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Emily Katherynn Simpson & Christine A. Helfrich

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Oppression and Barriers to Service for Black, Lesbian Survivors of Intimate Partner Violence

EMILY KATHERYNN SIMPSON
Midwestern University, Downers Grove, Illinois, USA
CHRISTINE A. HELFRICH
Boston University, Boston, Massachusetts, USA

This narrative study identified service barriers from the perspectives of 16 Black lesbian survivors of intimate partner violence (IPV). Qualitative analysis revealed diverse interrelated barriers similar to those identified by service providers in a previous study by the authors, including societal barriers such as heterosexism, and institutional barriers such as ambiguous policy. Results indicate that the theory of intersectionality is best poised to frame an investigation of the complex barriers encountered by these survivors. Results also demonstrate that although these women desire to receive services, current inequities prevent them from accessing support and further endanger, victimize, and isolate them. Strategies for improving services and reaching culturally diverse survivors are also discussed.

KEYWORDS *lesbian, intimate partner violence, services, barriers*

INTRODUCTION

Marginalized groups of individuals have historically been excluded from important discourse on critical social problems. They have additionally been omitted from efforts to develop preventative measures to address these problems as well as from reactive measures to respond to the resulting crises. Nowhere is this more apparent than in the literature related to intimate partner violence (IPV), or as it has been historically known, domestic violence (DV). DV is used in this article to refer to literature of the past as well

Address correspondence to Emily Katherynn Simpson, Midwestern University, Occupational Therapy Program, 555 31st Street, Downers Grove, IL 60515. E-mail: esimps@midwestern.edu

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as to theory and social service and criminal justice agencies, while IPV is used to describe the phenomena between individuals using contemporary terminology (National Coalition of Anti-Violence Programs [NCAVP], 2013). The domestic violence (DV) movement arose from early feminist work to raise the social status of women and to protect them from what was commonly accepted as the control and power over their lives by men (Dworkin, 1974; Figes, 1970). As a result, the DV movement embraced feminist theory that explained violence against women as a result of patriarchy and gender oppression. Intervention was primarily aimed at providing shelter and safety to survivors while working through the criminal justice system to regulate and punish batterers (Erez, 2002; Walker, 2002). These efforts have raised awareness of a serious social problem and have provided safety to countless abused women; however, through omission and silence, the DV movement has also neglected and alienated many more women (Ristock, 2003). Early feminist theory was grounded in the experiences of predominantly White, middle-class women. Since the DV service delivery system developed primarily as a result of early feminist theory in the 1970s, women of color have not benefited in the same ways as White women from its resources (Martinson, 2001). This underscores the urgency in recognizing that the differences among the experiences of women vary greatly depending upon cultural, social, racial, and class contexts. Without considering the multiple identities of women and the cultures in which they exist, and instead focusing on the universality of women's experiences of abuse, the DV movement has created yet another structural barrier to equitable service delivery.

While few would argue that DV agencies and advocates do invaluable work and provide critical services to survivors, many researchers and activists have begun to challenge the movement to reevaluate its theories and to develop policies and practices that more adequately include marginalized groups of women and account for the differences within and between them (Bornstein, Fawcett, Sullivan, Senturia, & Shiu-Thornton, 2006; Powers et al., 2002; Ristock, 2003; Sokoloff & Dupont, 2005; Tower, 2007). As a result, a body of literature has emerged that examines the complicated intersections between systems of power and privilege, such as racism, sexism, heterosexism, and class privilege (Conwill, 2010; Gillman, 2007; Grant, 1993; Heyes, 2006; Lockhart & Danis, 2010; Mann, 2000; Putman Tong, 1998; Yuval-Davis, 2006). This same body of literature calls for more research to examine the experiences of survivors of IPV among oppressed groups (for example, women of color and lesbians), and warns that without the inclusion of these women's voices, research may only serve to perpetuate existing systems of power (Sokoloff & Dupont, 2005; Sorenson, 1996). To contribute to an understanding of the diversity among survivors, this article describes the barriers to service as experienced by 16 Black, low-income lesbians living in an underserved area of a large, metropolitan city in the Midwest.

LITERATURE REVIEW

Domestic Violence Theory and Research

Current DV policy and legislation are grounded in feminist theories that have historically defined DV as a manifestation of a patriarchal culture's sexual dominance of women (Figes, 1970; Millett, 1970). Early feminist DV theory insisted that, as the most pervasive ideology of our culture, sexual domination defines the concept of power, thus declaring the rights of men as superior to the women that they control (Figes, 1970; Millett, 1970). The assertion that the relations between men and women are not merely personal and private, but are inherently political, jumpstarted the feminist movement aimed at naming and criminalizing DV (Dworkin, 1974). In addition, radical feminism further strengthened these arguments by insisting that, globally, the most pervasive form of oppression is sexism and that the dynamics of this oppression can be seen in men's use of violence against women (MacKinnon, 1987). These theories have provided the foundation for the social recognition of, and intervention into, a global epidemic of culturally sanctioned violence against women. The resulting intervention has focused primarily on responding to crises and providing safety and shelter to survivors as well as using the criminal justice system to regulate and mediate violence within families and intimate relationships (Erez, 2002; Walker, 2002). Unfortunately, this theoretical perspective does little to explain violence within same-sex relationships (Renzetti, 1998; Ristock, 2003). Without a theoretical understanding to frame and validate the abuse, many DV agencies have remained uninformed about the prevalence of same-sex IPV and, as a result, have not effectively acknowledged or addressed it (McLaughlin & Rozee, 2001; Ristock, 2003; Simpson & Helfrich, 2005).

