Article

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Sexual Assault Support Services and Community Systems

Understanding Critical Issues and Needs in the LGBTQ Community

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Lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals encounter social conditions that create important considerations for LGBTQ sexual assault victims. This exploratory, mixed-methods study examines the relationship between community attitudes toward LGBTQ persons and associated community responses to LGBTQ sexual assault victims. An online and paper-and-pencil survey (n = 130) and four focus group interviews (n = 14) are analyzed using frequency distributions and grounded theory methods. The central theme that emerged in focus group interviews, titled "low community awareness and support for sexual violence in the LGBTQ community," was corroborated by survey participants. Participants' views of unique considerations for LGBTQ sexual assault victims are presented, including causal factors, consequences, and recommended strategies.

Keywords: *bisexual; gay; lesbian; sexual assault; support services*

Listen to me and take seriously the situation that I am in.

Research participant

Sexual violence, including sexual degradation, forcible and nonforcible rape, and all versions of nonconsensual sexual contact, directed at children and adults (Logan, Cole, & Shannon, 2007) occurs at high rates in the United States. According to the National Institute of Justice, 17.6% of U.S. women have experienced completed or

attempted rape (Tjaden & Thoennes, 2000). Regional data are largely consistent with national data. For example, of the 1.3 million adult women living in Oregon, about 230,000 (or 18%) have been raped at least once in their lifetime (Kilpatrick & Ruggiero, 2003). Moreover, rape tends to occur early in victims' lives. According to the National Violence Against Women Survey, 54% of rapes of women occur before age 18 (22% before age 12). For men, 75% of rapes occur before age 18, and 48% before age 12 (Tjaden & Thoennes, 2000). Both males and females are raped, though the majority of rape victims are female, while the vast majority of perpetrators of rape are male (Catalano, 2004; Kilpatrick, 2002). These rates likely underestimate actual rates of sexual violence, as many male and female victims do not report sexual assault. Broad definitions of sexual violence—those that include sexual degradation and nonphysically forced sexual coercion—are associated with significantly higher incidence and prevalence rates. Furthermore, nonphysically forced sexual coercion experiences are sometimes perceived by victims and perpetrators as normal, thereby further contributing to lower reported rates of sexual violence (Basile, 2002).

Although researchers have now extensively studied several facets of sexual violence, data collection instruments usually assume heterosexuality among participants and rarely assess for sexual orientation (Balsam, Rothblum, & Beauchaine, 2005). Consequently, very little is known about sexual violence victimization rates for individuals who identify as lesbian, gay, bisexual, transgender, and/or queer (LGBTQ) (see Table 1 for a description of terms).[1] Similarly, rates of sexual violence among same-sex couples have received very little research attention.[2] The evidence that does exist is impaired by several methodological limitations, including varying definitions of sexual violence and sexual orientation, a small number of sexual assault items, lack of adequate probabilistic samples, and no data specific to transgendered persons (Kilpatrick & Ruggiero, 2004). A nonprobabilistic survey by Balsam et al. (2005) comparing lesbian, gay, bisexual, and heterosexual siblings found that bisexual and gay men reported rates of childhood sexual violence that were much higher than heterosexual men, though comparable to women of all sexual orientations. Difference by sexual orientation seemed to remain steady in adulthood:

> Although less than 2% of heterosexual men reported being raped in adulthood, more than 1 in 10 gay and bisexual men reported this experience. More than twice as many lesbian and bisexual women (15.5% and 16.9%, respectively) reported an experience of rape in adulthood than heterosexual women (7.5%). (p. 484)

Although other researchers have drawn similar conclusions, the comparative rates of sexual violence between straight and LGB populations remain uncertain and comparative rates for transgendered populations are unknown (Duncan, 1990; Heidt, Marx, & Gold, 2005; Hickson et al., 1994; Tjaden, Thoennes, & Allison, 1999).

Table 1
Description of LGBTQ Terms

Term	Description
Lesbian	Women whose primary emotional, erotic, and relational preferences are same-sex (homophilic) and for whom some aspect of their self-labeling acknowledges these same-sex attachments (Bieschke et al., 2007).
Gay men	Men whose primary emotional, erotic, and relational preferences are same-sex (homophilic) and for whom some aspect of the self-labeling acknowledges these same-sex attachments (Bieschke et al., 2007).
Bisexual	Individuals whose emotional, erotic, and relational preferences are toward both same- and other-sex individuals, either serially or simultaneously, and for whom some aspect of their self-labeling acknowledges the same-sex attachments (Bieschke et al., 2007).
Transgender	Individuals who are gender-variant or gender-"transgressive," that is, expressing their gender in ways not considered socially "appropriate" based on their (perceived) biological sex; also referred to as "gender-bending/blending." Transgender is a broad term that applies to people who live all or substantial portions of their lives expressing an innate sense of gender other than their birth sex (Human Rights Campaign, n.d.).
Queer	Queer is regarded as a derogatory term by some, though by others it is used as a unifying term for people who are lesbian, gay, bisexual, and/or transgender—or another nonheterosexual gender identity or sexuality.

Note: LGBTQ = lesbian, gay, bisexual, transgender, and queer. Designation as lesbian, gay, or bisexual refers to the sex(es) of one's (actual or imagined) intimate partner choices, not gender expression. Conversely, designation as transgender (or any of its variants) refers to gender expression, not the sex of one's (actual or imagined) partner choices. And self-labeling may change over time.

Relative to heterosexual sexual assault victims, a rapidly growing body of primarily nonempirical literature argues that social conditions create significantly unique experiences for LGBTQ sexual assault victims (Bieschke, Perez, & DeBord, 2007; Renzetti, 2001). These unique factors, rooted in discrimination, marginalization, and social oppression faced by LGBTQ persons overall, translate into poor access to services for LGBTQ sexual assault victims, disproportionate reduction in safety, and generally poor response to assault disclosure in the health, social service, and criminal justice sectors (Girshick, 2002).

Numerous socially derived perceptions of LGBTQ persons converge to reduce availability and access to services and contribute to discriminatory, accusatory, and insulting responses when services are sought and received. Poor service availability, for instance, is associated with gender and heterosexist assumptions (e.g., perceptions that males are not sexually assaulted and that same-sex sexuality is deviant and, consequently, that LGBTQ persons are less deserving of services). In an analysis of more than 20 national, statewide, and local studies of antigay violence, 52% to 87% of respondents were subjected to verbal harassment, 21% to 27% were pelted by objects, and 13% to 18% were stalked or chased (Berrill, 1990). Research suggests that harassment and violence directed at transgendered persons by the general

public may occur at even higher rates (Kenagy, 2005; Lombardi, 2001). Given these findings, LGBTQ persons live in an inherently dangerous environment and reasonably assume that they may be targeted, mistreated, and blamed—even by service providers, law enforcement, and health care professionals. Because of these negative perceptions of same-sex relationships, LGBTQ persons may endure internalized discrimination or may be reluctant to seek services in an effort to manage negative stereotypes.

