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“I KNEW I WANTED MORE FOR MYSELF”: SEXUAL MINORITY MEN’S NARRATIVES ABOUT GETTING HELP FOR INTIMATE PARTNER VIOLENCE

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"I KNEW I WANTED MORE FOR MYSELF": SEXUAL MINORITY MEN'S NARRATIVES ABOUT GETTING HELP FOR INTIMATE PARTNER VIOLENCE

DISSERTATION

A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Education
at the University of Kentucky

By
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Lexington, Kentucky
Director: Dr. Sharon Rostosky, Professor of Counseling Psychology
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ABSTRACT OF DISSERTATION

"I KNEW I WANTED MORE FOR MYSELF": SEXUAL MINORITY MEN'S NARRATIVES ABOUT GETTING HELP FOR INTIMATE PARTNER VIOLENCE

Sexual minority men experience intimate partner violence (IPV) at rates similar to, if not higher, than heterosexual individuals (Finneran & Stephenson, 2013). IPV is associated with a range of negative health outcomes in this population, such as increased risk for depression and anxiety (Miller & Irvin, 2017) and increased sexual risk-taking and subsequent HIV acquisition (Craft & Serovich, 2005; Houston & McKirnan, 2007). Many barriers prevent sexual minority men from getting help for IPV including stigma-related stressors, socioeconomic status, HIV status, perceived lack of helping resources, and a lack of knowledge about IPV (Duke & Davidson, 2009; Edwards, Sylaska, & Neal, 2015).

Little is known about how sexual minority men overcome these barriers and access the psychological support and help that they need. This study explored this process using a grounded theory methodology. Twelve sexual minority men volunteered to be individually interviewed about their experiences with seeking and getting professional psychological help for IPV in an intimate relationship. Findings revealed a process that included (1) triggering events; (2) motivation to seek help; (3) searching for help; (4) getting help and persisting with the therapeutic process. A triggering event (i.e., an incident of IPV or mental health concerns following IPV) resulted in participants searching for psychological help from psychologists, therapists, and/or psychiatrists. Personal motivators, such as character strengths, responding to important relationships, and wanting insight about their experience with IPV, led to help-seeking. Searching for help required participants to push past concerns and worries using character strengths to engage in web searches or to follow up on referrals from healthcare providers and from important people in their lives. Clinicians' flexible scheduling, therapeutic style and presence, and personal characteristics helped men persist with help-seeking. Implications for policy and psychotherapy practice with sexual minority men are discussed. In particular, implications for clinicians working with this population are explored based on each step of this help-seeking process. Inclusive education and training needs to be provided to health service providers, mental health practitioners, and community members. Mental health providers need training to provide culturally competent services to sexual minority men who are IPV survivors and for services to be visible and widely advertised to promote help-seeking.

KEYWORDS: Gay, Bisexual, Sexual Minority, Intimate Partner Violence, IPV, Help-Seeking

Jonathan Ryser-Oatman

November 13, 2020

"I KNEW I WANTED MORE FOR MYSELF": SEXUAL MINORITY MEN'S NARRATIVES ABOUT GETTING HELP FOR INTIMATE PARTNER VIOLENCE

By

Jonathan Ryser-Oatman

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Director of Graduate Studies

November 13, 2020______________

DEDICATION

To the brave and powerful participants who took part in this study: Intimate partner violence should happen to no one. Despite challenges and great pain, you have continued to live and make meaning of your experiences. As a fellow survivor, I see you and will continue fighting intimate partner violence in my personal and professional role as a Counseling Psychologist.

To men and women of color who were taken by violence at the hands of police brutality and systemic racism in the United States.

Philando Castile
Aiyana Mo'nay Stanley-Jones
Atatiana Koquice Jefferson
Akai Gurley
Megan Marie Hockaday
George Floyd
Tatayana Hargrove
Stephon Clark
Emantic Fitzgerald Bradford Jr.
Amadou Diallo
Tamir Rice
Trayvon Martin
Tony McDade
Breonna Taylor
Michael Brown
Sandra Bland
Ahmaud Arbery
Et alia

I say their names on published, scholarly record to both honor them and remind myself and my White colleagues of our calling to do better as Counseling Psychologists and as people working to uplift each other.

To the friends, family, and inspirational voices (shout out to Cheryl Strayed) who were essential to my own process of rebuilding my life and healing after intimate partner violence. The buds of my accomplishing this milestone would not be here without your branches lifting me.

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This dissertation was conceived, carried out, written, and disseminated on unceded lands of Indigenous people, including the Cherokee and Shawnee Tribes. I acknowledge Cherokee and Shawnee community erasure from past and current generations. I acknowledge that my ability to conduct this research was founded upon exclusions and erasures of Indigenous peoples, including those on whose land the University of Kentucky is located. This acknowledgement is both a commitment to working to dismantle the continuing legacy of settler colonialism and an apology for perpetrating these systemic processes by benefitting from centuries of oppression on Indigenous and other marginalized communities in the United States.

While hiking the Pacific Crest Trail to heal from and rebuild her life after the sudden death of her mother, Cheryl Strayed wrote, “I walked and I walked, my mind shifting into primal gear that was void of anything but forward motion, and I walked until walking became unbearable, until I believed that I couldn’t walk even one more step. And then I ran” (2012). There were many days during my graduate training I felt like I could not take a single step further. My own experiences with intimate partner violence, reflecting on and challenging my many privileged identities and biases, and training to become a Counseling Psychologist were demanding. So very many people helped me keep walking the trail of graduate school, and more broadly, my life. So many people were essential to my running when I felt like I could not take another step. Each of you deserve my individual thanks, and I could write endlessly of the ways in which my family, my friends, colleagues, peers, and mentors have been with me as I hiked the wilderness of my becoming a psychologist. My dissertation chair, Dr. Sharon Rostosky, has my unending thanks for her helping me embark upon this great walk and her mentorship as I have continued to advance, even on the days when I felt like I could not keep going. Her willingness

to help me explore my passion, develop an important research question, and carry out qualitative methodology for my first time is so, so deeply appreciated and I am continually humbled by her dedication to the LGBTQ community. My deep gratitude extends my dissertation committee and outside reader, respectively: Joseph Hammer, Ellen Riggle, Kenneth Tyler, and Edward Barrett. Joseph Hammer for helping me remember the importance of parsimony and mentorship through the advanced milestones of my doctorate. Ellen Riggle for consistently challenging me to think more critically and deeply about my research endeavors from start to finish while providing compassionate scaffolding. Lastly, Kenneth Tyler has been an unending source of inspiration for his thought-provoking questions and his awe-inspiring advocacy and dedication to social justice. I will continue to carry the lessons you have taught me as I continue on my trail as a psychologist who champions social justice.

I want to thank the brave and resilient sexual minority men who donated their time and told me about their journey with intimate partner violence help-seeking. Sharing one's intimate partner violence experience can be a painful and personal choice. Each story shared revealed that, while intimate partner violence is a deeply painful experience, it is possible to work towards a bright and beautiful future. I am truly honored to hold their stories and to share them in order to advocate for changing how we aid survivors of intimate partner violence. I wish to deeply thank my research team for helping me read through countless pages of participant interviews and to piece together their experiences to develop a meaningful narrative that captured my participant's stories. To my coding team members, Matt for offering constant encouragement as we moved through the coding process and to Sara for finding unique connections between participant experiences. Together, we worked to take the bravery displayed by each participant and create a roadmap that illustrates their lived experiences with intimate partner violence.

I must also thank both of my doctoral cohort members, Alex, Blanka, Brett, Holly, Alyssa, Carolyn, Cheryl, and Doug. I have been lucky to walk this journey with these remarkable Counseling Psychologists and to learn from them. Thank you for your motivation, patience, and willingness to hold space for me. Each of you inspire me daily. I thank and acknowledge the queer community, both in Lexington, Kentucky and my larger community, for standing with me through this long journey.

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Chapter One: Literature Review

Intimate partner violence (IPV), or "a pattern of behavior where one intimate partner coerces, dominates, or isolates another intimate partner to maintain power and control over the partner and the relationship" (Waters, 2017, p. 9), has a long history of public advocacy and research dating back to the 1970's. IPV is a major public health concern (Bevacqua, 2000), costing over four billion dollars in service delivery costs (Coker et al., 2004). Given the public visibility of IPV in different-sex couples it is unsurprising that when searching through online research databases there are numerous studies and literature reviews that explore a range of topics related to IPV in these relationships, with far fewer examining how IPV manifests in same-sex relationships. For instance, research focusing on sexual minority IPV constitutes less than one percent of IPV research produced in the last 15 years (Edwards, Sylaska, & Neal, 2015).

The Centers for Disease Control (CDC) define four major types of violence: physical violence, (i.e., use of physical force with the intent to harm); sexual violence (i.e., use of force to coerce non-consensual sexual acts); threatening physical or sexual violence; and emotional or psychological violence (i.e., actions aimed at emotionally harming one's partner, which includes stalking; Saltzman, Fanslow, McMahon, & Shelley, 2002). Sexual minority individuals also experience unique forms of IPV. For instance, one's partner could threaten to disclose the other partner's sexual identity which could lead to negative consequences such as loss of familial support or job loss (Goldenberg, Stephenson, Freeland, Finneran, & Hadley, 2016). In addition to the previously defined forms of relationship violence, previous research documents how men in same-sex relationships may use HIV status as an abuse tactic. This may include intentional transfer of the virus to their partner or disclosing their partner's HIV status to others (Stephenson

& Finneran, 2013). Furthermore, multiple forms of abuse can occur within a relationship, creating nuanced and complex presentations of IPV (Stults et al., 2020).