Despite research that suggests that lesbian IPV is as pervasive as IPV in heterosexual relationships (NCAVP, 2013), there continues to be a pronounced disparity in the provision and accessibility of appropriate services for lesbian survivors (Jones & Hill, 2002; Renzetti, 1996). In addition, much of the research that has examined this problem has focused on those lesbians who have been accessible to researchers (for example, women who have access to establishments of lesbian culture such as bars, social service agencies, etc.) and women who have the knowledge to seek out services. Unfortunately, this has resulted in the perhaps unintentional exclusion of lesbians living in rural communities, lesbians of color, immigrant lesbians, and lesbians who have fewer economic resources.

The problem of exclusion of oppressed minorities is not unique to research examining lesbian IPV. Current DV research and theory generally fail to adequately consider the differences between survivors of abuse, focusing instead on the shared experience of violence (Renzetti, 1998). The suggestion that all women are susceptible to abuse simply because they are women privileges gender as the lens through which the experience of abuse

should be viewed (Evans, 2005). For a woman who views her identity as being shaped by experiences other than just gender (for example, race or dis/ability status), current DV theory serves only to emphasize how various forms of oppression have been silenced by the dominant culture (Sokoloff & Dupont, 2005). Although gender and the patriarchal structures of contemporary society continue to remain critical to understanding the impact and experience of IPV, they should no longer be viewed as central to IPV discourse. If the DV movement does not progress into one that is pluralistic, it may cause difference to become invisible.

In response to the difficulties with traditional DV theory and the subsequent inequities in service provision, there is a new body of literature examining differences among women. This research suggests that an understanding of both cultural difference and social context are crucial to providing relevant services and reaching underserved women in all areas of social service delivery (Barnoff & Moffat, 2007; Jiwani, 2005; Moore, 2011; Potter, 2007; Renzetti & Maier, 2002; Swan & Snow, 2006). This research reveals that women claim multiple identities and also experience multiple types of oppression, sexism being only one of many factors that influence women's stories of IPV. As a result, it is most appropriate to consider the relationships among race, class, gender, and sexual orientation from a frame of reference grounded in the theory of intersectionality, without privileging any of these characteristics as the most important to an understanding of IPV (Nixon & Humphreys, 2010). The resulting model of practice within social service agencies that incorporate this perspective is the anti-oppression framework (Barnoff & Moffat, 2007; Campbell, 2003). Although not yet routinely used in program development for DV agencies within the United States, its use as a practice model within the field of social work has been noted to be successful (Barnoff, 2001).

Domestic Violence Services

The literature reveals a disparity in the provision of services among heterosexual and lesbian survivors of IPV (Eliason, 1996; Giorgio, 2002; Jones & Hill, 2002). Most often, service providers conduct screenings for IPV using heterosexist language that alienates lesbians and encourages both client silence and clinician ignorance (Hammond, 1989; Renzetti, 1996). It is often difficult for lesbians to receive appropriate health services and referrals. In addition to the barriers imposed by emergency and primary health care services, shelter and transitional services are also typically provided for heterosexual survivors of IPV (Peterman & Dixon, 2003; Renzetti, 1996). Thus, even if referrals are provided, services are rarely available specifically for lesbians, and when they are it is often difficult to access them (Jones & Hill, 2002). As a result of the limited number of agencies that specifically serve lesbians (NCAVP, 2013), these women must turn to DV agencies that

serve predominantly heterosexual women. Although not entirely excluded from the services available at these agencies, lesbians face barriers that prevent them from accessing services freely and safely such as discrimination, stigma, sexual orientation disclosure issues, and the potential danger of being exposed to further violence (Girshick, 2002; NCAVP, 2013; Renzetti, 1992; Simpson & Helfrich, 2005).

Consistent with the theoretical suppositions of intersectionality, there are additional barriers that result when a lesbian, who is oppressed by the heterosexist society in which she lives, is also impacted by other forms of inequality (for example, racism, class privilege, or disability status) (Butler, 2005; Sokoloff & Dupont, 2005). Although IPV certainly affects all women, there is research to suggest that it may not affect all women equally. For example, Browne and Bassuk (1997) found that a large number of homeless women were survivors of IPV and Lyon (2002) revealed that more than half of women receiving government assistance were also survivors of IPV. Other research has demonstrated that poverty is highly predictive of violence against women (Feldman & Ridley, 1995). This indicates that perhaps IPV has particularly severe consequences for low-income women. In addition, ethnic and racial minority members' negative experiences with the dominant culture's social institutions influence their views of service accessibility (Jiwani, 2005). For example, women of color are often fearful of the criminal justice response to DV and worry that using the services of this institution may result in additional victimization or in their partners being subjected to racism, discrimination, and violence (Potter, 2007; Sokoloff & Dupont, 2005; Williams & Becker, 1994). Since this is also a concern for lesbian survivors who worry that both they and their abusive partners will be victims of an abusive legal system, it is likely that such fears are compounded among lesbians of color.

Although lesbians, women of color, and other groups of survivors experience barriers to service, each group also has access to protections and supports that are specific to its cultural norms. These factors are crucial to an understanding of women's varied experiences of DV. For example, Potter (2007) identified spirituality as a particularly important factor in mediating the experience of abuse for Black women. Although Potter's findings suggest that religious institutions are frequently unsupportive of Black survivors of IPV, the results are significant in that they emphasize the nontraditional ways that this particular group of women looks for support. Similarly, Ellison, Trinitapoli, Anderson, and Johnson (2007) revealed a correlation between religious involvement and reduced rates of DV within American households. The results of this study also demonstrated that church attendance was a significant protective factor against DV in Black and Hispanic relationships. Both of these studies reinforce the need for service providers to not only acknowledge and tolerate diversity, but to actively seek to understand diversity within and between cultures. Although there

are many conflicting definitions of the term *cultural competency*, in general it must become an expectation within social service agencies that diversity is valued and that multiculturalism is embraced (Lum, 2005). Consistent with the presumptions of the theory of intersectionality, it is not expected that culture, race, sex, class, sexual orientation, religious affiliation, or any other single factor may explain the prevalence and dynamics of IPV within the respective groups of women; it is an understanding of the relationships between these factors that enables a contextual understanding of DV (Bent-Goodley, 2005).