An LGBTQ survivor legitimately may fear that his or her sexual orientation or gender identity may become the focus of attention—or even the perceived cause of the assault—rather than the assault itself and his or her needs and recovery (Renzetti, 1998). LGBTQ survivors also report being outed as a result of the sexual assault and are exposed to associated risks to their housing, employment, and faith community, as well as a negative response from family and acquaintances (Cruz, 2003; Mendez, 1996; Merrill & Wolfe, 2000). According to several reports, very few agencies reach out to sexually assaulted members of the LGBTQ community (Barret & Logan, 2002). Indeed, given that U.S. society generally does not accept same-sex partnerships (Vaid, 1995), there is very little motivation to create LGBTQ-sensitive services for LGBTQ survivors of sexual assault (Ristock, 2001).

Although proponents have persuasively argued that LGBTQ survivors of sexual violence endure unique obstacles related to social attitudes and system responses, research that delineates the nuances of these obstacles, drawn directly from LGBTQ persons' perspectives, is needed. A qualitative study that investigated the dynamics of abusive lesbian relationships generated several questions for further research, including "What is the impact of homophobia, heterosexism, racism, and other forms of oppression on abuse? What are the similarities and differences between gay male partner violence, lesbian partner violence, and transgender partner violence?" (Ristock, 2003, p. 339). Research addressing LGBTQ intimate partner violence and, for the purposes of this study, sexual violence in particular (a) can generate a more complete understanding of the relationship between community attitudes toward LGBTQ persons and associated community responses to LGBTQ sexual assault victims, and this increased understanding (b) can inform training and community attitudes, leading to improvements in service delivery and general community responses.[3] The central premise of this study is that understanding and preventing sexual violence of LGBTQ persons must be grounded in information from members of the LGBTQ community. For the purposes of this study, *community* is defined as a formal or informal network of individuals that exists because of members' sense of common identity, certain similar collective experiences relative to society at large, and a "unity of will" (Tonnies, 1887). With regard to the LGBTQ community, it should be recognized that not all persons who identify as LGBTQ or combinations thereof identify with, perceive, or feel a personal affiliation with the LGBTQ community and that tremendous diversity exists within the LGBTQ community (National Resource Center on Domestic Violence [NRCDV], 2007). Bieschke et al. (2007) stated that

"within LGBT communities there are multifaceted dimensions of individual differences and diversity, multiple layers of identity, and multiple layers of oppression" (p. 403).

The purpose of this exploratory, concurrent triangulation, mixed-methods study (Creswell, 2003) was to develop a more complete understanding of the issues and challenges facing LGBTQ survivors of sexual violence. The study collected quantitative descriptive data using an online and paper-and-pencil survey that included a mixture of Likert-type scale, dichotomous, and short-answer questions, as well as qualitative focus group data. By using a mixed-method approach, the researchers were able to corroborate findings by collecting Likert-type scale beliefs and attitudes and exploring variables in greater detail via open-ended focus group interviews. This study was organized around the following three aims: (a) to understand the LGBTQ community's knowledge, attitudes, and behavior in regard to sexual violence; (b) to understand the current ways in which sexual violence is discussed and handled in the LGBTQ community; and (c) to understand the most important steps toward sexual violence prevention in our community.

Method

This study occurred in the context of a project titled "Engaging Change" (EC), a community engagement project developed and coordinated by a sexual assault survivors' service organization located in a midsized city in the Pacific Northwest. EC is funded by federal Rape Prevention Education Grant Programs via the Oregon Attorney General's Sexual Assault Task Force. It is one of several statewide prevention projects in Oregon, though the only of its kind designed to enhance community awareness and change systems so as to prevent LGBTQ sexual violence. EC's vision is to support and enhance community involvement and engagement in sexual violence prevention in the LGBTQ community, to decrease sexual violence occurring in LGBTQ communities, and to instill LGBTQ-sensitive policies and procedures in key community systems. This study comprised one of EC's strategies, which was to engage the LGBTQ community in order to better understand sexual violence from the perspective of members of the LGBTQ community and to use this information to shape training, services, and prevention programs.

Participants

This study included two data collection methods: (a) an Internet-based and paper-and-pencil survey (see Table 2) and (b) focus group interviews. Survey participants were recruited via nonprobability convenience and snowball techniques, including a local listserve comprising largely sexual and domestic violence social service activists and providers, sexual violence agency bulletin boards, and two local organizations

Table 2
Sample Demographic Characteristics

	n	%
Sex		
Female	83	63.8
Male	40	30.8
Transgender/other	6	4.6
Did not respond	1	0.8
Sexual Orientation		
Gay	30	23.0
Lesbian	26	20.0
Bisexual	24	18.5
Heterosexual	24	18.5
Other/multiple categories	25	19.2
Did not respond	1	0.8
Race		
Minority status	31	23.8
White	99	76.2
Did not respond	0	0.0
Survivor of sexual assault		
Yes	70	53.8
No	50	38.5
Did not respond	9	7.7

providing services and outreach to the LGBTQ community. The survey announcement afforded participation by individuals who self-identify as heterosexual or LGBTQ (i.e., "You have been selected to participate because you have very good familiarity with the LGBTQ community in our area"). Survey participants had the option of completing the survey online or with paper and pencil. Both versions of the survey were identical. Among all completed surveys, 83 were completed online and 43 were completed in writing. Focus group participants were recruited with purposive strategies, including an invitation to participate at the end of the survey and via nomination by EC Advisory Coalition members. Given that survey responses were anonymous, the extent to which participants completed the survey only, the focus group interview only, or both the survey and the focus group interview is unknown.

Survey and focus group data were analyzed separately, although data collected during a pilot of the survey ($n = 23$) shaped the focus group questions.[4] For example, many pilot survey respondents reported that they were not aware of LGBTQ-friendly services for survivors of sexual violence in the local area. This survey finding led to the qualitative focus group question, "What are the main LGBTQ-friendly services and resources that are currently available for someone who has been sexually assaulted?" Likewise, the survey items were constructed based on two prestudy focus

group conversations with EC Advisory Coalition members. Although qualitative and quantitative strategies were used to develop the survey and the focus group questions in this study, the qualitative and quantitative data collected were analyzed separately. Information collected by both methods was very consistent. These consistencies are highlighted in the results section.

