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Chapter 8
Help-Seeking Barriers Among Sexual and Gender Minority Individuals Who Experience Intimate Partner Violence Victimization

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Sexual and gender minority (SGM) individuals (e.g., those who may identify their sexual orientation as lesbian, gay, bisexual, pansexual, or queer, and their gender identity as transgender or gender nonbinary) disproportionately experience potentially traumatic events compared to heterosexual and cisgender (non-transgender) individuals (Alessi et al. 2013; Brown and Pantalone 2011; Katz-Wise and Hyde 2012; Roberts et al. 2010). Intimate partner violence (IPV) victimization refers to the systemic use of physical, sexual, emotional, psychological, and economic abuse with the intent to harm, threaten, control, isolate, restrain, or monitor another person in an intimate partnership or dating relationship (Jewkes 2002; Sullivan 2019). Notably, IPV represents one of the most common forms of interpersonal violence faced by SGM individuals compared to hate crimes, childhood abuse, and non-partner physical abuse (Brown and Herman 2015; Roberts et al. 2010). Despite SGM individuals' heightened risk of IPV victimization, the feminist paradigm's exclusive focus on IPV victimization among cisgender, heterosexual women perpetuate heteronormative biases and fails to accurately capture IPV among SGM people (Brown and Herman 2015; Langenderfer-Magruder et al. 2016).

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Consistent evidence demonstrates mental and physical health consequences of IPV among SGM youth and adults including posttraumatic stress disorder, depression, anxiety, substance use, chronic health conditions, HIV, and suicidality (Bostwick et al. 2010; Miller et al. 2016; Scheer and Mereish in press; Woulfe and Goodman 2019). Moreover, mental and physical health consequences of IPV victimization are amplified for racial and ethnic minority SGM individuals, given their experiences of multiple interlocking systems of oppression (i.e., racism, sexism, homophobia, transphobia; Grant et al. 2011; Miller et al. 2016). In addition, psychosocial risk factors for experiencing IPV victimization among SGM individuals include lower socioeconomic status, younger age, substance use, low self-esteem, risky sexual behavior, HIV positive status, childhood abuse, and a history of sex work and incarceration (Finneran and Stephenson 2013).

Social support networks and formal services reflect critical components to improving the mental health and safety of IPV survivors (Coker et al. 2002). Given the widespread health consequences of experiencing IPV victimization among SGM individuals, intervention and prevention strategies should identify readily accessible and culturally competent services for this population (Calton et al. 2016). Nevertheless, SGM individuals experiencing IPV victimization face unique individual-, interpersonal-, and systemic-level barriers to accessing informal and formal support services needed to recover from abuse (Edwards et al. 2015; Helfrich and Simpson 2006).

In this chapter, we provide an overview of IPV victimization prevalence rates among SGM individuals in the context of the minority stress framework and highlight unique forms of IPV victimization affecting this population, namely identity abuse. We review the literature on help-seeking processes among IPV survivors in general and discuss help-seeking patterns specifically among SGM individuals who experience IPV victimization. Next, we highlight SGM individuals' IPV-related help-seeking barriers in the context of minority stressors (e.g., discrimination, internalized stigma, rejection sensitivity, concealment). We cover empirical evidence on the minority stressors at individual, interpersonal, and structural levels that act as barriers to help-seeking among SGM individuals who experience IPV victimization. Finally, we review emerging evidence for interventions aimed to reduce help-seeking barriers among SGM individuals experiencing IPV victimization and conclude with a discussion of future research directions on help-seeking barriers in this population.

IPV Victimization Prevalence Among SGM Individuals

Documenting the prevalence of IPV victimization experiences among SGM individuals is necessary to advancing knowledge of how best to serve and support this population. Epidemiological research suggests that SGM individuals experience IPV victimization at higher rates compared to cisgender, heterosexual individuals (Centers for Disease Control and Prevention [CDC] 2010). According to the National Intimate Partner and Sexual Violence Survey, bisexual (61%) and lesbian women

(44%) reported experiencing IPV victimization compared to 35% of heterosexual women (Walters et al. 2013). In addition, 63% of gay and bisexual men, compared with 29% of heterosexual men, reported experiencing IPV victimization (Walters et al. 2013). Further, sexual minority women assigned female at birth are at heightened risk for experiencing sexual IPV victimization compared to sexual minority men and heterosexual men and women (Messinger 2011; Whitton et al. 2019). Findings also suggest that sexual minority youth are at an increased risk of experiencing IPV victimization compared to cisgender, heterosexual youth (Edwards et al. 2015; Martin-Storey 2015). One study found that sexual minority youth reported physical IPV victimization (43.0%), psychological IPV victimization (59.0%), and sexual IPV victimization (23.0%) at greater rates than heterosexual youth, who reported rates of 29.0%, 46.0%, and 12.0% for IPV, respectively (Dank et al. 2014).