Gaps in the Literature

With a few notable exceptions (Nixon & Humphreys, 2010; Renzetti, 1992; Ristock, 2003), research into IPV in same-sex relationships has only really begun to appear in the literature during the past three decades. This research has examined a variety of issues, including prevalence, dynamics, theories, personal characteristics of batterers and survivors, and access to services (Burke & Follingstad, 1999; Giorgio, 2002; Girshick, 2002; Renzetti, 1996; Renzetti, 1998; Ristock, 2003; Simpson & Helfrich, 2005; Tjaden, Thoennes, & Allison, 1999). All deserve additional attention. Since service receipt is strongly affected by accessibility, knowledge, and perceived quality, and women's safety and health are linked to successful acquisition of services (Sokoloff & Dupont, 2005), it is particularly important that this topic be considered a priority for study.

Despite the improvements in investigation of the issues described, the literature remains largely uninformed by the voices of the women who have experienced abuse. There continues to be a need for qualitative research to shed light on the complex lives of survivors (Bent-Goodley, 2005; Bornstein et al., 2006; Giorgio, 2002; Potter, 2007). The majority of the studies conducted on IPV in lesbian relationships have used quantitative methodology, which, although valuable, does not allow for the rich examination of individual perspectives that qualitative methodology does (Creswell, 2014). In addition, research must also include the voices of those women most marginalized by society: women of color, women with limited income, disabled women, and immigrants. In order for emerging DV theory to adequately address the complicated impact of oppression, and thus influence systems and agencies to adopt an anti-oppression framework and improve cultural competency and diversity awareness (Lum, 2005), research must include those women that it seeks to represent (Bent-Goodley, 2001; Sokoloff & Dupont, 2005). In response to these documented needs in the literature, this article describes the experiences of 16 Black, low-income lesbian survivors of abuse. The purpose of this study was to identify and describe the barriers to service among a marginalized group of women and to reveal their recommendations for improved service accessibility and outreach.

METHODS

A narrative design was chosen based on both the gaps noted within the literature as well as the researchers' intention to collect information from the perspectives of an underserved population typically excluded from research on the topic of interest. All study procedures were approved by the University of Illinois at Chicago Institutional Review Board and data were collected in 2010. Two collaborating agencies assisted the researchers with the development of the interviews used in data collection. They also provided assistance initially with recruitment. Both agencies were located in a large, urban, Midwestern city. One provided comprehensive services to survivors of DV and the other was a lesbian, gay, bisexual, transgender, and questioning (LGBTQ) social service agency with an antiviolence project aimed at providing referrals and mental health assistance to survivors of all types of interpersonal violence.

Initial inclusion criteria for participation were as follows: ability to speak English, involvement in at least one same-sex relationship that was abusive as defined by the Illinois Domestic Violence Act (Illinois Coalition Against Domestic Violence, 2009), and self-identification as lesbian or bisexual. In addition, in order to ensure safety, once a woman met these criteria, the researcher conducted a brief screening to determine her status as the abused partner. The screening tool was created with assistance from the LGBTQ agency and included questions related to control and power within the relationship. Overall, 21 women were initially recruited to participate in this study using convenience sampling. One participant was removed from the study due to screening that revealed that she was the abusive partner in her relationship. Four women were recruited through the LGBTQ agency and were receiving services for IPV at the time of the interview. Three identified as White and one as Hispanic. When compared to the 16 Black women using disconfirming case analyses (Depoy & Gitlin, 2005), it was determined that they differed significantly in their experiences with services. Each of these four women were in a higher income bracket, had access to and knowledge of services, revealed themselves to be active members of a lesbian community, and lived in an area of the city in which there was a greater acceptance of LGBTQ culture. As a result of these differences, the four women are not considered in the resulting data analyses but are presented here because disconfirming cases enhance the rigor of qualitative analysis (Creswell, 2014).

Data Collection

Participants were interviewed in a private office at the researchers' university, at the agency of referral, or in a private room at a local library to accommodate for safety and inability to travel. Participants were reimbursed with

a small gift card to help offset expenses related to travel, day care, and time off work. Each participant gave written informed consent prior to participation. Interviews lasted between 60 and 90 minutes and were audio taped for transcription. The interviews were conducted in person to establish rapport and to promote comfort in discussing issues of violence, discrimination, and access to and provision of services.

Data Analysis

Data collection and data analysis are fluid, interrelated processes in qualitative research (Creswell, 2014). Approaching the processes in this way permits flexibility and adaptation throughout a study, thus enhancing its relevance to the population of interest. Both processes occurred simultaneously throughout the duration of this study so that initial analyses could inform additional data collection. For example, analysis of initial interviews consistently revealed lack of access to information as a barrier to services, so as a result, researchers modified recruitment efforts and venues to reach a wider audience. Thus, although data collection and analyses are presented separately, in actuality, they did not occur as a linear process.