The Survey

The survey (n = 130), developed for the purposes of this study and in collaboration with EC's Advisory Coalition, includes 11 dichotomous items, 16 Likert-type scale items, and 7 open-ended questions. Following human subjects approval, the survey was advertised and posted for 6 weeks. For the purposes of the survey, sexual assault was defined as "any touch or act that is sexual in content and is used for the gratification of the perpetrator by force, threat of force, trickery, coercion, bribery, or between two people where an imbalance exists in age, size, power, development, or knowledge. Sexual assault includes child sexual abuse, rape, incest, ritual abuse, sexual harassment and stalking."

Analytic Strategy

Frequency distributions for each of the outcome measures will be summarized for the entire sample and within three contrasts of interest: females versus males/transgendered persons, survivors of sexual assault versus those never sexually assaulted, and LGBTQ versus heterosexual orientation. Given the dichotomous and discrete ordinal nature of the outcome measures (i.e., 5-point Likert-type scale ranging from *disagree strongly* to *agree strongly*), a logistic regression analysis (Hosmer & Lemeshow, 2000) and corresponding odds ratios with 95% confidence intervals (CIs) will be used to examine relationships between outcome measures and the contrasts. Although a t test is fairly robust to violations of statistical assumptions, this is true mainly when there is a large sample size and an equal n in each group (Myers & Well, 2001; Pagano, 1995), a situation not present in the current study. In addition, some have argued (e.g., Velleman & Wilkinson, 1993) that ordinal levels are too limited to treat as an interval scale and examining mean differences between ordinal measures is not the best way to analyze the data.

Results

Sample Characteristics

Table 2 shows that most of the 130 survey participants in the study are White (76%), are female (64%), and report having been sexually assaulted (54%). Reports

of sexual orientation are relatively evenly split among gay, lesbian, bisexual, heterosexual, and the "other/multiple" category. The average age of the sample is 36.0 (SD = 13.9) years old, with the youngest participant 15 years old and the oldest 71 years old. Based on the definition of *sexual violence* used in this study, 70 (58.3%) respondents reported being sexually assaulted at some point in their lives, 50 (41.6%) have not been sexually assaulted, and 10 (7.6%) did not respond.

General Findings

The majority of participants in this study believed that sexual violence is a problem in society (94% agreed or strongly agreed), that sexual violence is a problem within the LGBTQ community (72% agreed or strongly agreed), and that sexual violence prevention tailored to the LGBTQ community is needed (86.7% agreed or strongly agreed). At the same time, many did not regard themselves as familiar with existing efforts to prevent sexual violence in the LGBTQ community, and many (41.5%) believed or strongly believed that open dialogue specific to sexual violence in the LGBTQ community is not occurring in the local region. An even higher percentage of participants (60.3%) disagreed or strongly disagreed that the overall local community is currently well equipped to handle incidents of sexual assault that occur in the LGBTQ community. And when asked if law enforcement is well equipped, 68.7% of participants disagreed or strongly disagreed.

Distribution of Items

The most skewed items in the distribution are "Would you recommend sexual assault support services (SASS) to someone you cared about?" (–4.02) and "Sexual violence is a problem in our society" (–2.81). These are items with the smallest variance and least likely to discriminate among groups. The least skewed items are "I think that most people in the local LGBTQ community have healthy sexual encounters" (–0.02) and "I think that alcohol is often used within the LGBTQ community to intentionally lower another person's sexual boundaries" (–0.21).

Logistic Regression Models

Twelve of the logistic regression contrasts are significant at $p \leq .05$. Although 57 models were run, no specific adjustments to the p values were made. Because of the exploratory nature of the study, all statistically significant results will be interpreted. However, p values are provided (see Table 3) for the reader so adjustments can be made.

The most statistically significant contrast category was the female versus male and transgender comparisons. Females were 2.8 times more likely to have used

Table 3
Logistic Regression Output for Contrasts

	Odds Ratio	*SE*	95% CI	*p*
Have you used SASS services or know someone who has?				
Female vs. males/transgender	2.8*	0.4	1.2 to 6.3	.013
Survivors sexual assault vs. no sexual assault	1.1	0.4	0.5 to 2.3	.887
LGBTQ vs. heterosexual orientation	0.5	0.5	0.2 to 1.3	.146
Would you recommend SASS to someone you care about?				
Female vs. males/transgender	1.0	0.9	0.2 to 6.0	.961
Survivors sexual assault vs. no sexual assault	0.4	1.1	0.0 to 3.6	.400
LGBTQ vs. heterosexual orientation	1.1	1.1	0.1 to 10.1	.950
I am aware of services that work with survivors of sexual violence that are not LGBTQ friendly?				
Female vs. males/transgender	3.1*	0.5	1.1 to 8.9	.036
Survivors sexual assault vs. no sexual assault	1.6	0.5	0.6 to 4.1	.336
LGBTQ vs. heterosexual orientation	1.4	0.6	0.4 to 4.5	.578
Sexual violence is a problem in our society				
Female vs. males/transgender	2.1*	0.3	1.1 to 3.7	.017
Survivors sexual assault vs. no sexual assault	1.7	0.3	0.9 to 3.1	.077
LGBTQ vs. heterosexual orientation	0.3*	0.7	0.1 to 0.9	.010
Sexual violence is a problem for members of the Eugene-Springfield LQBTQ community				
Female vs. males/transgender	1.6*	0.2	1.1 to 2.4	.031
Survivors sexual assault vs. no sexual assault	1.8*	0.2	1.2 to 2.8	.009
LGBTQ vs. heterosexual orientation	0.7	0.3	0.4 to 1.3	.270
Sexual violence prevention that is sensitive to the unique needs of the LGBTQ community is needed in the Eugene-Springfield area				
Female vs. males/transgender	1.3	0.2	0.8 to 2.0	.229
Survivors sexual assault vs. no sexual assault	1.3	0.2	0.8 to 2.1	.234
LGBTQ vs. heterosexual orientation	0.4*	0.5	0.1 to 0.9	.041
I am interested in working for sexual violence prevention				
Female vs. males/transgender	1.4*	0.1	1.1 to 1.9	.026
Survivors sexual assault vs. no sexual assault	1.2	0.1	0.9 to 1.6	.327
LGBTQ vs. heterosexual orientation	0.5*	0.2	0.3 to 0.9	.009
I think that our community members are interested in sexual violence prevention				
Female vs. males/transgender	1.3	0.2	0.9 to 2.1	.170
Survivors sexual assault vs. no sexual assault	1.3	0.2	0.8 to 1.9	.276
LGBTQ vs. heterosexual orientation	0.6	0.3	0.3 to 1.0	.054
I am familiar with existing efforts to prevent sexual violence in the LGBTQ community				
Female vs. males/transgender	1.1	0.2	0.8 to 1.5	.747