Recent research suggests that each of the major types of IPV can include multiple behaviors that manifest in same-sex relationships. Stults and colleagues (2020) interviewed 26 young sexual minority men from New York City about the types of IPV perpetration and victimization they experienced in their same-sex relationships. In this study, participants described multiple forms psychological, physical, sexual, and financial abuse experiences. For instance, psychological abuse included not just verbal abuse, but also behaviors such as manipulation, loss of autonomy, cheating, stonewalling, gaslighting, lying, isolating, use of slurs, threats, inappropriate social media use, entrapment, stalking, and embarrassment. Participant's detailed IPV recollections revealed that abuse can occur across a wide spectrum of unhealthy behaviors within men's same-sex relationships.

Prevalence of IPV in Gay and Bisexual Men's Relationships

A growing body of research documents the alarming rate at which sexual minority men experience IPV. Despite common assumptions that IPV is experienced primarily by presumed heterosexual women in different-sex relationships (Ristock & Timbang 2005), sexual minority men experience similar, if not higher, rates of IPV than heterosexual women across multiple forms of IPV (Finneran & Stephenson 2013). Ascertaining the actual prevalence rates of different types of violence in men's same-sex relationships, however, is difficult. Some findings document that men feel ashamed to report being a survivor of IPV (Duke & Davidson, 2009; Galdas, Cheater, Marshall, 2005) because masculine gender role beliefs suggest that men cannot be abused or that they should be able to defend themselves from abuse (Duke & Davidson, 2009). Thus, IPV is thought to be underreported by sexual minority men, leading to lower

observed prevalence rates than may actually exist in this population (Burke & Follingstad, 1999). Further barriers to ascertaining accurate prevalence rates stem from a lack of consistency in defining IPV across studies (Burke & Follingstad, 1999; Murray, Mobley, Buford, & Seaman-DeJohn, 2007).

Several literature reviews have concluded that sexual minority men are at high risk for IPV receipt across abuse types (Felix et al., 2020). Stiles-Shields and Carroll (2015) synthesized findings from an undefined number of studies of IPV conducted between 1998 to 2014 that included lesbian, gay, and bisexual (LGB) samples. The authors found gay and bisexual men were at higher risk than lesbian women and heterosexual men and women for all forms of IPV except for sexual violence, for which lesbian women were at higher risk. Lifetime estimates of sexual minority males' IPV prevalence rates range from 12% (Stephenson, Khospropour, & Sullivan, 2010) to as high as 45% (Craft & Serovich, 2005). Estimates suggest that up to 40% of sexual minority men are at risk for physical abuse (Bartholomew, Regan, White, & Oram, 2008) and up to 24% are at risk for sexual abuse by an intimate partner (Stephenson & Finneran, 2017). Further reports of lifetime risk for IPV suggest that 13% to 38% of sexual minority men will experience physical abuse (Rhodes, McCoy, Wilkin, & Wolfson, 2009), 12% to 30% will experience sexual abuse (Pantalone et al., 2012), and 5% to 73% will experience psychological abuse (Pantalone et al., 2012). Multiple forms of abuse in sexual minority male couples occurs at alarming rates and is associated with a host of negative outcomes.

Outcomes of IPV Exposure

IPV in sexual minority men's relationships is associated with a range of negative health outcomes. Recent findings suggest that this group is at a 70% greater risk for depression and a 60% greater risk for anxiety than self-identified heterosexual IPV survivors (Miller & Irvin,

2017) and report lower life satisfaction and perceived health following abuse (Blosnich & Bossarte, 2009). Additionally, exposure to IPV is associated with sexual minority men's risks for acquiring HIV (Craft & Serovich, 2005; Houston & Mckirnan, 2007; Merrill & Wolfe, 2000). IPV victimization may also be related to increased alcohol consumption. Some studies suggest that alcohol consumption may be a way to cope with abuse (McRae, Daire, & Lambie, 2017), and recent findings suggest alcohol consumption is more likely when experiencing cyber IPV (i.e., violence perpetrated over online dating apps for sexual minority men; Salter et al., 2020; Trujillo, Cantu, & Charak, 2020). IPV exposure is also associated with subsequent drug use (Salter et al., 2020), potentially as another way to cope with experiencing abuse.

More recently, authors have begun to examine trauma-related outcomes for sexual minority IPV survivors. Dickerson-Amaya and Coston (2019) examined data from the National Intimate Partner Violence and Sexual Violence Survey and reported that gay and bisexual men were not only at an increased risk for IPV compared to heterosexual men, but they also reported more negative mental health outcomes. Specifically, the authors noted that following IPV exposure, gay men are twice as likely to miss school or work. Additionally, gay and bisexual men reported increased post-traumatic stress disorder (PTSD) symptomology following IPV exposure, which is supported by other empirical findings (e.g., Stults et al., 2015). Specifically, Stiles-Shields & Carroll (2015) note that sexual minority individuals who experience IPV may develop complex trauma, or the experience of multiple and cumulative forms of interpersonal violence (Courtois, 2004) that affects one's affective state and includes a sense of dependence on the abuser despite continual abuse.

I located approximately 40 empirical studies of IPV published in the last 15 years have documented deleterious health outcomes for sexual minority men, yet we lack knowledge about

sexual minority men's help-seeking after experiencing abuse. Understanding experiences of seeking help may be critical to developing resources, programming, outreach, and other interventions to address this public health issue. The little research we have has often focuses on the barriers to help-seeking. The following sections summarize the multiple barriers this population could face when deciding to seek psychological help for IPV.

Barriers to Seeking Help

Some research on IPV in sexual minority individuals' relationships has begun to describe the collective barriers to help-seeking (e.g., Duke & Davidson, 2009; Edwards, Sylaska, & Neal, 2015). Research also examines the barriers men encounter when seeking help (e.g., St. Pierre, & Senn, 2010). The following sections describe the barriers to help-seeking that sexual minority men encounter. These include stigma-related stressors, adherence to traditional masculine norms, socioeconomic status and HIV status, a lack of available resources, and lack of knowledge about IPV.

Stigma-Related Stressors

Stigma-related stress, or minority stress (Brooks, 1981; Meyer, 2003) may impact the help-seeking practices of sexual minority male survivors of IPV. Minority stressors are associated with both perpetration and receipt of IPVand have a subsequent impact on help-seeking practices. Minority stressors are situated within societal stigma that devalues the identities, relationships, and experiences of sexual minorities (Calton, Cattaneo, & Gebhard, 2016). Minority Stress Theory posits that belonging to a marginalized group is associated with continual social stress because minority individuals are deemed "defective" by majority groups (Brooks, 1981; Meyer, 2003). The clashing of majority group and minority group individuals results in social stress and continually deteriorating mental health outcomes for minority group

members. Minority stressors manifest across a continuum of proximal to distal stressors and include internalized stigma, stigma consciousness, expectations of rejection, concealment, and experiences of discrimination. Research has documented a connection between specific minority stressors and the receipt and perpetration of IPV in same-sex relationships. Less research examines how minority stressors influence help-seeking. Available research relating to each minority stressor and its impact on seeking help for IPV are reviewed next.

Internalized Stigma. As sexual minority individuals experience negative societal reactions to their identity, they may internalize these values and apply them to themselves, resulting in subsequent internal conflicts and self-devaluation (Meyer, 2003). I found no research that explores how internalized stigma influences help-seeking for IPV. Stephenson and Finneran (2016) examined how internalized stigma is associated with gay and bisexual men's receipt and perpetration of emotional, physical, monitoring, and HIV-related IPV. Internalized stigma is also thought to be associated with staying in an abusive relationship (e.g., beliefs that one deserves abuse based on one's sexual identity; Gillum & DiFulvio, 2012). In this sense, internalized stigma may lead sexual minority men to feel that they do not deserve to seek help. Thus, they may not leave their abusive relationship because of internalized, negative messages about their sexual identity.

Additionally, internalized stigma may moderate the relationship between traditional romantic ideology (the set of beliefs surrounding love and romance that guide how an ideal romantic relationship should form and be maintained) and IPV exposure. Moskowitz and colleagues (2020) surveyed 449 sexual minority individuals about their endorsement of traditional romantic ideology, internalized stigma, and IPV exposure. Not only does endorsement of traditional romantic ideology predict IPV exposure, but internalized stigma strengthens this

relationship. The authors posited that abusers may use facets of internalized stigma, such as coercion and control via threats of outing, to keep survivors in a relationship.

Stigma Consciousness. Another minority stressor is stigma consciousness, or expectations of experiencing prejudice and discrimination based on one's minority identity if it is discovered by others (Meyer, 2003). Awareness of one's stigmatized identity may interfere with help-seeking. Indeed, sexual minority IPV survivors are less likely to tell family members about IPV experiences if they have not yet come out to their family for fear of losing their support. Carvalho and colleagues (2011) surveyed 392 gay and lesbian IPV survivors about how minority stressors influence IPV experiences, finding that survivors displayed greater stigma consciousness. The authors believed increased stigma consciousness in their sample could inhibit subsequent help-seeking behavior. These findings are consistent with St. Pierre and Senn (2010), who surveyed 280 LGB IPV survivors and found that gay men scoring higher on outness measures were more likely to seek IPV resources.