Researchers used a constant comparative method of analysis to simultaneously code and analyze the data between participant interviews (Charmaz, 2014). This method was employed continuously in order to allow for transcripts to be read, reread, and coded for themes based on patterns and counter-patterns (Creswell, 2014). To further enhance rigor, several methods of peer review were also employed. Once relationships had been established, themes were identified and defined. The review process then culminated in a thorough examination of the findings and recommendations for enhancing reflective analysis (Charmaz, 2014). Finally, to complement the peer review process, 3 of the 16 participants (~20%) were re-contacted to examine the researchers' interpretations of the data and initial interpretations were subsequently validated. Ideally a greater number of women would have participated in the process; however, a variety of factors caused difficulty maintaining contact (for example, transience or return to abusers). The reality that less than 20% of the original sample could be contacted further emphasizes their marginalized status in the community.

RESULTS AND DISCUSSION

In addition to the methods of data analysis described, it is important to note that, following the first level of data analysis, it became evident to the researchers that the women identified overarching barriers to receiving and seeking service that were similar to those identified by service providers in a study previously conducted by the researchers (Simpson & Helfrich, 2005).

After these similar themes were identified, an additional level of analysis was conducted comparing current participant responses to those responses of the service providers from the previous study. This confirmed the similarities between groups on major themes. Without providing this information to the initial peer review team, the peer reviewers generated nearly identical themes from their analyses. Thus, these themes became the structure by which additional analyses occurred. Ultimately, as was the case with the service providers, analysis of participant responses revealed the following categorical barriers to service: (1) societal barriers and (2) institutional or agency-specific barriers. Although the themes were similar, the ways in which the women addressed each were quite different from the service providers as were the various subthemes that defined each theme. This difference serves to strengthen the understanding of the diverse experiences of the women and provides a context in which to understand why service providers cannot treat all survivors using the same approach, thus illustrating the utility of the theory of intersectionality in understanding IPV.

Participants

It is important to note that in this particular urban area, neighborhoods are still sharply divided by demographic characteristics. For example, the highest concentration of both LGBTQ services and residents is located on the north side of the city. The north side also tends to be predominantly Caucasian and of higher socioeconomic status. Both the south and west sides of the city are more densely populated with racial and ethnic minority groups. There are also higher rates of crime, poverty, and violence in those parts of the city. All of the participants in this study resided on the south and west sides of the city. All 16 of the women identified as Black and were between the ages of 26 and 53, with an average age of 39. Three of the women identified as bisexual, and 13 as lesbian. Only one woman, the youngest at age 26, had never been in a relationship with a man. Five of the women had been married at least once to a man. In Illinois, the state in which the participants resided, same-sex marriage did not become legal until 2014; therefore, none of the participants were currently or previously married to their female partners at the time of the study. In addition, all women reported having been abused by at least 1 female partner and 10 of the women also reported abuse by at least 1 man with whom they had an intimate adult relationship. Nine of the women reported being currently in relationships with their abusive female partners. Only four of the women had no children; the remainder had between one and six children, with an average of two. Minor children's ages ranged from less than 1 year to 17 years old. Only two of the women currently had custody of their minor children.

The women's income ranged from $0 to $800 per month with an average income of $258 per month. Most women received some sort of public

funding, with the majority being subsidized housing and/or food stamps. Only two of the women were employed at the time of the interview. One woman had received an associate's degree in business, eight women had completed some college, and three women had participated in vocational training programs. The remaining four women had not completed high school. The women had held a variety of types and numbers of jobs in the past, ranging from housekeeping, telemarketing, day labor, maintenance, truck driving, and retail to nursing aide, personal attendant, and case manager. None of the women reported having even brief histories of stable employment. At the time of the interview, five of the women were staying in short-term shelters; six were living independently or with children in low-income housing, two were living in apartments with their abusive partners upon whom they were financially dependent, and the remaining three were living with relatives. Women reported between zero and four medical or psychiatric conditions, with the average being one. The most common conditions were depression and substance abuse. Since this number is lower than that which is frequently reported in the literature (Humphreys, Lee, Neylan, & Marmar, 2001; McCauley et al., 1995; Roberts, Lawrence, Williams, & Raphael, 1998; Woods, 2000), it is likely that the number of medical conditions was actually higher, but reporting may have been influenced by the women's lack of access to and use of health services. For example, at the time of the interview, only those women living in shelters reported any current use of medical or psychological services. It is also possible that a lack of trust affected the women's willingness to disclose information about illness.

Barriers to Service

The participants discussed diverse barriers to accessing and receiving services for IPV. The barriers represent the occurrence of problems at every level of service delivery and also within the larger social systems of American culture, ranging from the lack of preparedness of agency staff to the ambiguity of organizational policy, and the multiple layers of oppression within society that both contextualize the women's experiences and impact the responses of the service delivery system. Refer to Figure 1 for an example of the complicated interactions between barriers. Although interrelated and difficult to delineate, the barriers identified by participants will be discussed separately to emphasize how each barrier, through its individual variance and complexity, serves to compound the overall difficulties faced by lesbian survivors. These barriers include the following:

- Societal barriers: those resulting from the multiple oppressions within society and its cultural, political, religious, and social systems. These barriers are compounded by the intersections between them (for example, a traditional avenue of support such as the church may become a dangerous