(continued)

Table 3 (continued)

	Odds Ratio	*SE*	95% CI	*p*
Survivors sexual assault vs. no sexual assault	1.0	0.2	0.7 to 1.4	.996
LGBTQ vs. heterosexual orientation	0.9	0.2	0.6 to 1.3	.546
Open dialogue around sexual violence in the LGBTQ community is happening in the Eugene-Springfield area				
Female vs. males/transgender	0.8	0.2	0.6 to 1.2	.287
Survivors sexual assault vs. no sexual assault	0.9	0.2	0.6 to 1.4	.734
LGBTQ vs. heterosexual orientation	0.5*	0.3	0.3 to 0.9	.011
Our community is currently well equipped to handle incidents of sexual assault that occur in the LGBTQ community				
Female vs. males/transgender	1.1	0.2	0.7 to 1.6	.822
Survivors sexual assault vs. no sexual assault	0.9	0.2	0.6 to 1.4	.687
LGBTQ vs. heterosexual orientation	1.0	0.3	0.6 to 1.7	.977
Law enforcement is currently well equipped to handle incidents of sexual assault that occur in the LGBTQ community				
Female vs. males/transgender	0.8	0.2	0.6 to 1.2	.384
Survivors sexual assault vs. no sexual assault	0.8	0.2	0.6 to 1.2	.363
LGBTQ vs. heterosexual orientation	1.0	0.2	0.6 to 1.5	.883
ER medical staff are currently well equipped to handle incidents of sexual assault that occur in the LGBTQ community				
Female vs. males/transgender	0.6*	0.2	0.4 to 0.9	.008
Survivors sexual assault vs. no sexual assault	0.8	0.2	0.5 to 1.1	.146
LGBTQ vs. heterosexual orientation	0.8	0.2	0.5 to 1.2	.227
I am confident that in sexual situations, I know how to ask for consent				
Female vs. males/transgender	0.6*	0.2	0.4 to 0.9	.036
Survivors sexual assault vs. no sexual assault	0.8	0.2	0.6 to 1.3	.400
LGBTQ vs. heterosexual orientation	0.8	0.3	0.5 to 1.4	.480
I think that most people in the local LGBTQ community have healthy sexual encounters				
Female vs. males/transgender	0.9	0.2	0.6 to 1.3	.434
Survivors sexual assault vs. no sexual assault	0.9	0.2	0.6 to 1.3	.549
LGBTQ vs. heterosexual orientation	0.7	0.2	0.4 to 1.1	.105
I obtain verbal consent with every sexual encounter				
Female vs. males/transgender	0.9	0.2	0.7 to 1.2	.529
Survivors sexual assault vs. no sexual assault	0.8	0.2	0.6 to 1.1	.209
LGBTQ vs. heterosexual orientation	0.9	0.2	0.6 to 1.3	.478
I think alcohol influences a person's ability to give consent in sexual situations				
Female vs. males/transgender	1.2	0.2	0.7 to 1.8	.505
Survivors sexual assault vs. no sexual assault	1.4	0.2	0.9 to 2.2	.153
LGBTQ vs. heterosexual orientation	1.0	0.3	0.6 to 1.7	.989

(continued)

Table 3 (continued)

	Odds Ratio	*SE*	95% CI	*p*
I think that alcohol is often used within the LGBTQ community to intentionally lower another person's sexual boundaries				
Female vs. males/transgender	1.1	0.2	0.8 to 1.5	.682
Survivors sexual assault vs. no sexual assault	1.2	0.2	0.9 to 1.8	.252
LGBTQ vs. heterosexual orientation	1.3	0.2	0.8 to 2.0	.237

Note: SE = standard error; CI = confidence interval; SASS = sexual assault support services; LGBTQ = lesbian, gay, bisexual, transgender, and queer. The first category of each contrast is coded with the value of 1 and the second category the value 0.
*$p \leq .05$.

SASS services or known someone who has ($p = .013$, 95% CI = 1.2 to 6.3) compared to their male/transgendered counterparts. In addition, compared to their male/transgendered counterparts, females were 3.1 times more likely to be aware of LGBTQ-friendly services for survivors of sexual violence ($p = .036$, 95% CI = 1.1 to 8.9), 2.1 times more likely to see sexual violence as a problem in our society ($p = .017$, 95% CI = 1.1 to 3.7), 1.6 times more likely to see sexual violence as a problem in the local community ($p = .031$, 95% CI = 1.1 to 2.4), 1.4 times more likely to be interested in working for sexual violence prevention ($p = .026$, 95% CI = 1.1 to 1.9), 0.6 times *less* likely to feel that local ER staff are well equipped to handle incidents of sexual violence in the LGBTQ community ($p = .008$, 95% CI = .04 to .09), and .06 times *less* likely to feel confident asking for consent in a sexual situation ($p = .036$, 95% CI = 0.4 to 0.9).

The sexual orientation comparison of LGBTQ versus heterosexual shows four statistically significant differences. Compared to their heterosexual counterparts, LGBTQ participants are 0.3 times *less* likely to see sexual violence as a problem in our society ($p = .010$, 95% CI = 0.1 to 0.9), 0.4 times *less* likely to see a need for sexual violence prevention sensitive to the local LGBTQ community ($p = .041$, 95% CI = 0.1 to 0.9), 0.5 times *less* likely to be working for sexual violence prevention ($p = .009$, 95% CI = 0.3 to 0.9), and 0.5 times *less* likely to feel that an open dialogue around sexual violence is occurring in the local area ($p = .001$, 95% CI = 0.3 to 0.9).

Comparing survivors of sexual assault to those never sexually assaulted reveals one statistically significant difference. Compared to their never sexually assaulted counterparts, sexual assault survivors are 1.8 times more likely to see sexual violence as a problem in the local community ($p = .009$, 95% CI = 1.2 to 2.8).

Focus Group Interviews

Following human subjects approval, four semistructured focus groups, each 2 hours in length, were completed in a 3-week period and included a total of 14 participants.

