent while intervening in IPV (NCAVP, 2013).

Even if survivors have not had negative experiences with the police in the past, they may hear about disparate treatment from other survivors or fear police will be unhelpful, which may discourage them from calling them. In fact, LGBTQ IPV survivors appear to be contacting the police less frequently than in the past, as in 2012 only 16.5% of the nationwide sample of LGBT survivors interacted with the police, as compared with 21.7% in 2009 (NCAVP, 2012). Since rates of violence have actually increased in this sample (55.4% reported experiencing physical violence in 2010, as compared to 36.5% in 2009), this suggests violence is still occurring and survivors are not seeking support from law enforcement (NCAVP, 2012).

Prosecution. If officers arrest an abusive partner and the case goes forward, further systemic inequities may occur during prosecution. One study suggests that if the case is tried before a jury, an LGBTQ survivor will have a more difficult time obtaining justice than a COSIPV survivor. Hill (2000) found that participants who were told to act as jury members and respond to a series of vignettes rated LGB individuals as having less moral character than heterosexual individuals, appraised LGB rape as less serious than heterosexual rape, and reported that LGB rapists should receive a less severe penalty than heterosexual rapists.

Emergency shelters. Historically, most shelters have not provided services to males or to female LBTQ IPV survivors (Jablow, 2000) and hardly any caseworkers have catered to lesbian survivors (Freiss, 2000; Renzetti, 2001).[8] In recent years, of the 1,500 DV shelters in the United States, none have been dedicated to serving lesbian IPV survivors (Helfrich, Fujiura, & Rutkowski-Kmitta, 2008), and in 2011, 61.6% of LGBTQ survivors who sought assistance at a shelter were turned away (NCAVP, 2012). It is therefore unsurprising that Turell and Cornell-Swanson (2005) found that heterosexual survivors were significantly more likely to seek support from a DV shelter than LGB survivors. Although Violence Against Women Act (VAWA) specifically includes LGBTQ individuals in its protections today, LGBTQ individuals are aware of these historical biases and the extent to which all shelters are adhering to the mandates provided by VAWA is unclear. Even if an LGBTQ survivor is legally allowed to seek refuge in a shelter, it does not guarantee that she will feel safe when doing so. In the past, some lesbian women have reported being afraid to seek refuge in regular DV shelters because they feared rejection by other shelter residents or that their abusive partners would be able to locate and access the same shelter (Renzetti, 1996). In fact, Renzetti (1992) found that lesbians rated DV shelters as the least helpful of all of sources of support. These dynamics need to be continuously monitored, even as the landscape shifts.

Trans* individuals may also fear that they will be rejected or misunderstood by shelter residents or staff. Trans* women routinely experience exclusion from spaces intended to be safe spaces for women (e.g., Michigan Womyn's Music Festival; Vanasco & Earls, 2001). Trans* individual's experiences of acceptance or denial at DV shelters have not been studied systematically, but it is clear that even the shelters that accept LGBTQ survivors may not be able to meet their specific needs. The story of a transgender woman who was discriminated against when she sought shelter illuminates the issue:

> The shelter staff asked her a set of intensive and grueling questions about her body including, 'What is between your legs?' ... after this humiliating treatment, they told her that she could not be housed there because they decided that she was really a man. After being denied shelter, this woman went back to her batterer because she had no family, no friends and nowhere else to go. (GLBT Domestic Violence Coalition and Jane Doe, Inc., 2005)

Research indicates that service providers are aware of their inability to cater to LGBTQ IPV survivors' needs. Renzetti (1996) found that over half of shelter employees sampled said they had not received training on same-sex IPV, and they did not advertise LGBTQ services in their community outreach. If LGBTQ IPV survivors are turned away by shelters or recognize shelters are unprepared to support them, they may not seek support when they need it.

Recommendations

Here, we make recommendations for decreasing the obstacles we have reviewed through research and theory, policy, and practice. Table 2 provides key examples of these recommendations. We begin by discussing our recommendations for future research and theory, as they have the potential to provide a foundation for changes to practice and policy.

Research and Theory

Recruit large and diverse samples. In order to address the limited understanding of LGBTQ IPV, future researchers should recruit large and diverse samples of LGBTQ IPV survivors. To date, the majority of the research conducted on LGBTQ IPV has used lesbian samples (M. P. Johnson & Ferarro, 2000; Turell, 2000). In addition to gay men, researchers should include bisexual, trans*, and genderqueer individuals in their samples, as binegativity, transphobia, and transmisogyny may create unique barriers to help seeking.

Table 2. Key Recommendations for Research and Theory, Practice, and Policy.