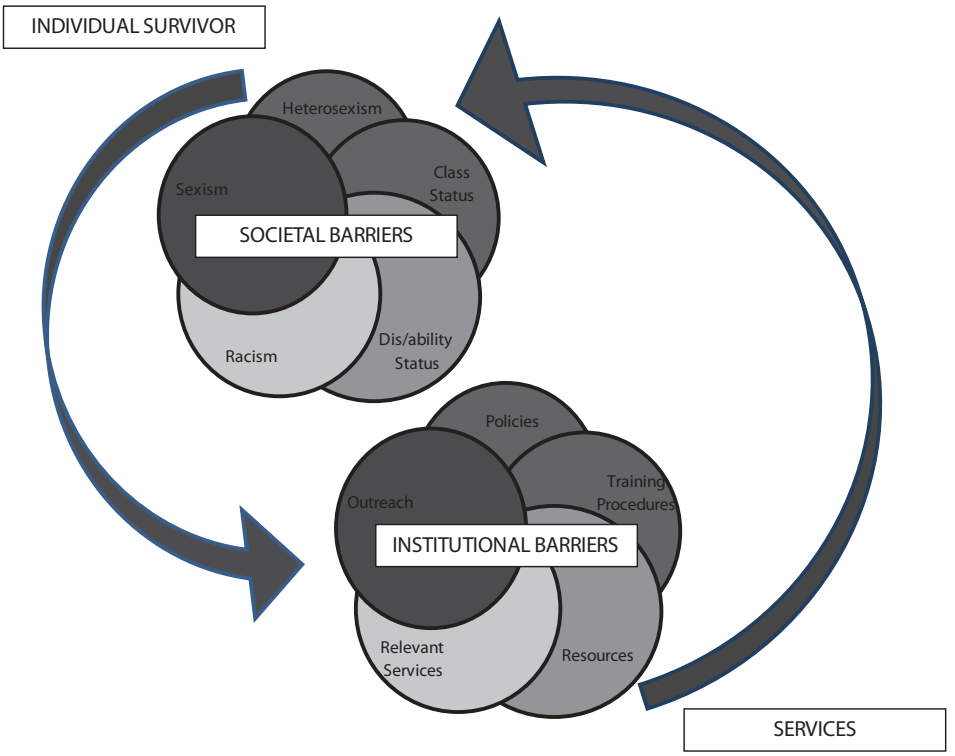

FIGURE 1 Intersecting barriers to service.

option for a battered woman who is impacted by the sexism, heterosexism, and even racism that she may find in her religious institution). All of the obstacles were identified by participants as being prevalent in the systems that govern and regulate individual well-being (for example, the criminal justice system, the welfare system, housing, health care, and social services).

- Institutional or agency-specific barriers: those resulting from the policies, training procedures, resources, and services of DV and other service agencies, including hospitals, mental health centers, homeless shelters, and rehabilitation services.

Societal Barriers

In addition to the concrete barriers identified by participants when they attempt to seek support or to make the decision to seek support, they acknowledged a series of more abstract, societal barriers that ultimately influence all other policies and individual biases. These barriers are a result of the multiple oppressions within society and its cultural, political, religious, and social systems. Not all of these will be discussed discretely here, but they were

identified to include heterosexism, socioeconomic and class status, sexism, racism, and/or disability status.

All of the women discussed how heterosexism influenced their choices in obtaining support and ultimately how homophobia was the most pervasive and powerful obstacle to their safety. They identified it as being so pervasive that they often felt vilified and powerless. For example, many of the women identified their traditional avenues of support as being off-limits for assistance with IPV because of homophobia. All of the women talked generally of the homophobia within their Black communities. Destiny described that, although there were some shelters in her neighborhood, she had chosen to seek help in another area of the city in order to feel safe.[1] She said the following:

> I probably shouldn't [have] been on the west side 'cause the [neighborhood] could be dangerous... if I run into someone in the shelter and they thought I was having a relationship with a woman... so it was best for me to get off that side 'cause [no one] could see me and know where I was.

She felt that she had to leave the neighborhood in which she had always lived in order to access support because of how homophobic her community was. Sarita also described this, saying that she sought help in an area of the city (the north side) that has a concentrated LGBTQ population. Although she had to travel very far to access services, she said that it was the only option, because "them being located on the north side, they see a lot of different type of people with different gender preferences... and seeing that they're educated, they deal with it much better and safer." She felt there was no safe alternative within her own community and then felt isolated and out of place in this unfamiliar part of the city, where she described lesbians as "being very, very different here—like okay with being lesbians and lettin' everybody know." This increased her discomfort and further alienated her from her own community.

Many women further described how, within their low-income, Black communities, homophobia is both acceptable and visible. As a result, they felt that they couldn't get support from their friends and family for IPV and that just being open about their sexual orientation might endanger them. Billie described how she felt that she couldn't share her experiences with her family or friends because they

> [t]alk down to you, talk about you, when you in a gay relationship, and you really can't talk to them because you can't be your true self.... My friends and my sister, they don't like if I'm with a woman, so how am I gonna tell them that a woman is hurtin' me?

Natalie described how her sister was ashamed to be seen in public with her as a result of her masculine appearance:

> I had problems with my own sister where we would be on the bus together and she would sit off away from me. And I said, "Why do you always sit over there?" and she didn't want no one to think we were together because of how I look—like maybe we were girlfriends.

Carlynda did not talk about feeling physically unsafe but did voice her frustration with feeling that there was no one to help her. She also said that, as a lesbian within her Black community, "It makes me feel lost and [I'm] just the outcast . . . there's no help." Stephanie emphasized the differences between neighborhoods in her city, saying,

> There's more gay people on the north side . . . I'm in a Black neighborhood on the west side and we all know that Black communities are less accepting . . . when I go up north, I see gay people just walking down the street holding hands not afraid of nobody.

Already isolated by race and income from the larger American society, these women described how heterosexism has isolated them even from their own communities.