Determining accurate estimates of IPV victimization among gender minority populations remains difficult due to a lack of studies with representative samples. In fact, excluding gender minority individuals from IPV research maintains a traditional gender-based heterosexual model of IPV (Goldenberg et al. 2018). Among the few studies that exist, results from the U.S. Trans Survey using a nonprobability sample of 27,715 gender minority individuals demonstrate that 35% reported physical abuse and 16% reported sexual abuse by a partner (James, et al. 2016). Further, some research suggests that gender minority individuals, regardless of sexual identity, report more physical IPV victimization compared to cisgender sexual minority and cisgender heterosexual individuals (35% vs. 14% and 12%, respectively; Landers and Gilsanz 2009).

SGM IPV in the Context of Minority Stress

In addition to risk factors that contribute to IPV among cisgender heterosexual individuals (e.g., alcohol abuse, childhood exposure to IPV; Balsam and Szymanski 2005), SGM individuals face additional stressors related to their stigmatized identities (i.e., minority stress; Meyer 2003) that may further elevate their IPV risk (Balsam and Szymanski 2005). According to the minority stress theory (Meyer 2003), commonly identified health disparities observed between sexual minority and heterosexual populations can be explained via the stigma associated with sexual minority status and the resulting higher levels of discrimination, internalized heterosexism, anticipation of discrimination, and identity concealment. While initially developed to contextualize vulnerabilities among sexual minority populations, this theory also helps to frame gender minority individuals' elevated health risks compared to cisgender individuals (Testa et al. 2015; Timmins et al. 2017). One central tenet of the minority stress theory reflects that SGM individuals experience higher levels of stress at individual, interpersonal, and structural levels deriving from their marginalized social status (Meyer 2003). Further, Meyer (2003) conceptualized minority stressors as: (1) additive to general stressors that the general population experience; (2) chronic, as they relate to stable social structures; and, (3) socially based rather than stemming from

isolated events or people (Hatzenbuehler and Pachankis 2016). In this chapter, we utilize the minority stress framework to contextualize help-seeking barriers among SGM populations who face IPV victimization.

Identity Abuse as a Form of IPV Victimization

For SGM individuals, IPV victimization occurs within a larger societal and systemic context of heterosexism (i.e., a system that privileges heterosexual individuals) and cissexism (i.e., a system that results in disadvantages for gender minority individuals; Katz-Wise and Hyde 2012; Scheer and Baams 2019). Along with more traditional forms of IPV, intrapsychic, interpersonal, and structural forms of stigma can be used as tactics of control against SGM people (Balsam and Szymanski 2005; Guadalupe-Diaz and Anthony 2017; Miller et al. 2016; Scheer et al. 2019; Woulfe and Goodman 2018; Woulfe and Goodman 2019). This IPV dynamic is known as identity abuse, or the targeting, discrediting, belittling, and devaluing of a partner's already-stigmatized SGM identity (Guadalupe-Diaz and Anthony 2017; Scheer et al. 2019; Woulfe and Goodman 2018). Identity abuse contains four broad domains: (a) disclosing a partner's SGM status to others such as family members or an employer without the partner's consent; (b) undermining, attacking, or denying a partner's SGM status; (c) using slurs or derogatory language regarding a partner's SGM status; and, (d) isolating a partner from SGM communities (Guadalupe-Diaz and Anthony 2017; Woulfe and Goodman 2018).

Few studies have formally examined prevalence estimates of identity abuse victimization among SGM individuals, because until recently, no formal measure existed to assess for SGM-specific identity abuse (Scheer et al. 2019; Woulfe and Goodman 2018). Within SGM populations, emerging findings suggest that gender minority individuals may be uniquely affected by identity abuse compared to sexual minority individuals given their differentially stigmatized status relative to their sexual minority counterparts (Scheer and Baams 2019; Woulfe and Goodman 2018). Additional research is needed to uncover the ways in which transphobia is used and experienced as a tactic of power and control among gender minority individuals.

Health Consequences of Experiencing IPV Victimization

IPV victimization experiences represent a key driver of SGM health disparities (e.g., suicidality, substance use, depression; Walters et al. 2013). Notably, sexual minority men and transgender individuals who experience IPV victimization are at heightened risk of HIV transmission, attributable to trouble negotiating safer sex practices due to a decreased perception of control over sex and fear of IPV (Heintz and Melendez 2006). In addition, identity abuse victimization is associated with depression and posttraumatic stress disorder above and beyond the effects of psychological and

physical forms of IPV victimization among SGM individuals (Woulfe and Goodman 2019). Emotional and tangible support from informal or formal avenues can protect against the deleterious health impact of IPV victimization (Liang et al. 2005). While it is critical for SGM individuals who experience IPV victimization to report IPV and seek assistance without fear of harm, rejection, or criminalization (Ford et al. 2013), this population faces significant help-seeking barriers directly related to their stigmatized social status (Calton et al. 2016). The next section discusses general IPV-related help-seeking processes and reviews the literature on help-seeking patterns and barriers among SGM individuals who experience IPV victimization.