Research and Theory	Practice	Policy
Recruit large and diverse LGBTQ survivor samples. Modify measures to be LGBTQ inclusive	Include LGBTQ IPV in IPV-related professional and public education, advertise LGBTQ services, and ensure all materials are LGBTQ sensitive	Lobby for laws that extend legal protection to LGBTQ IPV survivors
Conduct literature review on relevant theory, and develop a cohesive and accessible LGBTQ IPV theory that can frame research and practice	Make LGBTQ training mandatory for all employees and volunteers of organizations that serve IPV victims	Support LGBTQ—affirming policies in general
Evaluate the effectiveness of preventions and interventions designed to end LGBTQ IPV	Collaborate with LGBTQ organizations and researchers to develop and implement LGBTQ-inclusive programs	Advocate for regulation of VAWA to ensure its mandates are being followed by DV agencies
Develop the knowledge base about the relationships among stigma, help seeking for IPV, and mental and physical health	Ask LGBTQ individuals about their level of outness and barriers to receiving help, to tailor services to unique needs	Adopt additional state and private funding agency policies that regulate the quality of DV services to ensure LGBTQ survivors are well served

Note. LGBTQ = lesbian, gay, bisexual, transgender, and genderqueer; LGBT = lesbian, gay, bisexual, and transgender; IPV = intimate partner violence; VAWA = Violence Against Women Act; DV = domestic violence.

It is important to emphasize that research on small samples of LGBTQ IPV survivors is important as well, as it has the capacity to document the complexity of the experiences of many LGBTQ IPV survivors. Qualitative research is particularly useful, as it allows survivors to tell their stories in their own way, which provides researchers and activists with a rich understanding of the difficulties that many survivors face when seeking help for IPV that might not be captured using quantitative methods. However, assuming that the experiences of one individual, such as a lesbian woman, will be able to inform work with another individual, such as a bisexual trans* man, is problematic.

Researchers need to understand the diversity of experiences that can occur depending on identity and life history for all individuals that fit under the LGBTQ umbrella. Doing so requires both small and large diverse samples. Because it is difficult to collect such samples, researchers need to seek funding strategically, submit grants to LGBTQ-friendly organizations, and reach out to funders who do not include LGBTQ IPV in their requests for proposals (Murray & Mobley, 2009; NCAVP, 2010). Organizations such as the Funders for LGBTQ Issues (2014) have resources to assist researchers in those efforts. Studies that are supported by an LGBTQ or human rights organization may also be more attractive to potential participants. Both advocating for more resources from mainstream funders and connecting with organizations that clearly prioritize LGBTQ issues may help increase the amount of research conducted on the topic. When researchers obtain these samples, it is important not to replicate the methodological limitations described earlier. For example, researchers should assess causes of violence, the context in which violence occurs, multiple types of violence, and the sexual orientation and gender identity of the perpetrator and survivor, and they should report all of this information in publications.

Use relevant theory. In order to help address systemic inequities and stigma, researchers must draw on LGBTQ IPV-inclusive theory in their work. Where such theory does not exist, careful integration of multiple theories is possible. As described earlier, feminist theories are a useful foundation, connecting conflict in intimate relationships to power imbalances that are rooted in societal structures (A. Hattery, 2009). From here, researchers and advocates should return to theories that focus on the underlying power dynamics of violent relationships (A. J. Hattery & Smith, 2012). At the time of this writing, there is no literature review and user-friendly integration of relevant theory, and such a product would be concretely useful.

Researchers should use these theories to modify COSIPV research materials to be LGBTQ inclusive and/or specific (Murray & Mobley, 2009). For example, IPV assessments should include questions about whether one partner has threatened to out the other partner and about the use of heterosexism and homo/bi/transphobia against a partner. Recruitment materials should mention all types of gender identities and sexual orientations to reach out to diverse participants. Additionally, researchers should be sure to include items about the sexual orientation and gender identity of both the participant and their partner. Making these changes effectively will require piloting of materials with LGBTQ IPV survivors.

Conduct help-seeking research. Extant research suggests survivors' needs are likely to be complex, particularly for bisexual, trans*, and genderqueer individuals. In light of the changing social and political landscape, it is important for researchers to understand the ways in which more favorable attitudes and policies are affecting survivors' experiences with providers. Researchers should reexamine the discrimination that survivors experience when seeking help from various IPV providers. Without this research, advocates cannot assume survivors' experiences are better (or different) than they were in recent decades. Future work should also explore the ways in which LGBTQ individuals experience the help-seeking process, as previous research has established the importance of IPV

survivors' subjective help-seeking experiences (e.g., Calton & Cattaneo, 2014). Research on survivors' subjective experiences within the justice and medical systems would be particularly useful, as many LGBTQ IPV survivors report stigma in these contexts (Barrier 3). For example, some LGBTQ survivors report being falsely arrested for IPV (NCAVP, 2014), and in one study 19% of trans* participants reported having been denied medical care because of their gender identity, and 50% said they had to teach their medical providers about trans* health care (Grant et al., 2011). Focus groups and qualitative research are likely to be particularly helpful, given the early stage of the research in these contexts. Research informed by these recommendations will add to the knowledge base about the needs of LGBTQ survivors.