In addition to the lack of community support due to homophobia, the women also talked about feeling isolated and alienated from their strongest source of emotional support, the church. Abby said that she had wanted to talk to her pastor when "things had gotten to a point where I needed to talk to somebody and usually I had a church as support system but the churches that I go to, you can't discuss this with them . . . [because] it's a lesbian relationship." Destiny also referred to the homophobia within her religious organization, asserting that Black Christians are largely homophobic and "scared to death of gays. It's all about hell and never about understanding. How can I get help here and it's sad . . . 'cause this is where I want it most." All but two of the women discussed the impact that the church had in their lives and felt that spiritually they needed to continue to attend church to feed their faith. Despite this need, they also felt frightened by perceived intolerance for their relationship choices and, as Sarita said, "My preacher is my healer and he wants to heal me from my being a lesbian but doesn't want to heal me from the pain of being abused . . . because that's my punishment." She was one of only a few women who had even considered revealing her sexual orientation to a pastor or congregation. Most of the women didn't view it as an option.

Women also discussed the impact that their socioeconomic and class status had on their ability to access support. Bonita said that the police did not take any DV seriously because of the severity and frequency of other

crimes within her community. About the housing project in which she lives, a notoriously high-crime area, she said, "For me, living in [a housing project], you call the police and [if] it's not nothing really serious then they don't care about nothing like that." Jira felt that poverty prevented her from being able to choose services that would support her and her children, and as a result limited her to services which did not suit her needs:

> I've kinda looked into some . . . resources, of, like who do you go to? . . . I don't have insurance, so that poses a problem. So as far as like counseling and stuff like that . . . I don't have the finances to be able to afford it.

She also described how, when she would call the police, her partner would leave and so the police would inform her that her safest option was to change the locks on her home, something which she could not afford, and so her abuser continued to return. Natalie described how, while living with her partner, she would call the police when her partner was violent and falsely accept responsibility for the abuse so that she could "spend the night in jail just to have a place to go." She said that otherwise, her partner would force her to leave and, since she was poor and "didn't know anything," she would have no place to go but the streets. Both her poverty and her lack of education impacted her safety and potentially her criminal record.

The women discussed how sexism also influences society's view of DV, both in heterosexual and lesbian relationships. Jira said that female victims are viewed as "crackheads, drug addicts, alcoholics. [IPV] doesn't happen to the girl that goes to church. It doesn't happen to the good girls. If you were a good girl, it wouldn't be goin' on." She said that this stereotype is even worse when both the victim and the perpetrator are women, noting that society thinks that the violence is acceptable because "women are emotional, crazy people." Other participants talked about how stereotypes about women impact whether or not the violence is taken seriously in a lesbian relationship. Carol described how police have responded to her attempts for help by not taking the "altercation serious, 'cause the first thing they wanna know is why you ain't take care of your business . . . this here society do not take women same-sex gender relationship as a relationship." In reflecting on this, she felt that the police officers were influenced by the view that women cannot harm one another. Bonita saw this attitude in society as well, saying that people "think it won't fly, women being women, women are more gentle to each other, we know each other," and as a result, Bonita saw sexism as preventing society from taking lesbian IPV seriously.

Even the women themselves reported having used sexist stereotypes as a rationale for staying in abusive relationships. To explain why she stayed with her abuser for so long, Billie said that she convinced herself that "I got a better chance of protecting myself with this one since she's another woman . . . . She can't whoop me or beat me like [a man], 'cause I can't whoop

a man." She was so conflicted by the reality of the abuse and the stereotype of women as non-violent that she remained in a dangerous relationship. Sarita also described this, saying that for some reason "I mean, yeah, I'm hurt, I'm abused, I know she's hurting me, but the threat was not as intense as with a man . . . it's really sick." She acknowledged that her thoughts were irrational, but the influence of stereotypes was too strong for her to resist at that time.

Some of the women were able to compare the lack of support as abused lesbians to experiences in which they had been abused by men and noted the difference in acceptability as a result of both heterosexism and sexism within their communities. Sarita described what happened when she called the police when her male partner abused her:

> They seemed more helpful and aggressive towards making sure I was okay . . . . It was more like they . . . knew what they were doing in regards to domestic violence . . . with my girlfriend, they [acted] like I was stupid or something . . . to let her beat on me.

Some women talked about the intersections of oppressions in their lives. For example, Billie talked about her hesitation to call the police to report her abusive partner because of what she perceived to be both the pervasive racism and heterosexism within the criminal justice system. She felt that her partner would experience discrimination or abuse as a result of being a Black lesbian. She described how once, when she did call the police, her partner reported to her that the officers had "been jabbin' at her . . . in the car, they disrespected her. Like, [asked her] what kinda sex ya'll have." Natalie also described how being Black, poor, and gay had resulted in her being mistreated by the police. As a minor, she had lived with an abusive older woman in order to remain off of the streets. Once, she called the police when she was being abused and she said that the officers hadn't liked her attitude and so they had "pulled me, you know, slammed me against the floor, handcuffed me and took me to jail . . . and these were men officers that did this to me because I was a lesbian . . . no respect, I mean a woman is a woman." Sarita talked about how services failed to consider her multiple identities and that she had to seek services for each problem from a different source:

> You offer me this place over here for mental illness. Then I go to this domestic violence shelter . . . that's not helping me with my mental illness . . . . So, I go back over here [mental health agency] so at least they can monitor my meds.

She talked about how having to prioritize her personal problems in order to receive services negatively impacted her health and she wished for more

comprehensive services to address all of the problems that she experienced as a Black, poor lesbian with a mental illness.