Expectations of Rejection. Individuals from minority groups often anticipate rejection from those in majority groups based on their sexual minority identity, leading to vigilance in their interactions with majority group members (Meyer, 2003). Sexual minority individuals may refrain from help-seeking in anticipation of experiencing identity-based rejection from service providers. Some sexual minority male survivors report being more comfortable reporting abuse in anonymous settings, such as HIV treatment clinics (Morgan, Buller, Evans, Trevillion, Williamson, & Malpass, 2016), possibly because clients perceive service providers are more used to working with sexual minority men or because confidentiality is assured to help-seekers.

Concealment. Sexual minority men may attempt to conceal their identity as a coping strategy to avoid societal stigma. Concealing one's identity, while used to avoid negative

consequences can lead to more stress (Meyer, 2003). Becoming more visible as a sexual minority individual means increasing one's risk for experiencing negative consequences, such as anti-gay attacks or loss of legal benefits. Gillum and DiFulvio (2012) conducted focus groups with 109 LGB young adults to learn more about their IPV experiences. Several respondents described hesitancy to disclose relationship abuse or leave their abuser because they feared being discriminated against by family, friends, and service providers.

Traditional Masculine Norms

Adherence to traditional masculine norms may contribute to men not seeing themselves as survivors of abuse, thus making it less likely they will seek services for IPV (Pitt & Dolan-Soto, 2001). In some cases, they may find it difficult to admit to being abused by their partner for fear of seeming weak (Goldenberg et al., 2016; Tsui, Cheung, & Leung, 2010) or they may display more willingness to admit perpetrating abuse rather than receiving it so they appear strong (Stephenson et al., 2019).

Adherence to traditional masculine norms is frequently associated with IPV perpetration (McKenry et al., 2006; Oringher & Samuelson, 2011), but it is likely also linked to men's reluctance to report IPV exposure (e.g., Stephenson et al., 2019). Sexual minority men may be further reluctant to admit being abused because they also want to avoid internalized stereotypes that they are less masculine than heterosexual men (Rollè et al., 2019). Kay and Jeffries (2010) interviewed 12 IPV service providers in Australia about what they perceived as barriers to sexual minority men accessing IPV services. Notably, providers believed that IPV is typically framed as a heterosexual female problem, which likely limits sexual minority men's belief that they are survivors and can find and access relevant services.

Socioeconomic Status and HIV Status

Demographic characteristics might also prevent men from seeking help to leave abusive relationships. Socioeconomic status is thought to play a large role in men's perceptions of their ability to leave an abusive relationship (Bartholomew, Regan, Oran, & White, 2008; Cruz & Firestone, 1998; Goldenberg et al., 2016). Some heterosexual-identified women may fear not having enough money after leaving an abusive partner, but little research has explored this concern in sexual minority men. Goldenberg and colleagues (2016) interviewed 64 gay and bisexual men in small focus groups about what they believed contribute to IPV in same-sex relationships, and found that differences in financial income could make leaving an abusive relationship more difficult for survivors.

A survivor's HIV status could also present a barrier to seeking help for IPV. In one study, Freeland and colleagues (2018) interviewed 64 gay and bisexual men in focus groups. Participants expressed that HIV status could influence gay and bisexual men's willingness to seek help for IPV, as service providers working with this population are often exclusively focused on STI and HIV prevention and treatment, as opposed to also addressing other relationship concerns. In another study, Bacchus and colleagues (2016) asked sexual minority men whether their healthcare providers routinely asked about IPV in their same-sex relationships. The authors noticed a theme suggesting that a barrier to receiving help for IPV is healthcare providers' fears of asking about IPV and HIV status in this population. Being HIV positive might also prevent sexual minority men from leaving an abusive partner. Merrill and Wolfe (2000) found that HIV positive men feared becoming sicker if they left an abusive partner. If men had an abusive partner who was HIV positive, on the other hand, survivors felt guilt over leaving their partner, who may rely on them for care. While the participants in Merrill and

Wolfe's sample did not relate HIV status to help-seeking specifically, concerns about leaving an abuser when HIV positive could interfere with seeking help.

Perceived Lack of Helpful Services

Exposure to IPV may be hidden by sexual minorities compared to heterosexual survivors, accounting for less help-seeking. This may be particularly true considering distrust that may still exist between sexual minority communities and the practice of psychology (APA, 2012). Research focusing on sexual minority men's help-seeking frequently examines the services men are most likely to use when experiencing IPV, while highlighting that culturally responsive resources are not typically known by survivors. Current research typically focuses on reasons for not seeking professional help for IPV, fears and concerns about seeking help, a lack of tailored interventions, and perceptions of the utility of mental health services for IPV.

Edwards, Sylaska, and Neal (2015) reviewed 22 studies that assessed common reasons sexual minority men and women do not seek professional help for IPV. In one of the few studies in this review focusing on sexual minority men (N = 101), reasons for not seeking help for IPV included lack of awareness of services (St. Pierre & Senn, 2010), concerns over service providers sensitivity to LGB issues (Burke et al., 2002; St. Pierre & Senn, 2010), fears of outing oneself to obtain help (St. Pierre & Senn, 2010), distrust of service providers (Burke et al., 2002), and concerns the abuse would not be taken seriously (St. Pierre & Senn, 2010). These findings are consistent with other research suggesting therapists (Wise & Bowman, 1997), domestic violence shelter staff (Simpson & Helfrich, 2005), and law enforcement (Edwards et al., 2015; Duke & Davidson 2009) are perceived by survivors to not take same-sex IPV as seriously as heterosexual IPV.

Some men fear engaging with IPV resources that may not be sensitive to their needs. Donne and colleagues (2018) interviewed 32 men (26 identified as gay or bisexual) about their experience of being sexually assaulted and subsequent help-seeking. Themes related to help-seeking focused on barriers to seeking support services, such as not wanting to relive or discuss the event with service providers, finding a trustworthy service provider, and difficulty identifying as a male sexual assault survivor. Two participants did seek support services for sexual violence and reported negative experiences due to service providers' lack of knowledge and sensitivity for working with male survivors.

Some studies have found that sexual minority men's perceptions are that mental health professionals are unhelpful (McClennen et al., 2002). Other research suggests sexual minority men perceive psychological resources as helpful for IPV (Merrill & Wolfe, 2000; Torrell & Swanson, 2005). Torell and Swanson (2005) surveyed a diverse group of sexual minority individuals ($N = 677$) about their help-seeking behaviors when they experienced IPV and found that gay men ($N = 270$) were less likely to seek mental health services than sexual minority women, possibly fearing disclosing IPV and/or their sexuality (Morgan et al., 2016). These findings contrast with other findings that suggest that seeking help from informal resources (e.g., friends and family) was the most helpful for some samples, with counselors were rated as the next most helpful IPV resource by sexual minority men (Merrill & Wolfe, 2000; Sylaska & Edwards, 2014).

Despite the elevated rates of referrals to psychotherapy for same-sex IPV (Ford et al., 2013; Merrill & Wolfe, 2000), there is a paucity of relevant interventions available for sexual minority men who access these services. The lack of appropriate interventions could lead to reduced trust in service providers, and consequently, less help-seeking. Psychologists and mental

health professionals are critical providers of services for sexual minority men who are exiting abusive relationships (Island & Letellier, 1991). One avenue to increase perseverance with help-seeking is understanding what makes therapy effective for this population, particularly since some findings indicate sexual minority individuals do not see therapy as useful for IPV (McClennen et al., 2002). Therapeutic interventions for IPV in heterosexual relationships have been widely studied, including web-based protocols (e.g., Nguyen-Feng et al., 2015), individual therapy (Tirado-Muñoz, Gilchrist, Farré, Hegarty, & Torrens, 2014), and group therapy formats (e.g., Lothstein, 2013), which contrasts with the paucity of interventions specifically for sexual minority male survivors of IPV.

Survivors Lack of IPV Knowledge

Men in same-sex relationships do not always recognize that they are in a violent relationship (Merrill & Wolfe, 2000). Donovan and Hester (2008) interviewed an unspecified number of gay and bisexual men about their IPV experience. The authors found that participants often did not know their relationship was abusive since it was their first. Men who were not out to others did not talk about their relationship dynamics to others and could not get feedback that they were being abused. Sexual minority communities may also contribute to the problem of concealment of IPV by failing to acknowledge that someone well-known in the community is abusing their partner. Abused partners may fear losing the support of their sexual minority community if they leave their partner or speak out about abuse (Duke & Davidson, 2009).

Facilitators of Help-Seeking

Although IPV literature explores what facilitates help-seeking for male-partnered heterosexual women, no identifiable research explores what might facilitate sexual minority men's help-seeking for IPV. Little research psychological help-seeking for IPV, regardless of

sexual orientation. Some findings suggest that sexual minority men and women are more likely to report IPV and sexual assault to formal resources (i.e., therapist, doctor, police) than heterosexual women, who are more likely to disclose IPV to informal resources (i.e., Felix et al., 2020). This difference could be due to sexual minority individuals fearing coming out in the process of disclosing IPV to friends or family members. In heterosexual-identified women's IPV help-seeking literature, multiple factors have been identified that promote help-seeking. In a review of IPV help-seeking literature by Lelaurain, Graziani, and Lo Monaco (2017), seeking resources was more likely to occur when survivors were younger, had higher educational attainment, had higher income, and were White. Additionally, having children who witnessed IPV and were in danger of being harmed by abusive partners galvanized leaving an abusive relationship. Randell and colleagues (2012) conducted focus groups of heterosexual women in abusive relationships, and while their children were critical motivators for help-seeking, access to a supportive network of other people seemed to greatly influence leaving abusers.