Help-Seeking Processes Among Individuals Who Experience IPV Victimization

Help seeking among individuals who experience IPV victimization represents as a multistage process that involves: (1) recognizing and defining the abusive situation as unmanageable; (2) deciding to seek help; and, (3) accessing assistance from formal or informal avenues to remedy the situation (i.e., repair the relationship, protect against future abuse, leave an abusive situation or relationship; Liang et al. 2005). *Formal avenues* of support include seeking mental health, medical, legal, advocacy, and housing services whereas *informal avenues* may include asking friends, family, or co-workers for a safe place to stay, child-care help, financial assistance, or emotional support (Goodman et al. 2003).

Informal and formal support increase IPV survivors' sense of self-efficacy and adaptive coping efforts (Goodman et al. 2005). However, contextual barriers such as inadequate structural responses (e.g., non-enforcement of protection orders) and inaccessibility of appropriate resources (e.g., domestic violence shelters) can hinder IPV-related help seeking (Liang et al. 2005; Overstreet and Quinn 2013). In addition, barriers to accessing informal support may include experiencing dismissive attitudes from family or friends after revealing IPV experiences (Weisz et al. 2007). Recent work considers the cultural context of IPV-related stigma (e.g., loss of status within social networks because of IPV victimization) in reducing help-seeking behavior in general (Overstreet and Quinn 2013). Relevant to SGM individuals who experience IPV victimization, many also face stigma related to their SGM identity when seeking help (Finneran and Stephenson 2013).

IPV-Related Help-Seeking Patterns Among SGM Individuals

Understanding specific services that SGM individuals utilize following experiences of IPV victimization has important clinical and public health implications for outreach efforts and resource allocation. Similar to cisgender and heterosexual adults,

SGM adults initially disclose IPV victimization to informal supports (e.g., friends, family, co-workers) than to formal supports (e.g., law enforcement, clergy, crisis lines, shelters; McClennen et al. 2002). When accessing formal services, SGM individuals may prefer those that covertly address IPV victimization (e.g., mental health counseling) rather than IPV-specific services such as domestic violence shelters (Hardesty et al. 2011). In addition, rates of disclosure among SGM individuals may vary as a function of SGM status, among other demographic characteristics. For example, sexual minority women are more likely to report IPV victimization to legal services than sexual minority men due to internalized masculinity norms that discourage acknowledging victimization experiences (Kuehnle and Sullivan 2003).

Compared to cisgender, heterosexual youth and young adults, help-seeking patterns for IPV victimization may differ for SGM youth and young adults. For instance, SGM youth who experience IPV victimization, particularly gender minority youth, may seek formal services such as shelters, transitional living programs, crisis lines, and advocacy (Scheer and Baams 2019). One recent study demonstrated that among SGM youth and young adults who experienced IPV victimization, 1.9% sought housing support, 17.7% sought support services (e.g., advocacy), 21.7% sought medical care, and 37.8% sought mental health services (Scheer and Baams 2019). However, while almost a third of SGM young adults experienced IPV victimization in the past year, less than half of these participants sought IPV-related services (Scheer and Baams 2019). This same study documented gender identity disparities across several of the IPV-related services sought by SGM youth and young adults. Specifically, gender minority youth and young adults reported 2.06 times the odds of seeking IPV-related medical care services, 1.66 times the odds of seeking mental health services, and 2.15 times the odds of seeking support services compared to cisgender, sexual minority youth and young adults (Scheer and Baams 2019). Gender minority youth and young adults may be especially vulnerable to accessing affirming informal support for IPV victimization due to social isolation and anticipated or enacted rejection of their stigmatized gender identity and thus may turn to formal IPV-related services at greater rates than cisgender, sexual minority youth and young adults (Scheer and Baams 2019; Weisz et al. 2007). Taken together, given the high prevalence of IPV victimization and relatively low IPV-related help-seeking behavior among SGM youth and adults, service providers and policy makers should increase their awareness of risk factors associated with IPV victimization and determinants of help-seeking patterns and barriers in this population.

Minority Stress as a Social Determinant of Help-Seeking Barriers Among SGM Individuals

SGM-related stigma creates multiple barriers to seeking and receiving adequate care and support related to IPV victimization experiences. The current section explores

individual-, interpersonal-, and structural-level minority stressors in relation to IPV-related help-seeking barriers in this population.