Although not all women talked about each societal barrier, they did all acknowledge that their isolation and inability to access services was in some way a result of their oppression by society, whether for being Black, lesbian, poor, disabled, or a combination of these factors. While each of these barriers has been presented separately, most of the women experienced them simultaneously. The women were each aware of the contextual factors that exacerbated their situations and all had begun to question how so many societal barriers to health, wellness, and equity of services could be effectively addressed. Each woman also explicitly stated that nothing can truly change until society changes its perception and treatment of individuals who do not conform to mainstream culture. So, although the majority of the women did not directly articulate the multiple identities that they claimed or the complexities that resulted from being oppressed in a multitude of arenas, they each demonstrated frustration with feeling that they had to make choices about who they were at particular times in order to get what they need. They typically chose one aspect of identity at a time in order to avoid conflict or mistreatment. This speaks to the complex relationships of our identities as humans and to the role that the theory of intersectionality could play in responding to alienated and fragmented individuals.

Institutional or Agency-Specific Barriers

The women talked at length about the barriers that were created by the policies, training procedures, resources, and services of DV and other service agencies, including hospitals, mental health centers, homeless shelters, and rehabilitation services. While acknowledging that institutions are impacted by societal norms, the women also described how they have both a moral and social responsibility to make their services accessible to everyone. So, although shaped by societal barriers, institutional barriers were seen by the women as less acceptable and more immediately able to be affected by change.

Perhaps the most significant institutional barrier, one that was identified by every woman, was the overall lack of outreach to both lesbians and women living in underserved communities. Despite the fact that their city houses one of the most comprehensive LGBTQ social service agencies in the country with an Anti-Violence Project, only three of the women had any knowledge of the agency's existence. Many of the women speculated that the agency confined its outreach efforts to a particular part of the city, one in which there is a high concentration of LGBTQ individuals. Sue said,

> I'm an inner-city type of person . . . I don't hear too many things about lesbians. I used to look for places where I can go . . . but I never really

> hear of anything that could actually help of that type. I don't hear anything of services for lesbians.

Edna said, "I [am] just now hearing about this place today. I don't know if it's advertised, but I haven't heard about it. And if I had, I would've called there." Tanisha described how there had been multiple opportunities for her to receive a referral to a LGBTQ agency, and that in fact, she had even requested it. However:

> It was never mentioned . . . I didn't know anything about those places. On the north side, you [might] see a lot of little things . . . that cater to lesbians and gays, but I didn't think that they would serve me . . . I didn't know what the services were.

As a result, she remained isolated from other women with similar experiences, something all of the women said would have helped them heal from the abuse.

Although most of the women blamed the lack of knowledge of services on themselves, they all agreed that if there had been advertising for services, they would have been more likely to use them. Bonita reflected on her past abusive relationship, saying, "I wish I had known it was information for us and a place to go . . . so that would've helped and it's gonna help 'cause now I'm gonna get more information." Tanisha said, "I have friends living on the south side, the west side, never even heard of no nothing . . . they may have one lesbian bar . . . [not like] the north side with all those bars!" Many of the women noted that since they did not have other lesbian friends or participate in LGBTQ cultural activities they probably missed any advertisements for services, believing them to be posted in gay bars and clubs. Stephanie said, "I like to read the paper [but] they post it in the clubs . . . I don't go out that much, so if help exists, I haven't heard of it."

Carlynda also described how not being a member of a lesbian community likely prevented her from finding out about services, saying, "I haven't been a lesbian all my life . . . I've never been to gay clubs, or haven't been in the lifestyle like that to know other gay people." As a result of the women's isolation and lack of identification with lesbian culture, they were unable to find information from typical LGBTQ sources and so felt that an LGBTQ agency had an obligation to provide outreach to areas of the city that were less obviously populated by LGBTQ individuals. The failure of these agencies to adequately target diverse clientele is yet another example of how identity politics can hinder even the most altruistic efforts. These agencies seem to have made the assumption that they would target LGBTQ individuals who identified themselves primarily by their sexual orientation and failed to recognize that factors such as poverty, ghettoization, class, and race complicate the ability of many women to create a single identity. Nor is it desirable to

many LGBTQ individuals to be classified in one way. This also illustrates the intersection/overlap of barriers identified by the women.

In addition to the barriers presented by the LGBTQ agencies' lack of effective outreach, the women also described how DV and other social service agencies did not do enough to advertise the inclusiveness of their services. Most of the women felt that traditional DV agencies either would not serve them or would discriminate against them as a result of their sexual orientation. This was viewed as an institutional barrier because the agencies did not explicitly state that they served lesbians. All of the women reported having seen television commercials and pamphlets on DV, but none of them felt that the services described were for lesbians. Trinity assumed that the services advertised were for heterosexual women only because "they don't talk about gay or lesbian [people], they have nothing in there for people that are in the same sexual relationships." Abby described similar feelings, noting that "There could be a place right around the corner but because [you think] it doesn't service lesbians then you have to find another place that you might not be able to get to, so what you do is nothing." As a result, she recommended that "there should be more outreach outside of the quote unquote gay community because everybody lives in different geographic areas." The women's lack of access to information is a result of a variety of factors, one of them being an institutional failure to effectively provide outreach to and advertising for lesbian survivors. Again, among other things, this relates primarily to a failure to consider difference and diversity among survivors. The over-reliance on the idea of the universal experience of abuse has caused that experience to have a singular identity.

Additional institutional barriers included such things as ambiguous policy (for example, not defining guidelines on relationships between victims in shelters). This allowed for staff to interpret situations in an inconsistent and often discriminatory manner, forcing lesbians to leave shelters for fear of intimacy or endangering children. Natalie said that any time she was alone with another client in the shelter, others assumed that they were having sex and that rumors were started and never dealt with by staff members. She said that not only did this make her feel conspicuous and unsafe but that it likely led to her getting discharged from the shelter prior to her established exit date. Also, agencies failed to establish and enforce guidelines for treating all survivors with dignity and respect, which often resulted in staff and other clients using derogatory language and intimidation to alienate lesbians. This included a lack of respect for confidentiality, which many of the participants prized since they had not disclosed their sexual orientation for fear of further victimization. Sue worried that people in positions of authority allowed their biases to influence agency policy, saying that "people that's in charge . . . have something to say about it and so we have problems with . . . everybody else." Her recommendation was that administrators be properly trained to avoid discrimination.