Social support may influence help-seeking amongst heterosexual women and men in abusive relationships. In one study, a focus group made up of heterosexual-identified female survivors described how they would not have been able to leave their abuser without several motivators, including the escalating severity of the abuse, feedback from others, including formal sources (e.g., healthcare, police) and informal sources (e.g., friends, family), realizing their abusers would not change, and wanting a better life for themselves (e.g., wanting to be happy, seeing their self-worth; Randell et al., 2012).

Heterosexual-identified female survivors may be more likely to seek help than heterosexual male survivors. In a study of 515 female and 385 male IPV survivors, female survivors were predicted to be more likely to seek formal and informal sources of help for IPV

than men (Barrett, Peirone, & Cheung, 2020). In this study, one's age, fearing for one's life, experiencing two or more incidences of violence, and increasing severity of injuries from IPV increased the likelihood of help-seeking. The authors noted that these IPV characteristics were associated with increased likelihood of seeking psychological help for IPV (e.g., counselor or psychologist) and medical help (e.g., doctors and nurses). When disclosing abuse to a healthcare professional, being a female survivor, being older, and having a physical and mental health condition further increased the likelihood of seeking help.

Freeland, Goldenberg, and Stephenson (2018) conducted the closest study to the current study that explores facilitation of help-seeking in sexual minority male survivors. The authors conducted focus groups with 64 gay and bisexual men about how they thought they would cope with IPV if they were to experience it in an intimate relationship. Although the sample presumably had not experienced IPV themselves, they were asked what coping strategies they might adopt or resources they would use in response to IPV exposure. The participants reported they would want access to supportive friends, family and gay affirming services, such as mental health professionals.

Conclusion

Based on a review of the existing literature it is clear that there is a dearth of literature on how this population accesses professional psychological help after experiencing IPV and their experiences as they seek resources for IPV. In particular, almost no research addresses this population's help-seeking experiences to address the psychosocial consequences of IPV exposure. Additional research is needed to better understand how sexual minority men go from understanding they are in an abusive relationship to identifying and accessing psychological help.

IPV in sexual minority male relationships is important to study because of its prevalence and because of the barriers to help-seeking. These barriers are exacerbated by stigma and stigma-related stressors that are unique to this marginalized population. Despite these barriers, some men are successful in seeking professional help for IPV. Their lived experiences of seeking and obtaining professional help can provide important information to those who experience IPV, their families and communities, and their service providers. Therefore, this research study focused on the following research question: *"What are sexual minority men's lived experiences of getting professional help for IPV?"*

Chapter Two: Methodology

The aim of this study was to use constructivist grounded theory to address the research question: "*What are the lived experiences of sexual minority men who got professional psychological help for IPV*?" Professional psychological help includes psychotherapeutic services from therapists, psychiatrists, psychologists, or other mental health professionals. These are commonly used formal help-seeking resources for sexual minority survivors in IPV help-seeking literature (e.g., Felix et al., 2020; Merrill & Wolfe, 2000; Scheer & Poteat, 2020) that has focused primarily on heterosexual-identified women in relationships with men. A grounded theory qualitative methodology allowed me to inductively explore a complex process based on participants' perspectives and lived experiences (Charmaz, 2014), rather than trying to fit data into deductively created theories (Glaser & Strauss, 1967). An inductive approach prioritizes the experiences of the studied population, rather than relying on researcher assumptions and biases to draw conclusions (Charmaz, 2014; Glaser & Strauss, 1967).

Few empirical studies explore the psychological help-seeking experiences of sexual minority men, and no research specifically explores their psychological help-seeking for IPV. The lack of research limits understanding this help-seeking process, and subsequently developing theory and evidence-based practices to assist this population.

The Current Study

The purpose of this study was to interview sexual minority men about their lived experiences seeking and getting professional psychological help in response to IPV in a same-sex relationship. The following sections describe strategies for participant recruitment, interview protocol development, research subjectivity and reflexivity, data collection procedures, and the

data analytic process. All study procedures were reviewed and approved by the University of Kentucky internal review board for research with human subjects prior to commencing the study. **Participant Recruitment Procedures**

A variety of strategies were used to recruit a diverse group of sexual minority men to interview. Eligible participants for this study (a) self-reported as a cisgender male, (b) were 18 years of age or older, (c) self-identified as gay, homosexual, bisexual, or reported having been in a same-sex relationship, (d) self-reported lifetime experiences that met criteria for physical, emotional, sexual, or HIV-related IPV within a primary partner relationship (someone who you consider yourself to be in a relationship with, such as a boyfriend or partner; Kubicek, McNeeley, & Collins, 2016), and (e) sought professional psychological help for IPV (i.e., therapist, psychologist, psychiatrist, or social worker).

Participants were recruited using online postings to websites such as specific Facebook groups and other social media websites (e.g., Tumblr, Reddit, Twitter) for sexual minority individuals. I emailed and called sexual minority agencies and domestic violence shelters to ask if they would circulate the study flyer within their agency by posting to email listservs or posting flyers within their facility. Study flyers (Appendix A) included information about the purpose of the study, my contact information, and a link to a screening survey that included questions that determined study eligibility (Appendix B). To reach sexual minority men who may not have access to the internet or who would not see the study flyer online, I distributed flyers to venues where sexual minority men frequently visit including community events (e.g., pride festivals), bars, HIV/AIDS service organizations, and community centers. Interviewees were compensated with a $50 gift card for their time and willingness to share their story.

Sample Size

In grounded theory research, researchers typically sample participants until they reach saturation, meaning that no new patterns or themes emerge in the collected data (Charmaz, 2006). Saturation should be achieved to ensure that the researcher has not overlooked any possible themes or patterns that explain the studied phenomenon (Charmaz, 2006), yet the process of reaching theoretical saturation is not well-defined in qualitative literature (Dworkin, 2012; Francis et al., 2010). Twelve interviews were determined to be an adequate sample size for generating the quantity and quality of data needed to address the research question (Guest, Bunce, & Johnson, 2006).

Participants

Table 1 displays the demographic information for each of the 12 self-identified sexual minority men who participated in this study. Nine participants identified as gay, two participants identified as queer, and one participant identified as pansexual. Participants ages ranged from 22 to 59 years old. Nine participants resided in and sought help within urban geographic locations, while three had sought help in rural geographic areas. Participants reported seeing therapists, psychiatrists, and psychologists. One participant reported seeing a social worker for psychotherapy (see Table 1).

Table 1. **Participant Demographics**

Name*	Race/ Ethnicity	Age	Sexual Orientation	State	Environment	State Help was Sought	Type of Psychological Help Sought
Mark	White	33	Gay	TN	Urban	TN	Therapist
Jeffrey	White	27	Gay	KY	Urban	KY	Psychologist, Psychiatrist
Sam	White	22	Gay	KY	Urban	KY	Therapist, Psychologist
Matt	White	27	Gay	KY	Urban	KY, OH	Therapist

Travis	White	44	Gay/Queer	KY	Urban	KY, PA	Therapist, Psychiatrist
Aaron	White	37	Pansexual	GA	Rural, Urban	GA, NJ	Therapist
Dean	White	25	Gay	AL	Urban	AL	Therapist
Seth	White	47	Gay	AR	Rural	AR	Therapist, Psychiatrist
Paul	White	27	Gay	OH	Rural	OH	Therapist
Ray	Hispanic	48	Gay	LA	Rural	CA, LA	Therapist, Psychologist, Social Worker
Ben	White	59	Gay	KY	Urban	NC, NJ	Therapist, Psychiatrist
Trevor	White	36	Queer	CA	Urban	CA	Psychologist

Note. *pseudonyms

Interview Protocol Development

To collect rich information about participants lived experiences and have flexibility to delve deeper into different aspects of participants' stories, I developed a semi-structured interview. The semi-structured interview format allowed me to ask follow-up questions to learn more about participants' experiences with seeking professional psychological help for IPV. The full interview protocol is shown in Appendix C. The interview protocol was developed based on a review of IPV literature and consultation with my dissertation committee. I pilot tested the interview protocol with two sexual minority men who had experienced IPV and sought professional psychological help. Both of these pilot participants provided input on the interview protocol's content, question phrasing, length, and utility of questions. Pilot interview feedback helped me reword questions and led to the development of self-care resources to send participants following interviews. Self-care resources can be found in Appendix D. Open-ended

questions focused on participants' experiences with IPV in their same-sex relationship that led to help-seeking, what motivated them to seek help for IPV, finding their mental health provider, and their experience using the service they sought.

Data Collection Procedures

Individuals who were interested in the study followed a link to a brief pre-screening survey (see Appendix B) that included the purpose of the study and what participation would involve. The survey included a definition of IPV using the definition by the Centers for Disease Control (CDC; Saltzman et al., 2012), as well as definitions that have been developed through empirical research about specific forms of IPV that sexual minority men encounter (e.g., HIV/AIDS related IPV, threat of being outed by abuser; Finneran & Stephenson, 2013). The screening survey asked participants to indicate if they ever sought professional psychological help for IPV (as defined), what resource(s) they used (e.g., therapist, psychologist, social worker), and in what US state they sought help. Lastly, participants were asked to provide minimal contact information if they were willing to be contacted for an interview. Eligible participants were contacted via email and given the chance to ask questions about the study and to schedule a phone or Zoom interview.

Prior to interviewing participants, I sent a study consent form to participants in order to gain verbal consent before beginning each interview (see Appendix E for interview consent form). Upon contacting participants by phone (n = 7) or Zoom video conferencing (n = 5), I obtained verbal informed consent and administered the study interview protocol. Interviews were semi-structured in format and lasted between one and two hours. Each participant was sent a

$50 Amazon electronic gift card after each interview to thank them for their time and emotional labor.