Individual-Level Minority Stressors and IPV-Related Help-Seeking Barriers

Individual-level minority stressors refer to individuals' cognitive, affective, and behavioral responses to stigma (Hatzenbuehler and Pachankis 2016). Specific to SGM populations, individual-level minority stressors include: (1) internalized heterosexism and cissexism (i.e., negative feelings or beliefs about one's SGM status); (2) rejection sensitivity (i.e., a learned psychological process whereby SGM individuals anticipate stigma-based rejection based on previous discrimination experiences); and, (3) concealment behaviors (i.e., hiding an SGM status to avoid future victimization; Hatzenbuehler and Pachankis 2016; Mendoza-Denton et al. 2002; Meyer 2003). For SGM individuals who face IPV victimization, the shame associated with these experiences may be compounded by internalized homophobia, biphobia, and transphobia, which may have specific ramifications for IPV-related help seeking in this population (Scheer and Poteat 2018).

SGM individuals who face IPV victimization may internalize negative messages fueled by laws, policies, and social values that privilege those within the gender binary, portray homosexuality as deviant, *and* perpetuate a hegemonic understanding that only cisgender women—not cisgender men, transgender women, or transgender men—experience IPV victimization (Guadalupe-Diaz and Jasinski 2017; Helfrich and Simpson 2006; Scheer and Poteat 2018). These negative feelings and beliefs may prevent SGM individuals from identifying or addressing abuse within their relationship, further contributing to the denial of abuse, isolation, lack of reporting violence, and avoidance of seeking help commonly seen in this population (Bornstein et al. 2006; Edwards et al. 2015). Sexual minority men may normalize physical and psychological injuries as part of being a man (i.e., physical strength), and consequently, may actively work to conceal their IPV victimization (Bacchus et al. 2017). In addition, SGM individuals who experience IPV victimization fear that seeking help from formal services may reinforce negative stereotypes about the SGM community in general, and negative stereotypes about SGM relationships in particular, contributing to the silence about IPV in this population (Bornstein et al. 2006; Edwards et al. 2015; Ollen et al. 2017). As such, SGM individuals report interest in covert help such as through crisis hotlines to avoid further stigmatizing the SGM community (Edwards et al. 2015).

Experiences of discrimination also contribute to SGM individuals' sensitivity to or anticipation of rejection (Hatzenbuehler and Pachankis 2016; Meyer 2003), which may act as an important barrier to IPV-related help-seeking. Rejection sensitivity refers to the psychological process through which some SGM individuals

may anticipate or fear future rejection based on previous experiences of discrimination or prejudice (Mendoza-Denton et al. 2002). Indeed, fear of inappropriate, insensitive, or discriminatory treatment affects when and where SGM individuals who experience IPV victimization seek help (Freedberg 2006). For instance, SGM individuals who experience IPV victimization may choose to avoid seeking help from legal, mental health, medical, housing, or advocacy services due to the fear of rejection or stigma from service providers (Ard and Makadon 2011). In addition, SGM individuals may worry about further victimization by providers who lack competence in SGM-related issues and by other non-SGM clients accessing similar services (Bornstein et al. 2006). Expectations of unequal treatment in IPV-specific programs (e.g., domestic violence shelters) may also contribute to the likelihood that SGM individuals in general, and sexual minority men and transgender women in particular, do not seek help (Finneran and Stephenson 2013). SGM individuals may feel reluctant about reporting IPV victimization to law enforcement given the high rates of violence, including excessive force, unjustified arrests, and raids of this population by police, especially among sexual minority men and transgender women of Color (National Coalition of Anti-Violence Programs [NCAVP] 2013). SGM individuals who experience IPV victimization may also hesitate to seek help from their religious or faith community or from cisgender, heterosexual friends and family if they had previous experiences of heterosexism and cissexism in these contexts (Ard and Makadon 2011).

Experiences of heterosexism and cissexism can lead SGM individuals who face IPV victimization to conceal their SGM status to avoid future discrimination from formal and informal sources of support, including healthcare providers, co-workers, and family members. Both quantitative and qualitative work with SGM individuals suggests that fears around disclosing one's own or their partner's SGM status can act as a barrier to accessing and engaging in IPV-related support services (Finneran and Stephenson 2013; Guadalupe-Diaz and Jasinski 2017). Indeed, given that SGM individuals may carefully manage who knows about their sexual orientation or gender identity or expression, those who face IPV victimization may not reach out for formal or informal support and instead will remain in abusive relationships (St Pierre and Senn 2010). Notably, those who disclose their SGM identity generally report lower levels of internalized stigma, both of which are associated with increased likelihood of accessing help following IPV experiences (St Pierre and Senn 2010).