Practice

Training. A lack of LGBTQ IPV training within formal support services is a key practice-related barrier. LGBTQ IPV training should be mandatory for those working with survivors. At a minimum, this type of training would use LGBTQ inclusive language; define terms such as transgender, cisgender, and genderqueer; and provide examples of LGBTQ IPV-specific abuse, such as threats of outing. To develop these LGBTQ-inclusive trainings and other victim services, DV advocates should pull from theory that accounts for LGBTQ IPV (described earlier), as well as the vast amount of LGBTQ resources that exist (described subsequently). For example, the LGBTQ Power and Control Wheel is a useful tool that can be used to educate formal helpers and general public about power dynamics in LGBTQ relationships (Pence & Paymar, 1993). In addition, the NCAVP offers training and technical assistance to organizations, as they make their services more inclusive (Office on Violence Against Women [OVW], 2013). Researchers can help advocates determine the best materials to use by evaluating the effectiveness of current trainings and practices and by piloting new materials.

During trainings, trainers should also solicit and address victim advocates' concerns about working with LGBTQ survivors. For example, shelter employees have expressed concern about offering services to LGBTQ individuals because of the difficulty differentiating abuser from survivor, and the fear that they are going to protect the wrong individual and endanger other survivors who are utilizing their services. Based on the current literature, best practices in this regard are unclear. Until researchers and advocates refine these methods, trainers can guide formal helpers in evaluating power dynamics in abusive relationships, as described subsequently.

Support services. In addition to LGBTQ IPV training, there are several ways to facilitate effective LGBTQ-affirming IPV support services: First, activists should discuss LGBTQ IPV when raising awareness about IPV in public. Raising awareness should include defining LGBTQ IPV, providing examples of the ways in which violence in these communities may differ from COSIPV, and educating the community about available services. Second, practitioners should evaluate the accessibility of their services to LGBTQ IPV survivors and address obstacles. For example, a potential obstacle to support is that survivors do not know whether service providers are LGBTQ-friendly. To address this barrier, providers should make their accepting views known by ensuring that the resources they distribute to the community are explicitly LGBTQ-inclusive (e.g., using gender and sexual-orientation-neutral language and mentioning LGBTQ-specific support services; St. Pierre, 2008). Third, providers should adapt services to ensure they are meeting the needs of LGBTQ IPV survivors.

The ways in which formal support services are adapted to be LGBTQ-inclusive will differ across contexts, but at the most basic level all service providers should ensure services and resources are available to LGBTQ survivors, including shelter, financial aid, legal aid, and victim advocacy. The need for LGBTQ affirming shelters is especially clear (Freiss, 2000; Jablow, 2000; Renzetti, 2001). Under the amended VAWA, domestic abuse networks supported by the federal government cannot discriminate against LGBTQ survivors (VAWA, 2013). The act also specifies that domestic abuse networks can use VAWA funding for programming or services that will specifically address the needs of LGBTQ survivors (VAWA, 2013). Antidiscrimination policies such as these have been reported to be helpful by members of the LGBTQ community (e.g., Schrock & Boyd, 2006). However, the federal law does not specify the quality and quantity of services. It is important for activists and researchers to monitor the implementation of VAWA to ensure domestic abuse networks provide LGBTQ survivors care.

To ensure that IPV intervention programs are LGBTQ IPV-inclusive, IPV service providers should collaborate with LGBTQ leaders. The following organizations specifically serve LGBTQ survivors of violence and provide excellent resources on their websites: NCAVP, FORGE, The Network la Red, Survivor Project, National Resource Center on DV, National DV Hotline, Gays and Lesbians Opposing Violence, HIPS, and Community United Against Violence. LGBTQ survivors have suggested that sensitive programs require staff who are knowledgeable about LGBTQ issues and experienced in working with LGBTQ individuals, and collaborations can help build such expertise (St. Pierre & Senn, 2010). This type of collaboration is aligned with a coordinated community response perspective (Shepard & Pence, 1999), which may be particularly important for LGBTQ individuals given the research that suggests participation in LGBTQ communities buffers the effects of stigma (e.g., Garnets, Herek, & Levy, 1992). Victim advocates working with LGBTQ survivors who are not linked with the community might facilitate such connections.