Interviews were audio recorded with two recording devices. Upon completing each interview, audio files were immediately uploaded to my password protected computer, deleted from the recording devices, and uploaded to a password protected folder. Interview audio files were then uploaded to Amazon Transcribe for initial transcription. Amazon Transcribe uses voice recognition technology to transcribe interviews, meaning I was the only person who heard the participant audio. I read each transcript to ensure the accuracy of the transcription service. During this process, I listened to the interview audio while reviewing the transcripts generated by Amazon Transcribe. While listening, I made corrections to the transcription documents, such as filling in words the transcription did not include, correcting spelling, and making transcription formatting more streamlined for data analysis. Audio files were deleted as soon as I finished editing the automatic transcriptions for accuracy.

Researcher Subjectivity and Reflexivity

Research team members were selected based on their prior experience conducting qualitative research and their experience conducting and critically examining research about LGBT individuals. The research team was composed of myself (Principle Investigator), two coders, and my dissertation research advisor. I identify as a White, gay, cisgender male possessing prior experience conducting data analysis using grounded theory methodology and several years of experience conducting and reviewing psychological research on LGBT individuals. Furthermore, I openly identify as a survivor of multiple forms of IPV within a long-term relationship, and I have also sought professional psychological help as a result of this IPV experience. The two members of the coding team identified as a White, gay, cisgender male and a White, non-binary, queer individual. Both research team members had prior experience conducting qualitative research using grounded theory methodologies. The supervising auditor of

the coding and theme development process identified as a bisexual cisgender female in her early 60s with over 20 years of experience in conducting and supervising qualitative psychological research on LGBT health and well-being.

To ensure trustworthiness of my dissertation project, I engaged in reflexivity, or continually reflecting on my personal biases, interests in the research area, and assumptions about participants' experiences that could influence data analysis and subsequent findings (Charmaz, 2014). Reflexivity includes remaining cognizant about how one's identity influences the entire research process, which includes recognizing how one's identities and experiences shape the methodology. I engaged in reflexivity from project inception through data analysis and solidifying findings with my research team and project auditor.

Another facet of reflexivity is acknowledging my motivation for conducting this study. My motivations included my awareness of the lack of research and interventions available for sexual minority survivors of IPV, a desire to see more culturally competent practices, my identity as a strengths-based clinician who strives to facilitate making meaning of difficult experiences, and my identity as an IPV survivor. I spent time throughout the research process reflecting on my assumptions about how participants experienced IPV and their help-seeking, and I was purposeful in allowing them to describe their own experiences in-depth. I sought feedback from the research team and from participants in order to accurately portray the participant's stories without letting my preconceptions or biases influence my execution of the research.

To ensure that researchers stay close to the data and are aware of their biases, grounded theory research entails memo writing, requiring research team members to take ongoing notes during the research process (Charmaz, 2014). I recorded methodological decisions, personal reflections, and trends I noticed during the research process. My research team members also

engaged in memo writing during data analysis. Reactions and memos were discussed as they arose during our research team meetings. Additionally, my external auditor provided feedback and oversight during the research project, providing insight into developing the research question, refining the interview protocol, and overseeing the inductive and recursive data analytic process.

Data Analysis

The first step of data analysis involved initial coding participant interviews. Initial coding began after completing eight interviews. The research team met to discuss and practice the process of performing initial coding to ensure each team member coded similarly (Charmaz, 2014). Research team members coded participants' experiences line by line to stick closely to their words and meaning (Charmaz, 2014). In line by line coding, research team members look at every line of text and attempt to capture participants' descriptions of events and actions while also fostering ideas about what the data suggest. Research team members were encouraged to write short, simple codes quickly for each line that captured their initial impressions about what the data illustrated. After coding each interview, the research team met and discussed line by line codes to ensure we had consensus about our initial codes before engaging in the next stage of data analysis.

After comparing our initial codes from the first eight interviews and discussing our experiences and reactions during coding, the research team then engaged in focused coding. Focusing coding involves identifying the most salient, frequent, and meaningful initial codes that address the research question and capture the experiences of participants (Charmaz, 2014). We discussed line by line codes to discern which codes captured participants' experiences and which codes appeared most consistently within and between interviews. Following focused coding the

team met to further consolidate focused codes and begin to generate categories to better organize codes.

The next step of the coding process involved grouping and organizing codes in a way that accurately described the men's help-seeking process (Charmaz, 2014). Using the first eight interviews, the research team, and with the external auditor's input, grouped together similar focused codes while consolidating codes into overarching categories that described the process of professional psychological help-seeking for same-sex relationship IPV. The research team agreed that the generated categories described important aspects of the experience of professional psychological help-seeking in this sample.

The final step of the grounded theory methodological process involved theoretical sorting, or careful examination and organization of the generated categories to create a clear and parsimonious model of the help-seeking process (Charmaz, 2014). During the theoretical sorting phase, I met with my external auditor two times to combine the generated categories in a way that captured participants' experiences with seeking professional psychological help for IPV. Theoretical sorting included a careful review of my dissertation results, written memos, and the coding process to arrange generated categories in a parsimonious model that accurately portrayed the help-seeking process as experienced by this sample of sexual minority men. To further aid the development of theoretical sorting, I drew upon consensual qualitative research (CQR; Hill et al., 2005) techniques for summarizing participants' experiences. I wrote page-length case examples of each participants' experiences in order to summarize the generated focus codes more succinctly (Hill et al., 2005). I also charted the results in order to visually depict relationships across generated theoretical categories, which is useful for illustrating a sequence of events (Hill, Thompson, & Williams, 1997).

A criterion for ensuring quality of findings in qualitative research are trustworthiness of findings. Trustworthiness is the quality and rigorous practices that the coding team and I put into place to ensure that my own understanding and experience of the phenomenon did not influence the research process and interpretation of the data (Morrow, 2005). Multiple steps were taken to ensure the trustworthiness of the findings. Since there is little existing research about sexual minority populations who engage in IPV help-seeking and given the distrust sexual minority men may feel toward psychologists given a history of pathologizing their sexual identities (APA, 2012), ensuring trustworthiness of my data gathering and analysis was critical to developing findings. To ensure participants' voices were accurately reflected, I emailed each participant a copy of their transcribed interview to check it for accuracy of their experience. Participants were given two weeks to respond with any changes to their transcript. Three participants responded after receiving their transcript, and none of them reported any inaccuracies or requested changes.

I used a stability check, derived from CQR methodology to further ensure trustworthiness (Hill et al., 2005). To conduct a stability check, Hill and colleagues (1997) recommend at least two interviews be withheld from the initial analytic process and be used to check if the new data fit into the existing process model, and to see if any substantial variations arise in the subsequent content analyzed. I analyzed the last four participant interviews independently from the initial coding and focused coding process with my research team to see if these data fit within the proposed help-seeking model for IPV in men's same-sex relationships that was developed using the first eight interviews. Using a CQR stability check also helped ensure that data saturation was reached. My external auditor provided feedback about my use of the stability check and to confirm that the derived findings accurately fit into the developed help-seeking model.

Conclusion

The goal of using constructivist grounded theory methods in the current study was to explore and describe the process of how sexual minority men get professional psychological help for IPV. Current psychological research and practice literature focuses on women with male partners who experience IPV; therefore, it was important to take an exploratory, inductive approach to understanding lived experiences of which we currently know little.

Chapter Three: Results

This chapter presents the findings from the systematic analyses of the rich data participants provided during their interviews. Findings are illustrated using quotes from participants' transcribed interviews. Participants' quotes are presented verbatim except for minor grammatical changes to promote flow, or to protect the privacy of individuals. Additions are represented by brackets ([]) and signal any modification to participants' transcripts, while ellipses (…) note any omission of words or phrases to improve the flow and brevity of quotes. Following quotes, participants' pseudonyms, ages, and sexual self-identities are provided.

Collectively, this sample of participants described a help-seeking process that began with their IPV experience and led to obtaining mental health services. Descriptions of the process included four steps (1) triggering events; (2) motivation to seek help; (3) searching for help; (4) getting help and persisting. Participants' triggering experience that launched them into psychological help-seeking either occurred immediately or after a delay. Participants then described their motivations for searching for psychological help before describing the help they received and what kept them engaged in the help-seeking process. Each of these major steps contained multiple categories that varied across the men's narratives. Table 2 lists the major steps of the help-seeking process and the number of participants who engaged in each category of help-seeking steps. A model displaying the flow of participants' help-seeking process can be found in Figure 1.