Interpersonal-Level Minority Stressors and IPV-Related Help-Seeking Barriers

Minority stressors experienced at the interpersonal level include overt forms of prejudice and discrimination such as victimization and harassment as well as unintentional actions including microaggressions (Hatzenbuehler and Pachankis 2016). Concerns

about potential interpersonal prejudice when seeking IPV-related services seem justifiable based on a sizeable literature documenting service providers' homophobic and transphobic attitudes towards SGM individuals as well as denial that IPV victimization occurs in this population. For instance, Legal (2010) documented that more than half of all sexual minority individuals in general—not just those who experienced IPV victimization—reported refusal of needed care, blame for their health status, and experienced healthcare professionals as physically rough and verbally abusive. SGM individuals who face IPV victimization often report experiences of police misconduct after the initial violent incident, including excessive force, unjustified arrests, entrapment, and raids (NCAVP 2013). Moreover, reports of discrimination by service providers are associated with delayed service usage and reduced likelihood of future service usage among SGM populations (Jaffee et al. 2016). Indeed, providers' lack of awareness of SGM IPV as well as discriminatory attitudes towards SGM populations contribute to the overall health burden and thwart SGM individuals' recovery and healing by preventing those who experience IPV victimization from receiving adequate care.

Similar to service providers more generally, those who work with IPV survivors in particular may have received little training on the specific needs of SGM populations (Simpson and Helfrich 2005). As a result, consistent evidence demonstrates that among SGM individuals who sought formal help for IPV victimization, many reported that services were not tailored to SGM individuals' needs and thus were perceived as unhelpful and even harmful (Bornstein et al. 2006; Edwards et al. 2015; St Pierre and Senn 2010). For example, Turell and Cornell-Swanson's (2005) review of the help-seeking literature indicated that SGM individuals who experienced IPV victimization were broadly dissatisfied with formal support services, including domestic violence agencies, shelters, crisis lines, police, attorneys, and clergy. Moreover, service providers, including police officers and victim advocates, may view SGM IPV as less serious than IPV among cisgender, heterosexual individuals, are less likely to see an SGM person in a same-gender relationship as a victim, are more likely to see both partners as perpetrators, and perceive violence between same-gender couples as being less likely to escalate over time (Russell et al. 2010, 2015; Russell and Kraus 2016; Russell 2018; Simpson and Helfrich 2005). As a result, SGM individuals who experience IPV victimization and report negative experiences with staff at non-SGM agencies and programs may instead rely on the SGM community for assistance (Bornstein et al. 2006).

Such experiences of discrimination regarding service usage disproportionately affect vulnerable subpopulations of SGM people, including transgender women, sexual minority men, bisexual women, those living in poverty or with HIV, and SGM individuals who identify as racial, ethnic, or immigrant minorities (Grant et al. 2011; Lambda Legal 2010). These disparities in healthcare quality are especially concerning because of the heightened need for services—as well as barriers to service usage—among these groups. For instance, SGM individuals who are immigrants or living in poverty report that their abuser uses the survivor's financial strain and/or citizenship status as additional leverage to discourage the survivor from leaving the abusive relationship and accessing IPV-related services (Greenberg 2012).

Notably, sexual minority men and transgender individuals underreport IPV victimization to police because of systemic maltreatment from law enforcers (Herek 2002). Among those who do report IPV victimization, Black gay men are 2.8 times more likely to experience excessive force from police than those who do not identify as Black (NCAVP 2016). Moreover, shelters—often the first point of contact for IPV survivors—are inaccessible to transgender individuals because of the gendered assumptions of victimization and discriminatory-housing practices in shelters. Gender minority individuals report disbelief from formal service providers about their IPV victimization experiences either because they are "too butch" or they were "once a man" (Guadalupe-Diaz and Jasinski 2017). Indeed, enacted stigma reduces the propensity for seeking help among multiply marginalized SGM individuals who experience IPV victimization.

Beyond formal help seeking, enacted interpersonal discrimination and prejudice may also impede informal help seeking for SGM individuals who experience IPV victimization. Due to hegemonic heterosexism and cissexism, SGM individuals who face IPV victimization may have fewer options, compared to cisgender, heterosexual individuals, when seeking informal support such as from family, friends, or clergy members (Pearson and Wilkinson 2013). Further, SGM individuals often create 'chosen families' consisting of friends, mentors, and other members from the SGM community. While 'chosen families' provide an important source of support, accessing IPV-related support from these networks may be particularly difficult given that many SGM people in relationships share the same network of SGM peers. Furthermore, isolating SGM individuals from accessing social support reflects a common tactic of IPV in general (Bornstein et al. 2006), and of SGM-specific identity abuse (Woulfe and Goodman 2018). Finally, perpetrators who have not disclosed their SGM identity for fear of discrimination may deter their partners from forming close friendships and openly discussing their intimate relationship in effort to continue to conceal their own stigmatized identity (Walters et al. 2013).