Focus group participants ranged in age from 19 to 76 years (mean age = 41 years). Six participants identified as male, eight as female, and two as transgendered. Five focus group participants identified as lesbian, three as bisexual, six as gay, and four as queer. Thirteen identified as White, one as Native American, and one as Latino (one participant selected two race identity categories). Each focus group interview included eight questions that centered around LGBTQ needs, service availability, and prevention specific to sexual violence in the local community: For example, (a) what are the main LGBTQ-friendly services and resources that are currently available for someone that has been sexually assaulted? And where are the main barriers/gaps in services for the LGBTQ community? (b) What are the attitudes about sexual violence in the LGBTQ community—both from the point of view of those in the LGBTQ community and those outside the LGBTQ community? (c) What do you think is the best way to do sexual violence prevention work in the LGBTQ community? In other words, if you were in charge, how would you design a sexual violence prevention plan?

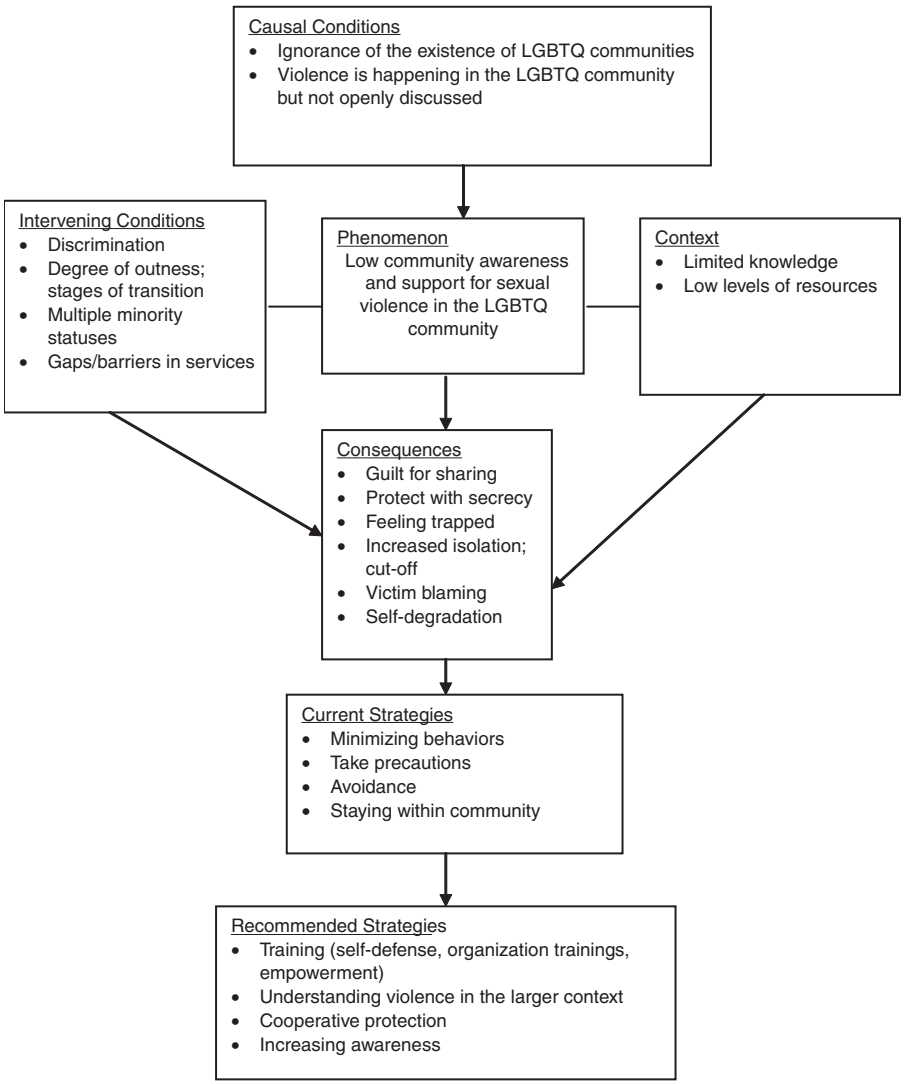
Qualitative Data Analysis

The researchers used a grounded theory method of analysis for the focus group data. As suggested by Strauss and Corbin (1990), data analysis began with open coding where sections of words, sentences, and phrases were examined for specific phenomena. These segments were coded and the phenomena were conceptually labeled and developed into initial categories. The language of focus group participants often guided the development of codes and categories. The categories were further divided into subcategories. Axial coding that involved making new connections between categories and subcategories followed open coding.

As the categories were compared, questions were asked about how each category related to the others in order to denote the nature of the relationships between them. These questions aided in organizing the data by determining the causal conditions that gave rise to or maintained the category (phenomenon), the context in which the phenomenon was embedded, the intervening conditions (general environment) that influenced the phenomenon and facilitated or constrained the strategies adopted to manage the phenomenon, and the consequences of the phenomenon. Verifying the relationships between the categories and their subcategories was achieved by gathering supportive evidence of those relationships in the data. The goal was to craft a comprehensive understanding of the phenomenon that is both grounded in the data through direct and indirect collection of multiple perspectives or voices and consistently examined by the researchers for personal biases (Merlis & Linville, 2004).

As suggested in selective coding (Strauss & Corbin, 1998), a storyline was then created to identify the core category and central phenomenon of “low community

Figure 1
Theoretical Model of Understanding Critical Needs and Issues Around Sexual Assault in the LGBTQ Community



Note: LGBTQ = lesbian, gay, bisexual, transgender, and queer.

awareness and support for sexual violence in the LGBTQ community." The core category was then systematically related to other categories through the grounded theory paradigm to produce an overall analytic version of the story. The story was then laid out in graphic form to show a theoretical model of the central phenomenon (Figure 1). Saturation occurred at this stage because the analysis did not produce any new codes or categories and all of the data were accounted for in the core categories of the theoretical model.

Each category was assigned a color, and then the researcher highlighted statements made by the participants with the appropriate color that matched the statement to the category. To foster trustworthiness of the findings, the qualitative analysts cross-coded each transcript, and feedback was elicited from other researchers to check for any inherent biases. Additionally, to foster dependability of the study findings, an audit trail was created that provided a step-by-step process of data collection and analysis (Anfara, Brown, & Mangione, 2002). Finally, to ensure transferability of the findings, the researchers strove to provide thick descriptions of the study phenomenon and used a criterion-based sampling strategy (Anfara et al., 2002).