Table 2. **Frequencies of Participant Involvement in Steps and Categories for Help-Seeking**

Step in the Process	Category	Number of Participants
Triggering Event	Immediate Help-Seeking	4
	Delayed Help-Seeking	8

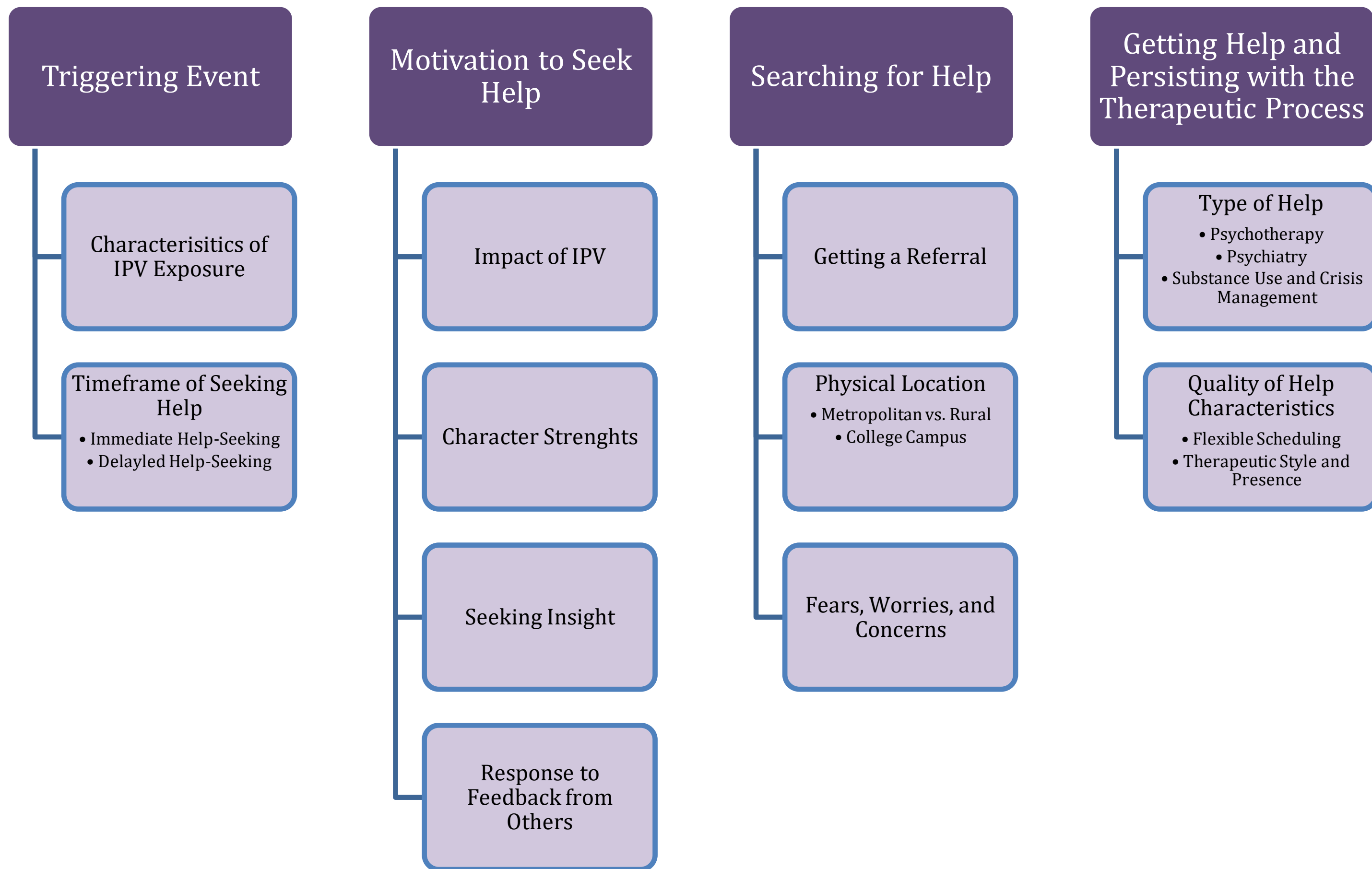
Motivation to Seek Help	Impact of IPV	12
	Character Strengths	12
	Desire for Insight	7
	Supportive Feedback from Others	12
Searching for Help	Getting a Referral	6
	Physical Location: • Metropolitan Versus Rural • College Campus	10
	Fears, Worries, and Concerns	10

Getting Help and Persisting with the Therapeutic Process	Type of Help
	• Psychotherapy
	• Psychiatry
	• Substance Use and Crisis Management
	  ○ Substance Use Management
	  ○ Crisis Management
		
		9
		3
		12
		3
		4

	Quality of Help Characteristics • Flexible Scheduling • Therapeutic Style and Presence	 6 9

Figure 1

Model of Help-Seeking Process for Professional Psychological Help to Address Intimate Partner Violence in Men's Same-Sex Relationships



Step 1: Triggering Event

All 12 participants described an event that initiated their search for professional psychological help for the IPV they experienced. Participants' triggering event included describing characteristics of their IPV exposure and the timeframe during which they sought help. Participants were triggered to seek help either because of a specific IPV event or because of IPV-related mental-health symptoms such as depression, suicidal thoughts, other concerns that occurred as a result of the abuse they experienced.

Characteristics of IPV Exposure

All 12 participants described IPV occurring in at least one romantic relationship with a same-sex partner. Almost all of the participants reported experiencing multiple forms of IPV within their relationship, including physical, emotional, sexual, financial, stalking behaviors, and HIV-related abuse. Psychological abuse typically preceded other forms of abuse and occurred throughout the relationship. Often, participants thought their partner's alcohol and/or other illicit substance use contributed to their abusive behavior. Almost half of the participants reported fearing for their lives at the hands of their partner or by their own hand if they stayed in their relationship. The severity of IPV and its impact on participants' mental health led to their seeking help. Frequencies at which participants experienced different types of abuse can be found in Table 3.

Table 3. **Types of IPV Experienced**

Type of IPV	Number of Participants
Physical Abuse	10
Emotional Abuse	10
Sexual Abuse	2
Financial Abuse	4
Stalking	2
HIV-Related Abuse	2

Timeframe of Help-Seeking

Participants described seeking psychological help either immediately after experiencing a severe IPV episode or after waiting for a period of time that ranged from a few weeks to several months. About one third of the participants sought help immediately after an IPV experience and reported distress from the event or severe mental health conditions that needed to be addressed

(i.e., suicidal thoughts). The rest of the participants described seeking help after a delayed period of time.

Immediate Help-Seeking. Four participants shared that they sought help immediately after an intense IPV experience. Jeffrey (27, gay) sought psychological help after his partner broke into his home and physically assaulted him. Additionally, Mark (33, gay) realized he needed help when he had suicidal thoughts upon discovering his partner was unfaithful to him, which added to the trauma he had experienced after being physically, psychologically, financially, and sexually abused for several months.

> I went out to the grocery store, came back home, and he was in bed with somebody else… at that point, I lost it. I packed up my car with stuff and drove away from the house… I called the employee assistance program to get some emergency help. Because at that point, I was, as I was driving away, I was figuring out ways to kill myself. (Mark, 33, gay)

The other two participants sought psychotherapy while still in their relationship, immediately following severe instances of physical IPV. For example, Jeffrey (27, gay) said, "I sought [couples counseling] out… And obviously we were having these arguments, and … you know, if I was going to make the relationship work, if we were going to make it work, we needed to get some outside help. And the services at [SCHOOL] were free and included in my tuition." While Jeffrey and his partner were attending couples counseling, his partner assaulted him for the second time, breaking multiple bones that required reconstructive surgery. After this episode, Jeffrey ended the relationship and continued to see his psychologist for individual psychotherapy.

Delayed Help-Seeking. The rest of the participants (*n* = 8) described seeking help due to mental health concerns that developed several weeks or months after leaving their abusive relationships. Symptoms that arose included feeling depressed, anxious, experiencing PTSD symptoms, having thoughts of suicide, and losing one's sense of self. After experiencing IPV, these participants wanted to rebuild their lives prior to seeking help or may not have even thought about seeking help. Some participants needed to find new housing, move to a new city, or begin saving money. Finding a therapist, as a result, was difficult and delayed. Ben (59, gay) had to completely rebuild his life after he left his partner; he took only the clothes on his back and felt the need to sell his car, change his route to work, and hide his location to ensure his safety. Almost all of the participants had difficulty immediately seeking help because they did not know what IPV resources were available to them, even if they had attended psychotherapy or accessed psychiatry in the past. Sam described the difficulties that delayed his help-seeking.

> As things continued it progressed into the sustained mental health issues, and not necessarily knowing what services, and if there were services specifically available for me to seek, so that was an added layer. I wanted help but didn't know where to go. (Sam, 22, gay)

Most participants spent anywhere from a few weeks to several months searching for a therapist. Dean (25, gay) waited seven months after breaking up with his partner to begin looking for psychological resources for IPV, and then it took another month to locate a therapist. Despite how long it took Dean to locate services, engaging in this search helped him feel hopeful.

Lastly, two participants delayed getting help because they felt ambivalent and initially thought they could recover on their own from IPV. In this sense, help-seeking was not delayed

solely from a lack of visible resources, but because these men did not think they needed psychological assistance to work through their mental health concerns following IPV.

Step 2: Motivation to Seek Help

All 12 participants discussed what motivated them to seek psychological help. They attributed their motivation to seek help to the impact that IPV had on their lives, their own personality and character strengths, their desire for insight into their experience, and in response to supportive feedback from others in their lives. In summation, participants were motivated to seek help because of negative experiences (i.e., the impact of IPV on their lives) and positive experiences (i.e., character strengths, desire for insight, and supportive feedback from important people in their lives).

Impact of IPV

Over half of the participants said they were motivated to seek help because of the impact of IPV on their mental health. They reported symptoms that were not present before the IPV (e.g., flashbacks and intense nightmares, depression, and/or suicidal ideation). Some reported the return of mental health symptoms that they had addressed previously in their lives. For instance, Matt (27, gay) said, "It was traumatizing. I… I definitely contribute it to some relapses when I did get sober. There was a suicide attempt. It was at least partially related to [the IPV]." Seth (47, gay) went to his primary care practitioner and asked if he could speak to someone about all the stress he was experiencing. Stressors in his life included not only IPV, but financial stress, worsening mental health symptoms, and concerns over a chronic health condition. Seth's mental health concerns were related to the IPV occurring in his current relationship, and he recognized symptoms from when he previously experienced depression in his life. Ray (48, gay) described withdrawing from other people, avoiding dating, and not having sex after his relationship ended.