Additional concerns for SGM individuals include fears of losing one's social network by disclosing IPV (Ollen et al. 2017). SGM people may hold dismissive attitudes towards SGM IPV, which may relate to the limited support they can provide. As is the case with formal help seeking, fears of confirming negative stereotypes about SGM relationships, or even concerns about outing themselves or their partners as abusers in the process of seeking informal support, may also reduce informal help-seeking behavior among SGM people.

Structural-Level Minority Stressors and IPV-Related Help-Seeking Barriers

Minority stressors at the structural level include societal conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing

of SGM people and contribute to the production of SGM health disparities (Hatzenbuehler et al. 2013; Hatzenbuehler and Pachankis 2016). Anti-SGM structural stigma also uniquely hinders SGM individuals from accessing trauma-informed, effective, and culturally sensitive formal services (Edwards et al. 2015; Helfrich and Simpson 2006), particularly among those with multiple stigmatized identities. For example, SGM individuals who face IPV victimization and also live with HIV, identify as people of Color, are sex workers, or live in poverty may experience additional institutional barriers to accessing formal support (e.g., geographic isolation, lack of outreach to these communities and transportation options to domestic violence programs; Miller et al. 2016). Transgender women of Color in particular face disproportionate levels of poverty, discrimination, and denial of health care, contributing to their overall greater risk for IPV, HIV, and service barriers compared to other SGM people (Guadalupe-Diaz and Jasinski 2016).

Resulting from the extensive systemic adoption of the gender paradigm that frames cisgender men as batterers and cisgender women as victims, policy and intervention services ignore SGM people's needs and prevent effective and accessible services for this population (Cannon and Buttell 2015). For example, not until 2013 did the Violence Against Women Act (1996) include protections for SGM people (Cannon and Buttell 2015). Perceptions that abuse among SGM people is mutual and less severe than among cisgender, heterosexual people reflect the justice system's gendered model of IPV (Guadalupe-Diaz and Jasinski 2016). These harmful myths further contribute to the profound difficulty that police officers and service providers have in assessing for and identifying IPV among SGM individuals (Cannon and Buttell 2015).

Law enforcement and service providers' general lack of understanding, language, and education about SGM IPV may deter SGM individuals who experience IPV victimization from seeking help from general domestic violence services that are not SGM-specific (Calton et al. 2016; Hamel and Russell 2013). Transgender individuals who experience IPV victimization report needing to educate their doctors about transgender issues to receive adequate care (Grant et al. 2011). Moreover, providers lack the knowledge and skills related to SGM issues, despite wanting to improve services for this population (Helfrich and Simpson 2006). Providers' lack of awareness of SGM issues can result in the expression of non-affirming beliefs through culturally insensitive policies (Helfrich and Simpson 2006).

Mainstream domestic violence programs may use heterosexist and cissexist language in program materials or have ambiguous policies regarding service provision for SGM people who experience IPV victimization (Helfrich and Simpson 2006; Miller et al. 2016). One study found that of the 15% of SGM individuals who experienced IPV victimization and sought shelter services, 21% were denied entry due to services designated only for cisgender women (NCAVP 2014). In addition, homeless shelters are often segregated based on sex assigned at birth, which may alienate or endanger transgender individuals who require housing services to leave abusive situations (NCAVP 2014; Simpson and Helfrich 2005). Indeed, transgender men may be less likely to access support from domestic violence shelters due to fears that their masculine gender expression will result in rejection from service providers and

clients (Simpson and Helfrich 2005). In fact, transgender men and women are 3.5 times more likely to experience hate crimes while in shelters compared to cisgender men and women (NCAVP 2015).

Legal and police remedies represent the least sought forms of help and are often the least helpful among SGM individuals who experience IPV victimization (Grant et al. 2011). SGM individuals who experience IPV victimization do not report their experiences of IPV or seek other types of help from law enforcement given the well-documented history of violent maltreatment and harassment of SGM communities by police, especially among SGM people of Color, those living with HIV, transgender women, immigrants, and sex workers (Nadal et al. 2015). For those SGM individuals who do report IPV victimization to the police, the NCAVP found that in 2010, almost a fourth of SGM people stated that either the victim or both the victim and the perpetrator were arrested and 29.7% who called the police received no arrest—up from 21.9% in 2010 (NCAVP 2013). Transgender women are increasingly unlikely to report IPV victimization to police due to their experiences of harassment and discrimination by law enforcement (Finneran and Stephenson 2013). One study found that transgender women who experienced IPV victimization were over six times as likely to report physical violence while interacting with police than cisgender individuals (NCAVP 2015). These findings are consistent with existing theoretical and empirical work suggesting that transgender women may face significant structural barriers to accessing IPV-related legal services due to societal and institutional transphobia, homophobia, and misogyny (Greenberg 2012; NCAVP 2013).