Focus Group Results

Focus group participants identified the central phenomenon as "low community awareness and support for sexual violence in the LGBTQ community." In fact, many participants described their sense that because it did not seem like the larger community even recognized the LGBTQ community, they certainly did not acknowledge or provide help for sexual violence within the LGBTQ community. The central phenomenon of low general community awareness about LGBTQ sexual violence and low support for LGBTQ sexual assault survivors reported in the focus group interviews was also reported by survey respondents. Among the seven open-ended survey questions, participants overwhelmingly and primarily attributed lack of community awareness about sexual violence overall, and bias and misunderstanding toward the LGBTQ community specifically, as key factors for improved intervention and prevention. In that regard, participants' open-ended survey responses were remarkably similar to the ideas and opinions offered by focus group participants. In the sections that follow and in Figure 1, the causal conditions, context, and intervening conditions that influence this phenomenon are described and illustrated. Consequences of the phenomenon and the current and recommended strategies will also be described. Furthermore, complementary survey and focus group responses will be illustrated throughout this section. Survey responses portrayed in this section were selected based on the following criteria: (a) The comment appears to reflect the sentiment of many study participants, (b) the comment is consistent with the findings generated by the focus group interviews, and (c) the comment illuminates key qualitative findings in a clear and vivid manner.

Causal conditions. Two types of causal conditions emerged from the data that gave rise to the central phenomenon. These causal conditions were (a) societal ignorance of the existence of LGBTQ communities and (b) limited open discussion of the sexual violence occurring within the LGBTQ community. The majority of focus group participants talked about how society in general ignores LGBTQ persons, making the education and awareness of sexual violence within the LGBTQ community even less likely. One participant talked about how the media are unlikely to increase awareness of sexual violence within the LGBTQ community when "you don't see very many commercials to begin with that pertain to gay issues, anyway." Another participant stated, "From my perspective, most people I run across are very ignorant; they seem to think that we [queer people] don't exist."

Nine focus group participants talked about how sexual violence definitely exists within the LGBTQ community, but there is very limited within-community open discussion about it. One participant stated, "I don't in general feel that I am around queer situations where there is a lot of discussion of sexual assault." Another participant supported this position: "I have never really heard of anyone talking about sexual violence, even though I have known of people who were sexually assaulted within the [LGBTQ] community." Given that focus group participants generally felt that society ignores LGBTQ people and that sexual violence within the LGBTQ community is not discussed, it makes sense that participants also felt that there is low awareness and support for sexual violence within the LGBTQ community.

These findings were also reported by survey respondents. One individual stated, "I think there isn't as much talk about what sex and sexual violence looks like for LGBTQ folks, so people have a hard time understanding how and if they've been assaulted." Another survey respondent commented, "This community rarely talks about LGBTQ domestic violence, let alone sexual assault. It is too much a taboo subject for the community—but needs to be addressed." And another said, "Gay men need to talk about it. Domestic sexual violence and rape are a reality. Rape of heterosexual/gay/bi men by heterosexual men is fairly unaddressed."

Context of the phenomenon. Particular contextual markers—or the patterns of conditions that contribute to low community awareness and support for sexual violence intervention and prevention in the LGBTQ community—were described by focus group participants. These contextual markers included (a) limited knowledge about LGBTQ people and sexual violence in the general community and (b) limited resources.

The majority of focus group participants talked about poor understanding in the general community with regard to LGBTQ people and sexual violence. Within this contextual marker, three subcategories emerged: (a) unhelpful myths about LGBTQ people, (b) a need for a definition of sexual violence, and (c) the dismissal of sexual violence as a problem in the LGBTQ community. Some of the unhelpful myths in the general community reported by focus group participants were that "old lesbians

are not sexual," "gay men are promiscuous," "men can't be raped," "rape can only happen between a man and a woman," and "transgender people are predatory." Several focus group participants described that they believe they have needed to justify why gender violence affects LGBTQ people. Survey respondents also described harmful myths:

> Many people don't want to hear about the "gay lifestyle," let alone try to help prevent sexual assault. Many haters don't want to hear about the sex life aspect of gay people; they would either like to believe we are asexual or pedophiles [sic].

Another myth centered on assumptions about gender-based violence: "People don't believe the survivors because they believe sexual violence only happens between men and women."

One third of focus group participants discussed the need for a clear definition of sexual violence. One participant even declared that she did not ever correlate sex and violence as she felt that violence could never be sexual. She stated, "Even if it is violence against sexual organs, it is not sexual." Another participant said that the lack of clarity can lead to different interpretations of behavior based on the sexual orientation of the people involved in the behavior:

> A woman might go to a bar and they might have a guy slap them on the butt and the woman would be like, "Hey, what are you doing?" and the guy would say, "I am gay so it is not sexual and therefore okay."

The need for a clear definition of *sexual violence* was also mentioned by many survey respondents; for example, one participant said, "There needs to be a clear understanding of sexual violence. There should be little ambiguity."

Finally, several focus group participants remarked that the larger community's dismissal that sexual violence even exists within the LGBTQ community contributed to the poor understanding of sexual violence in the LGBTQ community. This point was also raised by survey respondents, several of whom believed that lack of acknowledgement of sexual violence within the LGBTQ community also occurs among members of the LGBTQ community: "People need to start talking about this issue. I think queer communities haven't even begun a dialogue about sexual assault that occurs within queer couples. This needs to begin and be acknowledged before any activism even starts." Another stated, "There needs to be greater awareness within the LGBTQ community that sometimes perpetrators of sexual violence are within our community."

Many of the focus group participants mentioned that resources are hard to find and that they found certain individuals to be more helpful than organizations. For instance, one participant said, "If I have a problem, the resources I go to are not going to be organizations for the most part. So, it is more of a community of individuals that I would go to for help." Additionally, focus group participants expressed concern that agencies and organizations often do not advertise their level of openness to LGBTQ

people. These ideas were also very widely described by survey respondents, and many associated lack of resources with oppression. For example, one participant said, "One reason is the homophobia in our society; it influences everyone. Not as many services are available which are safe and welcoming." And "if you believe you will not be supported you will not likely seek help."

Intervening conditions. In addition to context, several "intervening conditions" influenced "low community awareness and support for sexual violence in the LGBTQ community." As described by Strauss and Corbin (1990), intervening conditions are the factors that facilitate or constrain the strategies taken within the specific context and can serve as mediating factors. Four intervening conditions were described by focus group participants: (a) discrimination, (b) multiple minority statuses, (c) gaps/barriers to services, and (d) degree of outness/stage of transition.

The majority of focus group participants thought that discrimination against LGBTQ people affected the general community's ability to effectively serve LGBTQ people around issues of sexual violence. Focus group participants discussed the different faces of discrimination (e.g., health care system, legal rights), as illustrated by the following quotes:

> There is no show of respect for transgender people by doctors, nurses, clinic personnel, counselors.