Ray reported that his friends noticed he was withdrawn and that his personality changed. In looking back, he recognizes that he was in denial about the impact that IPV had on him despite visible weight loss and frequent dissociation. “I didn’t even realize I was zoning out,” reported Ray.

Character Strengths

All the participants described personal motivation and character strengths that helped them persevere during the search for professional psychological help. Motivators were particularly important when dealing with the negative outcomes (e.g., psychological symptoms) of IPV and when encountering barriers (e.g., lack of resource awareness, financial concerns) to finding resources. Several participants struggled with suicidal ideation in the wake of IPV exposure, however their will to live was a strong motivator to seek psychological help. Mark (33, gay), for example, felt suicidal upon leaving his abusive partner, but also perceived it was “not [my] time to go yet.” His survival instinct helped him keep going, and reaching out for help was a last resort. Other notable characteristics mentioned by participants included being resilient, open to new experiences, having a strong sense of self-worth, being a smart person capable of problem-solving, being stubborn, and having a desire to be well. As Matt (27, gay) noted:

> I think that, uh, I'm a very resilient person. And as bad as things have gotten in my life at different points in time, I have ultimately never given up, you know? And so… still having hope that I can get better past all this stuff. I mean, if I didn't have that, then why even bother?

Multiple participants also had hope for a better future for themselves that could be achieved by seeking professional help. Jeffrey (27, gay) perceived that going to therapy would lead to gains such as success in future relationships. Travis (44, queer) wanted self-improvement,

saying, “That’s why I go to therapy. I worked really hard to become a better version myself, you know?” Ben (59, gay) also had a vision of a better life for himself, and he knew that to get there he needed to get help because he could not recover on his own.

Two participants described a fear of failure that motivated them to seek help. Matt (27, gay) described grappling with shame and guilt after experiencing IPV. For Matt, “struggling with shame and guilt actually has been a big motivator, because they got me to the point where… I can't stand this anymore.” Needing to deal with these emotions prompted him to explore ways he could work through them in a therapeutic context.

Desire for Insight

Over half of the participants described seeking help because they wanted to understand why IPV happened to them. This included wondering, “Why me,” “Why did I stay?” and “How do I learn to cope so IPV does not derail my future?” Several participants reported that service providers explicitly told them they, themselves, were responsible for the abuse they received from their partner. Other participants stated that they never imagined they would be in an abusive relationship and wondered what was wrong with them for staying with their partner for as long as they did.

> And then when I moved to [CITY], I kept saying, I want to see a therapist. I wanted to know, is there something wrong with me? Am I attracting the wrong kind of person, am I the wrong person? Am I the person that he's told me I am… because he would say literally this is your fault. You did this, this, this, and this. And you're paying the consequences of those actions. (Travis, 44, gay)

Paul (27, gay) began to seek help when he realized he wanted to learn why he kept choosing to be with unhealthy partners. He described his first same-sex relationship as physically

and emotionally abusive. In a subsequent relationship he chose a partner who abused alcohol, although that partner was not violent. To understand why he chose these partners, he first spoke to his healthcare provider about finding a psychiatrist. His provider connected him to a therapist who worked with gay men. Paul attended psychotherapy for four months, looking for insight into his relationship choices and dynamics.

Supportive Feedback from Others

All twelve participants described seeking help in part because of feedback received from others in their lives. Participants sometimes directly disclosed experiencing IPV to friends, family members, or work supervisors, which was followed by encouragement to seek help. Additionally, some participants sought help when someone noticed drastic changes in their mental health and expressed concern. Ray (48, gay) was especially influenced by his social support network. One of Ray's best friends, who was also a clinical psychologist, arranged for him to return home to Louisiana and attend an inpatient hospital where he could process his IPV trauma. Ray's mom and a few close friends supported this decision. While initially hesitant, Ray realized he needed help to heal and get his life moving again. Ray knew of no IPV resources for men despite being deeply connected to help-seeking resources in the area. He was convinced to seek help in large part because of the involvement of his social support network.

Sam (22, gay) said some people knew pieces of his IPV experience, but not the whole story of his relationship with his partner. At his university, one sociology professor and his resident advisor supervisor were particularly helpful as he sought help for IPV. Sam talked with his resident advisor supervisor about his abusive relationship and she was able to direct him to campus resources. "[She] helped me process my trauma and helped me learn how to survive. At that point, even if I wasn't thriving, I was surviving." Sam's sociology professor provided Sam

with a space to talk about his abusive relationship and recommended resources he might use. Lastly, Sam's friends listened to his experience and supported him when he felt triggered by stimuli that reminded him of his abusive relationship. They also supported him in seeking out therapeutic resources for IPV.

Step 3: Searching for Help

Participants described a multifaceted process of searching for professional psychological help. In particular, they spoke of how the following aspects of their experience shaped their help-seeking: their ability to get a referral to a resource, physical location, and their fears, worries and concerns about getting help. Despite facing barriers to accessing treatment, participants were able to recognize and find professional psychological resources. As one participant states, "just [make] sure that [other men] know that there's a safety net out there. It may be hard to find sometimes, but it is out there," (Ben, 59, gay).

Getting a Referral

Three participants said that their HIV service provider referred them to a therapist. Three other participants received a referral from their primary care physician. In this sense, healthcare providers were essential in connecting these six participants to therapeutic services. Without a referral from a primary care or HIV services provider, searching for a therapist may have taken longer. For example, Ben's (59, gay) HIV care network connected him to a psychiatrist that was a short drive away:

> It took about three phone calls. [The first] one to a psychology center, where there was a lot of different psychologists, just making some phone inquiries. Then I actually called my HIV doctor who was chief of staff in a large health system. I had seen that doctor at

that time for close to 26 years… He is the reason I found a psychiatrist though. (Ben, 59, gay)

Aaron (37, pansexual) initially talked to his primary care provider and a nurse during a routine checkup; he ended up disclosing the substance misuse and IPV occurring in his relationship. His provider was able to connect him to an in-house therapist that used a sliding scale so that he could afford to pay for services.

Six participants found help through a referral from either a friend or colleague (n = 4) or by searching on the internet for a clinician (n = 2). For those receiving referrals from friends or colleagues, participants first had to disclose IPV to these people in their lives, but subsequently learning of a provider expedited their search process. For example, Trevor (36, queer) did not want to explicitly ask others for help, but when his friends saw him struggling after his IPV experiences, several of them offered to let him stay in their homes and encouraged him to tell his story while he decided on next steps. Opening up about his IPV experience led to a friend's referral to a psychologist. Aaron (37, pansexual) had access to multiple therapists through his health insurance at work and was able to type in specific therapist criteria he desired.

Physical Location

All of the participants noted how their geographic location either facilitated or hindered their help-seeking for IPV. Typically, participants in more populated cities and regions found IPV-related psychological resources more easily because they were visible and available.

Metropolitan Versus Rural. Ten participants said that their living in or near a metropolitan area facilitated their finding a provider. Ben (59, gay) did not know of any resources while living in North Carolina, but when he moved to New Jersey he reported it was easier to locate help because of his proximity to a large, metropolitan city. He said that it helped

"being close to a major city… I mean more resources. More ability to find the resources. There was more technology by then so much easier to find things."

While the majority of participants attributed living in a metropolitan area to facilitating their finding psychological help for IPV, one participant had a different experience. Mark (33, gay) worked with multiple therapists in a larger city who suggested that his sexual orientation could have been responsible for his IPV exposure. After moving to a different metropolitan city within his state, he was able to find a clinical resource that did not express this view.

Five participants said their rural location influenced their help-seeking. Specifically, two participants found it challenging to locate psychological resources for same-sex IPV while living in a rural region. For example, Seth (47, gay) described living in Arkansas and how most of

the services he sought initially were a long drive from where he worked. He typically would have to leave work early to make it to therapy appointments. Like Mark, above, participants living around rural areas described fears about beginning this process, worrying that helping professionals in the area would blame their IPV exposure on their sexual minority identity:

> I was very tentative and uncertain at first. In several areas near where I live it's just unaccepted to be gay down here. And so, I was terrified of being, uh, what's the word? I've been criticized, for who I was… (Dean, 25, gay)

Another participant, Paul (27, gay), was worried he would have to drive several hours from his rural hometown to a bigger city in order to find competent therapeutic services. Because he got a helpful referral from a friend, he only had to drive 25 minutes to his sessions.

College Campus. Two participants noted that they had an easier time finding and paying for clinical services because they attended college. Both participants had college medical insurance and access to campus clinical facilities. They reflected on how having access to

campus resources as college students made it easier to seek help because they did not have to pay for therapy sessions or even leave the campus.

Fears, Worries, and Concerns

Ten participants felt concern and even fear about beginning to search for professional psychological help. They experienced uncertainty about finding a clinician who had experience working with sexual minority men (n = 7), worried about insurance coverage and paying for psychotherapy (n = 7), were concerned about the driving distance to the clinician (n = 2), and were uncertain about taking time off of work to attend psychotherapy (n = 1). Trevor (36, queer), similar to several other participants, noted concerns about finding and keeping a therapist due to limited insurance and inability to pay out-of-pocket for a clinician:

> My health insurance was the first [barrier], because no PsyDs are in network. It was out of pocket when I finally did find her… And it was the reason that it stopped, unfortunately. I have a better plan now but it's still fairly limited and hard to get a PsyD.

Dean (25, gay) similarly noted that, “At first, it was financial issues. I had medical bills from surgery I was worried about… on top of that. I had my regular bills like, rent, car payments, insurance, phone bills. I really couldn’t afford to see a therapist. Especially if it was gonna be $50 a session.”