Barriers to accessing legal services among SGM individuals who experience IPV victimization may directly relate to anti-SGM stigma and discrimination by the justice system. State laws for protective orders are written using language that excludes SGM people (Calton et al. 2016). For example, SGM individuals are either omitted from protection order statutes and thus unable to apply for protection or there lacks clarity whether SGM individuals are included in the statutes—resulting in inconsistent and biased decisions from local authorities (Potocznick et al. 2003). In 2010, the NCAVP documented that 55% of the protection order requests were denied among SGM people who experienced IPV victimization (Calton et al. 2016). SGM survivors of IPV victimization who have a cisgender or heterosexual partner also face resistance from the courts when attempting to maintain or gain custody over their children (Courvant and Cook-Daniels 2003). Further, judges may determine the threshold for obtaining a protection order and thus require that SGM IPV survivors—but not cisgender, heterosexual IPV survivors—prove they were cohabitating with their abusive partner at the time the violence occurred (Calton et al. 2016).

Practice and Policy Implications

Insufficient education in SGM-related issues among mainstream providers and legal and domestic violence services translates into lack of culturally sensitive care for SGM individuals who experience IPV victimization. As such, reducing help-seeking

barriers among SGM individuals who experience IPV victimization, requires that prevention and intervention efforts focus on enhancing SGM-affirmative training among providers, agencies, and services. To prevent enacted anti-SGM stigma in healthcare and legal settings, agencies and providers should implement interventions that promote: (1) the use of SGM-inclusive language and services; (2) awareness of minority stressors at individual-, interpersonal-, and structural-levels; (3) education of the bidirectionality of abuse as well as unique power and control dynamics in SGM relationships; and, (4) awareness of the strengths and resiliencies of this population (Woulfe and Goodman 2019). Practitioners should also evaluate the accessibility and availability of their services in terms of inclusivity (e.g., SGM-specific shelters, gender options beyond man/woman on intake forms), location, and implementation of SGM-affirmative care (Scheer and Poteat 2018). Providers, agencies, and legal services should consider consulting with SGM-specific organizations such as NCAVP, FORGE, and the Northwest Network to ensure SGM-affirmative approaches to service delivery (Calton et al. 2016).

In order to provide maximally effective services for SGM individuals who experience IPV victimization, providers, agencies, and services should assess for: (a) the gender identity and sexual orientation of the survivor and the person using abuse in the relationship; (b) the frequency and severity of unique tactics of violence that leverage systemic oppression such as heterosexism and cissexism (i.e., identity abuse); (c) psychosocial and health effects of IPV victimization experiences; (d) access to affirming informal supports that SGM individuals who experience IPV victimization can seek help from; (e) whether IPV is bidirectional; and, (f) the degree of outness of the SGM survivor and/or abuser. Ongoing assessment of support systems could also provide information when making community-based referrals and treatment recommendations for this population. In addition to facilitating training and assessment among sources of formal support, enhancing SGM-affirming informal support services for those experiencing IPV victimization also represents a critical public health and clinical need. Recognizing that SGM individuals disclose IPV more often to informal supports such as family, friends, and the SGM community than to formal supports, and that community connectedness protects against the effects of stigma and violence (Meyer 2003; Scheer and Poteat 2018), activists and allies should continue to raise awareness of IPV among the broader SGM community and the general public. Moreover, interventions aimed at informal supports can have positive effects, including fostering understanding and acceptance of SGM individuals' minority statuses and IPV victimization experiences (Edwards et al. 2015).

Trauma-Informed Care for SGM Individuals Who Experience IPV Victimization

Trauma-informed care (TIC) represents a service delivery approach initially developed in response to the realization that most people who seek services experience

some form of trauma or violence (Harris and Fallot 2001). At its core, a TIC approach involves providing culturally sensitive services that build on survivor strengths, facilitate opportunities for social connection, and foster empowerment to help survivors regain control (e.g., offering collaborative opportunities during treatment planning; Elliott et al. 2005). Designed to minimize the risk of re-traumatization while seeking services, TIC includes six dimensions: (a) fostering agency and mutual respect; (b) providing psychoeducation about trauma and its effects; (c) increasing opportunities to connect with other survivors; (d) building on clients' strengths; (e) cultural sensitivity; and (f) support for parenting (Elliott et al. 2005; Goodman et al. 2016). Although TIC does not target specific SGM minority stressors (e.g., identity concealment, institutional discrimination; Meyer 2003), cultural sensitivity is increasingly central to healthcare service provision (Elliott et al. 2005). Thus, when applying TIC principles to SGM individuals who experience IPV victimization in service delivery, it is critical to include an understanding of—sensitivity towards—the additional and unique minority stressors that SGM people face (Scheer and Poteat 2018).