> I think that one thing that is true for all of us is that we are not just dealing with what someone who is part of the mainstream society is dealing with, this straightforward event that occurred. We are dealing with a whole layer of who we are that is considered a perversion. This neutralizes it for some people, and they might say, "Well, you are a lesbian anyway, big deal." And then you don't know if you will be further victimized by society who is supposed to be part of the solution for you.

Survey respondents also discussed the impact of discrimination at length. For instance, one participant said, "There is way too much stigma associated with sexual assault, particularly same-sex sexual assault." And "basic medical forms are set up for hetero relationships. That in and of itself is not LGBTQ positive." Another survey respondent stated:

> People in the LGBTQ community are discriminated against and may still carry huge amounts of shame, and are subjected to (disproportionately) more shame, which makes it even harder to speak out. When people are afraid to be treated differently, they have a harder time disclosing rape or any unwanted sexual advances.

Ten focus group participants identified multiple minority statuses as an intervening condition. The following quote exemplifies how the different layers of minority statuses affected the support that LGBTQ people received around sexual violence:

> I was talking to a friend of mine who does HIV outreach work, and he was telling me that he met a handful of homeless transwomen of color but they could only stay so long at the shelter because of the racism in the shelter. Like I cannot live there because I got call the n-word too many times and because there are White supremacists walking up and down the street.

Focus group participants described the gaps in services in great detail, such as (a) limited LGBTQ-friendly health care services, (b) lack of adequate training at agencies around LGBTQ issues, (c) limited medical access, and (d) intake forms that are not LGBTQ-friendly. One participant shared her thoughts about some of the problems with intake questionnaires at local social service/medical settings: "Intake forms are very rigid. You have to write down your sex, and a lot of times there is not an option for someone to put down a name different than their legal name."

Survey respondents described other gaps and barriers to services:

> I think many agencies are less LGBTQ-friendly than they realize, simply by mostly talking about heterosexual relationships. When it comes to getting help, it is not automatically assumed that all providers will be welcoming. This can make it harder to take necessary steps.

Finally, focus group participants identified the degree of out-ness and the stage of transition for a transgendered person as an intervening condition for the phenomenon because some people might match in appearance more closely with the gender into which they are transitioning and therefore not be questioned in the same way as someone who does not easily pass as the gender into which they are transitioning. Similarly, focus group participants noted that when LGBTQ people are not out, it can be assumed that they are mostly associating with heterosexual people and therefore have no one to talk to if they are sexually assaulted within the LGBTQ community. For example, one participant made the following statement:

> I would want to know if the person was out for the simple fact that if the person is not out and say they meet someone on the Internet that sexually violates them, then who do they have to come back to? They don't want to tell their heterosexual friends that they met someone on the Internet who raped them. So you would want to know how comfortable they are with themselves as this will influence their ability to ask for help.

Current strategies to deal with sexual violence. In light of the context and intervening conditions described above, focus group participants reported that they believed the LGBTQ community had employed the following strategies to deal with sexual violence in the LGBTQ community: (a) minimizing behaviors, (b) taking precautions, (c) avoidance, and (d) staying within the LGBTQ community. Several focus group participants stated that they felt the LGBTQ community was doing things to minimize the recognition and impact of sexual violence by encouraging silence, rationalizing the violence, or joking about it.

Other focus group participants talked about precautions that they and others around them take to try and stay safe, like gaining more weight so that they might feel less vulnerable or targeted. Six focus group participants described the use of avoidance by the LGBTQ community as a strategy for dealing with sexual violence within the community. For example, one focus group participant said, "I think that there is definitely the sense that while people understand sexual violence can happen; they really don't think it will." Another focus group participant said, "I have heard of some gay people being assaulted, but it is not really discussed because maybe folks don't really think it happens." Finally, many focus group participants reported that discussing sexual violence within the LGBTQ community is an emerging strategy.

Consequences. The strategies used to deal with sexual violence in the LGBTQ community were not without consequences. The consequences that focus group participants mentioned most often were (a) guilt for sharing, (b) protect with secrecy, (c) feeling trapped, (d) increased isolation and feeling cutoff, (e) victim-blaming, (f) lack of support, and (g) self-degradation. These consequences are illustrated in the following quotes:

> I think a lot of the themes we have talked about deal with isolation and people having space. Eugene is a small city, and then in the queer community the space keeps getting smaller and . . . continually . . . smaller in different aspects. So part of it is about not wanting to lose support when you are already facing so much crap. How do you find people to even reach out to?

> The community is smaller and already struggling with so much oppression that any negative press is unwanted; thus, rape and intimate partner violence is sometimes hushed up since the very idea of LGBTQ relations themselves is controversial in our society.

> I think it's harder for us to talk about the bad things that happen in our community, which makes it even harder to find a solution.

Recommended strategies. An overwhelming majority of focus group participants emphasized the need for sexual diversity and sensitivity training across many sectors of society. Training should raise awareness about the impact of sexual minority status overall as well as its influence specific to sexual violence. Many focus group participants also remarked that training of this nature should be ongoing and would demonstrate commitment to justice among agency and community leaders. Training, many remarked, would lead to needed increased competencies among service providers: "Competent services are needed. Agencies need to educate and train staff on LGBTQ needs." Another participant stated, "Education to care providers about what abuse looks like in queer relationships, as well as the unique health needs of queer individuals, queer positive counseling, and availability of therapists is needed." Several others remarked that mainstream education should incorporate LGBTQ needs: "Better sex education that includes LGBTQ issues is needed. It [the curriculum]

should be more open about sexual violence; teach it in classes." And "LGBTQ persons should be included in general, and as a part of any conversation around sexual violence."

Other strategies recommended by focus group participants were (a) to understand violence in the larger context, (b) cooperative protection, and (c) increasing awareness with events. In terms of understanding violence in the larger context, focus group participants reported feeling that sexual violence should not be viewed in isolation but instead be viewed as being within larger cultural influences. One participant stated:

> The sexual violence stuff is not separate from the entire culture. So you have to look at what it means to grow up male in our culture. There is something, just something about that. What is the whole thing that is driving this violence?

Seven focus group participants introduced the concept of "cooperative protection," which meant a strategy of facilitating connection to, and responsibility for, each other's neighbors as illustrated in the following quote:

> And I think the need is, again, cooperative protection. That is one of the first things I realized 50 years ago that we had to make friends with our neighbors in our [LGBTQ] community in order to protect ourselves. What is needed is awareness that it is your responsibility to reach out and make solid connections within your small community.

Several survey participants extended the concept of cooperative protection and argued that society and agencies must develop a good understanding of sexual violence and LGBTQ needs and issues: "For LGBTQ survivors to feel safe reaching out, there needs to be somewhere they have heard about previously which they know understands LGBTQ issues as well as sexual assault."