In addition, the women perceived that staff members were not trained properly by their agencies to communicate effectively with diverse clients. They identified heterosexist language as being a significant barrier, one that should be addressed by agency policy. Many of the women described how staff members made the assumption that their abusers were male, and as a result, the women felt that they could not disclose the truth. For example, Edna said that a social worker at a hospital had referred to Edna's abuser as a "he" and Edna said, "If she would've asked me, I would've told her because I'm not ashamed of my sexual orientation . . . . But that really made me not want to tell her because I didn't want her to not help me." All of the women described similar incidences in which a staff member's use of heterosexist language made them feel that they could not disclose the truth about their relationships. Women felt that the lack of training was particularly evident within the criminal justice system and described a variety of responses by police officers, ranging from a lack of knowledge of appropriate referrals to insensitivity and abuse and also to a lack of understanding or disregard for the law. For example, Billie described an incident in which the police witnessed her partner physically assault her, and then arrested and charged her partner with disorderly conduct. Billie said,

> I just wonder why it wasn't domestic . . . I thought it would be a [charge] of domestic violence and the next day she came home and they didn't give me a court date, so if I wanna go to court, I have to find out when she's goin' . . . . I don't think the [police officers] even knew they coulda charged her with domestic violence.

Billie did not have knowledge of the law, but from her perspective, neither did the responding police officers.

The women noted many barriers created by ineffective agency policy and felt that this made it more difficult for them to receive help when they needed it. They also recognized that the policies of agencies were influenced by societal barriers but had little tolerance for the negative ways in which agencies handled this. Overall, the women saw it as the responsibility of social service agencies to challenge the oppressions of society and to develop programs and services to reflect this. In this way, they felt that they, as Black, poor lesbians, would have safe and equitable access to the services that others routinely do. None of the women desired specialized treatment, only equitable treatment. All of the women wanted the opportunity to define for themselves who they are and what aspects of their identities are most important or relevant to their situations at a particular point in time. Although they didn't want to be treated differently, they wanted their differences to be valued.

CONCLUSIONS

This study was limited by the small geographic region in which participants resided. Although homogeneity of the sample was desired, there were other areas of the city in which Black women with limited resources were also clustered. Since proximity to resources and individual attitudes within service agencies impact the experiences of IPV survivors, it is possible that sampling from other neighborhoods may have influenced the findings. In addition, only three participants were available to provide input on the initial findings. Follow-up interviews or greater participation in member checking could have helped to clarify and validate the findings. Finally, because of the screening conducted to exclude batterers, it is possible that some survivors may have been unintentionally eliminated from participation.

Ultimately, the results of this study strengthen the findings of Simpson and Helfrich (2005) in that both service providers and consumers view the difficulties with accessing services similarly. It is irresponsible to simply blame the complicated nature of IPV in minority groups on the individual prejudices of staff members or the reticence of survivors. This study has revealed that the larger social structures and institutions compound the difficulties faced on the front lines of DV survivorship and service provision.

This study also revealed that multiple aspects of identity influence and shape women's experiences of abuse. In addition, responses to abuse and help-seeking behaviors are equally impacted by the complicated interplay of characteristics of women's personal identities. Although there are many schools of thought on the specific relationships between systems of oppression that conceptualize one system or another as being particularly problematic (Collins, 2004; Evans, 2005; Sokoloff & Dupont, 2005), this study revealed that women experiencing multiple types of oppression ultimately perceive their oppression as being influenced by many social factors, without necessarily privileging one system over another. This underscores the need to tailor services to meet individual needs and to adopt client-centered approaches that consider the unique goals and experiences of very diverse clientele. For example, whereas one survivor may determine that her church is the most appropriate place for her to receive help, another may perceive the church as particularly oppressive and may wish to receive help from informal supports, such as family members. In both cases, service providers must work to meet the needs of clients by helping to create safe spaces for them to explore support options. This approach may encourage other hesitant survivors to believe that their individual stories and needs will be appreciated by service providers.

In order to move forward in improving services, efforts must emphasize outreach and cultural competency as the key areas to address. This is a call

for service providers to improve cultural competency, make more effective and informed efforts to reach diverse groups of underserved women, and to commit to actively working to challenge and change societal barriers such as racism and heterosexism. There is an overall need to approach the provision of services, both within LGBTQ agencies and DV agencies, from an intersectional perspective and to apply an anti-oppression framework to practice. It is not enough to merely acknowledge that these intersecting oppressions exist. As advocates for survivors of abuse, it is imperative that this knowledge is reinforced by deliberate engagement in efforts to reduce the impact of these oppressions within society. This will not only result in successful and individualized treatment of survivors, it will address prevention of violence in all forms.

Finally, as a thought for future research, the power of oppressive social systems such as racism and heterosexism must be directly addressed through activism and advocacy on multiple levels. Due to increased demands on DV service agencies and fewer financial and human resources, it is important that individuals working within the field of DV emphasize the value of both direct and indirect services. By providing arguments for the power and importance of local and national advocacy work, agency administrators can more effectively earmark funding for such efforts. They are supported by this research as well as the growing body of literature that provides evidence of the impact of societal barriers on women's ability to access support.

NOTE

1. Pseudonyms have been used for all participants.

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