Furthermore, to ensure service providers are meeting LGBTQ survivors' unique needs, it is important that providers evaluate each survivor's unique circumstances using integrated theory and tailor support services based on this integrated approach. Formal helpers should (a) evaluate the power dynamics in an abusive relationship, rather than masculine/feminine attributes (Potocznick et al., 2003); (b) identify and question

the assumptions that underlie their assessments; and (c) explore risk and power in ways that are relevant based on a survivor's identities. For example, when working with a lesbian female who has not told her family members about her sexual orientation, an advocate might ask a survivor to complete an outness measure (e.g., Outness Inventory; Mohr & Fassinger, 2000) along with a risk assessment measure (e.g., Danger Assessment; Campbell, Webster, & Glass, 2009) to create a safety plan that is sensitive to her level of outness and to locate appropriate emergency shelter during her time of need.

The notion that service providers must attend to the complex needs of survivors fits with a broader call to attend to the entirety of each survivor's situation, where IPV may only be one of multiple threats to a survivor's well-being, and addressing it may be only one of several pressing priorities (Davies & Lyon, 2013). Truly answering this call is likely beyond the capacity of individual providers and requires system change. Smyth, Goodman, and Glenn (2006) coined the term "full-frame" to describe services that work with and for marginalized populations in a holistic way. The Full Frame Initiative has called for broad system change in order to fit these complexities, rather than forcing help-seekers to fit their complex problems into predefined categories (Melbin, Smyth, & Marcus, 2014). For example, once inside a program that serves IPV survivors, a potential client may feel that he must leave his experiences of oppression as a gay man at the door, and only focus on his experiences with IPV. In reality, those experiences are intertwined, and plans for change need to account for both. Gaining more understanding of the ways in which traditional services do and do not meet the needs of LGBTQ survivors builds on the full-frame assumption that the nature of services needs to change in a fundamental way.

Policy

Make LGBTQ IPV visible. Increasing federal and local support for LGBTQ IPV services will be helpful in addressing all three barriers to help seeking. To highlight the need for funding, activists, advocates, and researchers must make LGBTQ IPV visible to policy makers. Several LGBTQ rights organizations seem well suited for this cause. For example, the Human Rights Campaign (HRC) has supported LGBTQ IPV survivors in the past by lobbying for the LGBTQ-inclusive amendment to VAWA (McCarty, 2013). The HRC can lobby for legislation that would be helpful to survivors and allocate funding toward survivor-centered initiatives. Organizations like the HRC can also raise public awareness about LGBTQ IPV by making LGBTQ IPV more visible on their websites and within their newsletters. Other professional associations have divisions devoted to LGBTQ rights, such as The American Psychological Association's Graduate Student Committee on LGBTQ concerns. In recent years, this committee rallied to support/oppose bills that affect LGBTQ rights, such as the *Employment Non-Discrimination Act* and the *Every Child Deserves a Home Act* (American Psychological Association, 2014). Researchers and practitioners can lend their time and expertise to such groups to support relevant legislation.

Support relevant legislation. The 2013 amendment to VAWA that made it illegal for federally funded providers to deny service based on gender identity and sexual orientation is an excellent example of the type of policy change that is possible, and of the need to continue advocating even after a legislative victory. Now that VAWA has been reauthorized with this provision, the OVW is tasked with implementation. OVW funds the NCAVP to train and support organizations, as they adapt services to meet the needs of LGBTQ survivors (OVW, 2013). However, it is possible that organizations will need to make such substantial changes to their infrastructure in order to be truly inclusive that they will take little action unless the provision is enforced via federal regulations. NCAVP is partnering with several LGBTQ and DV organizations to urge the Department of Justice to issue such regulations (NCAVP, 2014).

Many other systemic issues will also need to be addressed through policy changes and sustained pressure to ensure implementation. For example, there is a need to lobby for changes to the PO statutes that allow for discrimination against LGBTQ individuals. The state of Hawaii's PO statute includes "current or former same sex partner" in order to ensure equal access to POs (American Bar Association, 2008). Other states should follow suit. As discussed previously, the experience of LGBTQ IPV survivors is tied to the general experience of LGBTQ individuals in society. In order to address systemic inequities and stigma, activists and advocates can work to support bills that extend rights and protections to all people, regardless of sexual orientation and gender identity. For example, legislation that makes employment discrimination based on sexual orientation or gender identity illegal allows LGBTQ individuals to feel safer coming out at work. Passing legislation that is not specifically aimed at addressing IPV affirms LGBTQ rights and contributes to a more supportive environment for LGBTQ individuals within society. Once these bills are passed, it is important to provide officials with feedback on the quality of the interventions, and for officials to amend policy or implementation accordingly.