Although developed in the context of mental health, TIC principles apply across various service settings, including medical, housing, and legal services (Miller et al. 2016). Moreover, previous studies provide substantial evidence for the effectiveness of TIC in addressing and improving numerous psychosocial and health concerns such as depression, substance use, physical health concerns, shame, and loneliness among those who experience trauma—including SGM individuals who face IPV victimization (Butler et al. 2011). TIC should be delivered in conjunction with evidence-based treatment protocols adapted for SGM populations (e.g., SGM-affirmative cognitive-behavioral therapy; Pachankis 2014) to improve the psychological functioning and health for this population.

System-Level Changes to Address Structural Barriers to Help Seeking

Federal and local policies that protect SGM civil rights consequently disrupt the social exclusion and societal-level stigma faced by SGM survivors of IPV victimization and could ultimately reduce the overall health burden in this population. Anti-SGM systemic and institutional policies need to be addressed and reformed such as including SGM individuals in protection orders statutes (Calton et al. 2016). In addition, passing legislation that renders systematic discrimination against SMG people (e.g., housing and employment discrimination) illegal, may help to improve societal acceptance of this population. Increasing awareness of SGM IPV could increase funding and allocation of services specific to this population. Finally, it is important for activists and researchers to monitor the implementation of the Violence Against Women Act to ensure domestic abuse networks provide equitable services for LGBTQ survivors.

Summary and Future Directions

This chapter highlights the increased prevalence of IPV victimization for SGM individuals compared to cisgender, heterosexual individuals. Estimates suggest that 23–63% of SGM individuals experience at least one form of IPV victimization—two-fold the prevalence among cisgender, heterosexual individuals. As previously mentioned, IPV victimization is clearly detrimental to SGM people's health and wellbeing: SGM individuals who experience IPV victimization have poorer mental and physical health outcomes such as posttraumatic stress disorder, depression, anxiety, substance use, chronic health conditions, HIV, and suicidality compared to SGM people who do not face IPV victimization. Risk is further amplified for SGM individuals of Color and immigrant minorities who navigate multiple systems of oppression that perpetuate stigma associated with race/ethnicity, sexual orientation, gender identity/expression, and IPV victimization (Miller et al. 2016).

Stigma related to IPV victimization experiences and SGM status creates multiple barriers to seeking and receiving adequate care and support. First, individual-level barriers include minority stress processes (e.g., internalization of negative beliefs about one's identity or experiences and fearing rejection and unequal treatment by service providers or family and friends) that may prevent SGM individuals from seeking help or disclosing their experiences of IPV victimization. Second, interpersonal-level barriers include experiences of discrimination and prejudice by service providers, law enforcers, family, friends, and clergy members, or isolation from SGM communities (e.g., identity abuse). Third, minority stressors at the structural level include cultural norms and societal conditions that prevent SGM individuals from receiving the support they need, such as a lack of effective care and services tailored to this population.

Future directions. Although research on SGM IPV consistently shows disparities related to sexual orientation and gender identity/expression, we have limited information about IPV victimization and barriers to service usage among certain SGM subgroups, for example transgender and gender non-binary individuals. Data-collections—local and federally mandated—should include comprehensive measures of sexual orientation and gender identity/expression to identify at-risk SGM groups and their unique experiences, relationship trajectories, and service needs. More research is needed to better understand the risk factors for bidirectional IPV among SGM people as well as service use and barriers to help-seeking among SGM people who perpetrate IPV. In addition, considering that existing research highlights increased risk of IPV victimization experiences among SGM individuals of Color and immigrant minorities, future work should focus on mechanisms of risk, marginalization, and discrimination as barriers to help seeking in these communities. Further, research discussed in this chapter highlights the risks of IPV victimization experiences among SGM adolescents and young adults. We currently know very little about how SGM youth navigate their first intimate relationships, nor do we have any knowledge on how previous experiences with rejection and violence in the peer-context impact their intimate relationships or help-seeking behaviors.

As outlined in this chapter, efforts are being made to reduce help-seeking barriers among SGM individuals who experience IPV victimization, for example affirmative training and tailoring interventions to SGM individuals' needs. However, work still needs to be done to evaluate the effectiveness, accessibility, and inclusiveness of intervention approaches such as trauma-informed care for SGM individuals who experience IPV victimization.

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