Finally, many focus group participants recommended a strategy for increasing awareness about sexual assault against LGBTQ people through community events. They gave multiple examples of events that already take place within the larger community and also provided suggestions for other events. For example, one participant made the following recommendation:

> I went to a drag show that was here last year, and there was a really big turnout of not just gay people but heterosexual people as well. I think that it is not only a time to come together and do fun events but also a chance to address facts. Address things that are going on in your community because nobody wants to go to a simple LGBTQ meeting. I mean people have other things to do. But people will take the time to do something fun. An event where people can say, "Hey, let's get together, pull together and realize that sexual violence is out there in our community, so let's voice it out. If this has happened to you, let it be known."

Several survey participants believed that a key function of community events is to promote LGBTQ-safe services:

> Advertising that there are places and people in the first place who can and will help. There is a need for a higher profile for helping agencies that makes it clear that they have services specifically available to the LGBTQ community. Nobody knows these places exist or if they are safe.

Additionally, survey respondents had much to share about what they identified as the key characteristics, skills, and behaviors of an ideal health care provider. These characteristics included openness to diversity and valuing a diverse staff, an openness and awareness of the needs of LGBTQ community members, and a guiding belief that sexual assaults happen to queer people. Some of the behaviors and skills that survey respondents hoped that an ideal health care provider would have included the following: using language that is nonheterosexual (not assuming heterosexuality), obtaining accurate knowledge on sexual violence in the queer community, networking their practices into the gay community, posting queer-friendly symbols in the front office, continuing education and providing culturally sensitive trainings with a commitment to applying the knowledge, offering real and unbiased information about where to seek help, examining knowledge of their own privilege and baggage and then reexamining it, and understanding and working to overcome the barriers that prevent and discourage LGBTQ people from reporting violence.

Discussion

This exploratory study investigated the experiences and needs of LGBTQ survivors of sexual violence from the perspective of individuals who perceived themselves as familiar with the LGBTQ community. Several limitations should be considered. For instance, it is not known whether these findings represent the views of the majority of individuals who are familiar with and sensitive to the needs of the LGBTQ community. And certainly everything that could be said about the issues and needs of LGBTQ sexual assault survivors—even among the participants in this single study—is not captured in this data set. In addition, the data are largely one-dimensional; they do not tease out the many similarities and differences within the LGBTQ community. Despite these limitations, this exploratory study supports several previous assertions in the literature and provides a focal point for further examination.

The findings of this study closely match the existing literature with regard to (a) emphasis placed on overall discrimination and misunderstanding toward and about the LGBTQ community and the impact of those factors on sexual violence response, intervention, and prevention; (b) sexual violence not generally being discussed in the

LGBTQ community, perhaps largely because of the need to protect the community from additional discrimination; and (c) associated gaps and barriers in services for LGBTQ persons. Many survey and focus group participants, for example, reported that sexual violence is a problem in the LGBTQ community and believe that the problem is exacerbated by social conditions that force silence, breed denial, and thwart the development of and access to LGBTQ-friendly services.

Although 94% of survey participants agreed or strongly agreed that sexual violence is a problem in society overall and 72% agreed or strongly agreed that sexual violence is a problem in the LGBTQ community, many were not familiar with local efforts to prevent sexual violence in the LGBTQ community, and many (41.5%) believed or strongly believed that open dialogue specific to sexual violence in the LGBTQ community is not occurring locally.

This study also supports the ongoing need to understand the multiple identities held by members of the LGBTQ community and the impact of those identities on access to services, community relations, and sexual violence risk. As described by the NRCDV (2007), "LGBT people are not members of a monolithic community or unified culture. Each lesbian, gay, bisexual or trans individual holds membership in many overlapping communities that face similar as well as very different issues" (p. 1). In the survey portion of this study, for example, the largest between-groups differences emerged around gender and victimization status. Compared to their male and transgender counterparts, females were 2.8 times more likely to have used SASS services or to know someone who has, 3.1 times more likely to be aware of LGBTQ-friendly services for survivors of sexual violence, and 2.1 times more likely to see sexual violence as a problem in our society. Moreover, female respondents were 1.6 times more likely to see sexual violence as a problem in the local community, 1.4 times more likely to be interested in working for sexual violence prevention, and 0.6 times *less* likely to feel that local ER staff are well equipped to handle incidents of sexual violence in the LGBTQ community. Victimization status was also associated with significant differences. For example, when compared with nonsurvivors, survivors of sexual assault were 1.8 times more likely to see sexual violence as a problem in the local community.

Barriers to services expressed by participants also closely matched the existing literature (Bieschke et al., 2007; Kenagy, 2005; Lombardi, 2001). For instance, participants believed that members of the LGBTQ community cannot assume that services are LGBTQ safe and friendly, that services are not properly tailored for members of the LGBTQ community (e.g., services for males, inclusive language), and that cultural oppression and sanctioning of sexual minorities enforce silence. Finally, participants offered many recommendations, ranging from sweeping and foundational changes (e.g., reduce oppression of sexual minorities and eliminate the conditions that contribute to sexual violence) to feasible and immediately applicable ideas. Pragmatic recommendations included, among others, LGBTQ awareness training across health care provider and social service curricula, inclusive language in

agency paperwork, surveillance and advertising of organizations that are sensitive to the needs of the LGBTQ community, and recognition that agencies and agency staff are often not as LGBTQ friendly as they may believe.

Survey and focus group participants in this study highlighted the importance of changing attitudes about the LGBTQ community, increasing access to LGBTQ-friendly services, and developing and implementing LGBTQ-sensitive training protocols for key social and health service delivery systems. Research that evaluates the impact of training modules on provider knowledge, attitudes, and behavior is needed. Ristock (2005), for example, argued that cultural competency training should include same-sex issues, including domestic and sexual violence, and that LGBTQ-friendly practices should be incorporated into mainstream systems. We support this important recommendation and urge the use of program evaluation and participatory action research methods (e.g., Israel, Schultz, Parker, & Becker, 2000) toward measuring the impact of these efforts.

Notes

1. Many sexual minority people do not identify with any one of these labels.
2. The definition of *same-sex sexual assault* is the same as *heterosexual sexual assault*, with the exception that same-sex sexual assault involves a perpetrator of the same gender.
3. This study investigated sexual violence service issues for the LGBTQ population and same-sex couples. The researchers did not assume that all sexual victimization occurred in the context of same-sex relationships. For instance, a lesbian woman may have been sexually assaulted by a male relative and not by her female partner in adulthood.
4. Pilot survey data are not included in the survey data.

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