Regulate the quality of services. Government officials have the power to regulate the quality of the services that DV organizations, especially those supported by federal or state funding, offer survivors. First and foremost, it is important for all state government and private funding agencies to follow in the footsteps of the federal government and adopt policy that ensures LGBTQ survivors are served. Once these protections are in place, government entities can evaluate and regulate them. Some states have regulations in place that ensure DV centers regularly evaluate their services, and these requirements might be explicitly extended to their work with LGBTQ survivors. For example, Florida Statute 39.905 mandates that all certified DV centers provide certain services (http://www.flsenate.gov/laws/statutes/2011/39.905). In order to receive state funding, DV organizations must evaluate their trainings and support

services to ensure they are providing quality care to survivors. Organizations that interface between shelters and policy makers, such as the Florida Coalition Against Domestic Violence (FCADV, 2014), can lobby for an amendment to this statue that specifically includes services for LGBTQ survivors, as well as ask for funding to increase and evaluate LGBTQ IPV-inclusive services. Combined, these types of system-level changes will help to address the systemic inequities that make it difficult for LGBTQ survivors to attain adequate support.

In addition, communication between researchers, advocates, and policy makers is vital. For example, the LGBTQ-inclusive amendment to the VAWA was originally voted down, because representatives that opposed the bill claimed little data existed to support the notion that LGBTQ IPV survivors need such protection (C. Johnson, 2012). Although lack of research on the need for such legislation is not the largest reason the bill did not pass, this example highlights the fact that research can be used (or misused) to establish a need for action at grassroots and governmental levels. Additionally, although we focus on policy related to the justice system in this review, policy focused on improving the ability of other major systems (e.g., health care) to meet the needs of LGBTQ IPV survivors is also critical. For example, based on emerging understanding of the role of outing in LGBTQ survivors' decisions to seek help, activists might raise awareness about the importance of protecting a survivor's privacy and lobby for legislation that provides additional protections and support for closeted survivors.

Conclusion

In this review, we illuminated three critical barriers to help seeking for LGBTQ IPV survivors: a limited understanding of the problem of LGBTQ IPV, stigma, and systemic inequities. Collectively, these barriers prevent LGBTQ survivors from seeking and receiving help during times of crisis. Perhaps the most important recommendation for the future is to make these barriers visible, and consequently for the field to wrestle with the complex needs of this population, and we hope this review and its recommendations can contribute to that effort.

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Notes

1. While this statistic is enough to document the importance of understanding violence that does not fit the COSIPV norm, the gender of the perpetrator in such statistics is not always clear. In this data set, approximately 90% of bisexual women reported having only male perpetrators of IPV, whereas about 68% of lesbian women reported having only female perpetrators of IPV. Similarly, 79% of bisexual men reported having only female perpetrators of IPV, but most gay men (90.7%) reported having only male perpetrators of IPV.
2. Transmisogyny, a term coined by Julie Serano (2007) and used widely in the LGBTQ community, describes cissexism/transphobia combined with misogyny.
3. Out refers to when one person discloses another person's same-sex relationship or minority sexual orientation or gender identity.
4. To live stealth: "non-disclosure of one's trans history" (Edelman, 2009, p. 165). Living stealth may also be described as passing for one's preferred gender, and intentionally not revealing one's trans* history. For example, if a trans* woman passes, it means that others assume she is a cisgender woman.
5. According to Meyer and Dean (1998), internalized homophobia is "[a LGB] person's direction of negative social attitudes toward the self, leading to a devaluation of the self and resultant internal conflicts and poor self-regard" (p. 161). Internalized transphobia is analogous.
6. Scholars have also noted that the narrative tends to focus on men and women who are White and middle class (see Sokoloff & Pratt, 2005, for compelling discussion).
7. Cruz and Firestone (1998); Garnets, Herek, and Levy (1992); Liddle (1996); Renzetti (1992, 1997); Russo (1999); and West (1998) are also cited for these reasons. It is possible that LGBTQ IPV survivors' concerns have changed over time due to shifts in the social and political landscape. However, whether change has occurred is an empirical question that warrants attention, and it is possible that the landscape has not changed across all contexts.
8. Perhaps in an attempt to fill the void in DV services for LGBTQ survivors, some LGBTQ IPV organizations offer safe beds or homes to those in need (e.g., GLBT DV Project; The Network La Red).

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