Seven participants felt concern about finding a clinician who would accept them as survivors of IPV and as sexual minority men. Dean (25, gay), noted:

> I was worried about seeing a therapist for the simple fact that I didn’t want to be judged and ridiculed after I'd already gone through so much. I didn't want to go through more. I was afraid of if they did accept me at first, that… I’d eventually tell them about, [the

abuse] I went through with my ex-partner, and I was afraid they'd look at me as if I deserved it.

Other participants echoed Dean's fears of being judged by their therapist, including Aaron (37, pansexual) who would email therapists before attending an initial session to try and get a feel for how accepting they were of sexual minority clients. Paul powerfully stated his fears about going to see a therapist without knowing about their competence to work with sexual minority men, stating:

> Yeah, I'm not going to schedule an appointment with someone if I don't know that you've, at the very least, worked with same-sex individuals or had experience with that group in some way. Maybe this still stems with me living in a very rural, conservative area… I don't know if everyone's cool with that. I'm not about to go spill my guts to someone if I don't even know if they're supportive of me as a human being, and that might be a bit extreme. But based on where I grew up, not really. Contextually, it makes a lot of sense. I just want to be able to know before I go. (Paul, 27, gay)

The need to see a clinician who was competent to work with sexual minority male IPV survivors was critical. Mark (33, gay) saw multiple clinicians in a row and received the message that same-sex IPV could be attributed to him being gay and in a same-sex relationship, a sentiment that several other participants also experienced. To mitigate the likelihood of receiving rejecting messages from a clinician, Jeffrey (27, gay) said that it was important to find a therapist with knowledge of IPV in same-sex (male) relationships.

> … even being able to come to them with examples of other men who have experienced this… I think a huge part of it is that there's just not a lot out there. There's a ton of stuff out there for women that experience this kind of thing from their male significant others.

> But I feel like this is an area that has gone largely ignored, but it's probably something that the prevalence of it… is a lot higher than we realize. And … there's not a lot of specific help out there for guys who have experienced this kind of stuff.

Participants described several experiences as they sought professional, psychological help for the IPV they experienced. Several men in this study were able to find psychological resources by talking to a primary care provider or HIV care provider, while others disclosed to a friend who could refer them to a clinician. Physical location also influenced finding help. Participants who lived closer to larger metropolitan cities had access to a wider pool of psychological resources. Throughout the process of seeking help, men in this sample reported fears and concerns about finding a clinician who was a good fit and qualified to work with sexual minority male survivors of IPV.

Step 4: Getting Help and Persisting with the Therapeutic Process

After garnering their motivation and searching for providers, participants located and engaged in professional psychological help. Participants described seeing their clinicians for a period of time ranging from six weeks to four years. Their accounts fell into two categories: Type of help and characteristics of helpers. These categories included accessing psychotherapists, accessing psychiatrists, engaging with substance use and crisis management resources, and facilitating factors that helped with engagement and persistence in help-seeking. During this time, many participants emphasized that they engaged in therapy not only for IPV, but for other mental health concerns, such as substance misuse, physical health concerns, and general life stressors. In this sense, IPV did not occur in a vacuum, but rather exacerbated and was exacerbated by other concerns. Most commonly, participants accessed psychotherapists to address their IPV exposure.

Type of Help

Participants used multiple resources to access psychotherapy for the IPV they endured. All the participants in this study described accessing a variety of resources, ranging from psychotherapy, psychiatry, and crisis management services.

Psychotherapy. Nine participants attended psychotherapy with therapists and psychologists for IPV. Six of these participants went to therapists and three participants went to psychologists; two of the participants saw psychologists in a university counseling center and the other saw a psychologist in a private practice. Trevor saw a licensed psychologist in a private practice after receiving a referral to her practice given her specialty of working with sexual minority clients:

> I mean, quite a bit of her response to the emotional abuse was that I needed to hold space for my own emotions. Because I have a tendency to receive and respond to [NAME's] emotional stuff without ever really figuring out where my stance is. So, a lot of discussion about that stuff… first don't respond, you know, let it simmer. Feel it. Wait until your emotions arrive. And then maybe have a discussion about it or come to me to talk about it. (Trevor, 36, queer)

Other participants saw therapists across an array of settings including healthcare clinics and community mental health settings. Four participants saw clinicians connected to either a healthcare provider or their HIV care provider. Paul (27, gay) and Aaron (37, pansexual), for example, were referred by their healthcare providers to therapists that offered sliding scale fees, which alleviated the difficulty of finding a clinician who fit their financial options. Other participants, such as Matt (27, gay) found his therapist by conducting an online search for therapists who met the criteria and clinical experience he desired. Mark (33, gay) located therapists in his area who were listed as being covered by his insurance through work. Dean (27,

gay) and Aaron (37, pansexual, seeking his second psychotherapist) found several providers by searching online for clinicians that met his criteria for treatment. He was discouraged that several promising clinicians worked several hours away from where he lived in a rural area, however, a friend was able to refer him to a psychotherapist who worked within a 30-minute drive and offered sliding scale session fees.

Several participants (*n* = 4) began to work with one therapist before being transferred to a different one. Transfers occurred for several reasons, including clinicians changing jobs or retiring. Transfers impacted participants in several ways. Some decided to terminate services because they had become attached to their clinician, or because they could not find another clinician after theirs relocated. As Matt (27, gay) said, "… the therapist I had there ended up having to leave her job because of health issues and so that's not her fault at all, but I fell out of treatment after that because I guess I'd gotten pretty attached to that therapist." Seth's (47, gay) therapist had left his community practice to work in a school setting, leaving him without a clinician for several weeks. During this time, he learned he could access a phone therapy application, which he began to use out of convenience rather than waiting for a new clinician who could accommodate his busy work schedule.

Psychiatry. Three participants saw a psychiatrist for therapeutic services. Participants who saw psychiatrists were seeking psychotherapy services while using medication to help reduce the mental health symptoms that resulted from IPV. Sam (22, gay) initially sought psychiatry to discuss his depressive symptoms and learned his psychiatrist could also provide psychotherapy in addition to medication management.

> Typically, the stigma of seeking a psychiatrist is that they're going to throw pills at you then send you off. But I've seen two providers since I've started going to our university

> clinic and both have been very interested in doing therapy. Therapy services were presented before medication was an option. That felt good too, since it didn't feel like they were just trying to get me to run down to the pharmacy and swipe my debit card. They seemed to have an interest in following my case to make sure I was getting better… They were genuinely invested in seeing me, and processing this, and learn to cope so I could move on.

Seth (47, gay), Travis (44, queer), and Jeffrey (27, gay) sought psychiatry in addition to psychotherapy from a therapist or psychologist in order to receive medication to help reduce the impact of mental health symptoms they experienced after leaving their abusive relationships. Jeffrey (27, gay) sought out a psychiatrist while seeing a university psychologist to address cognitive impairments that arose as a result of the physical trauma from his IPV exposure.

Substance Use and Crisis Use Management. Participants used multiple resources in addition to or separately from psychotherapy. One third of participants described using multiple resources, both psychological and non-psychological, during their help-seeking process to address crises and substance misuse concerns.

Substance Use Management. Three participants needed to first address other concerns that were exacerbated by their IPV experience, such as substance misuse. Each of them accessed Alcoholics Anonymous (AA) either prior to or concurrently with psychotherapy. Travis (44, queer) attended AA to help treat substance use concerns that were exacerbated by the IPV he endured. Conversely, Matt (27, gay) and Aaron (37, pansexual) described their AA experience as homophobic, and both participants felt blamed for the IPV they experienced. Matt reflected that "I felt they were telling me that I had to take responsibility for the fact that he was abusive to me." Aaron's (37, pansexual) clinician in Georgia emphasized that Aaron should prioritize his

substance misuse concerns, which frustrated him since IPV exacerbated his substance misuse. Matt (27, gay) struggled to find clinical services that addressed his substance misuse concerns and mental health symptoms after his abusive relationship, stating:

> That's not helpful since I don't think any of this stuff happens in a vacuum… you're set up to fail then if you can't get access to all the help that you need… I just had a relapse… that had a lot to do with it. So, when I got help after that relapse and after that suicide attempt, I think that, uh, it's hard for me to remember exactly. But those [mental health struggles] probably encouraged me to get help for the violence. (Matt, 27, gay)

Crisis Management. Four participants experienced police intervention for IPV, and two of those further became engaged in the criminal justice system to obtain no-contact orders and to press charges against their abusers. Furthermore, three participants accessed a 72-hour psychiatric hospitalization for suicidal ideation. One participant said his hospitalization was an outcome of discovering his partner's infidelity. The other two experienced a combination of suicidal ideation and substance use that was connected to the stress of their violent relationships, leading to hospitalization. Matt (27, gay), for instance, experienced several drug relapses and a suicide attempt that were related to the trauma of his IPV experience. Each of these three participants found that being in a 72-hour hold was important for realizing they needed more intensive and long-term help. Mark (33, gay) said:

> After having been in the hospital for that hold period, I knew I could not work through this on my own… It was gonna have to be something outside of myself to help me with [the IPV] and guide me through it.

Characteristics of Helpers

Once participants found a provider to help them heal from their IPV experiences, all 12 participants described the ways that their provider kept them engaged in the therapeutic process. In general, participants had difficulty remembering specific components of their therapeutic experience that they found useful but could generally describe how service providers facilitated participants' feeling safe and motivated. Participants developed a confidential and empathic relationship with their therapists.

> I liked that I knew that I had someone that I could tell all these details to and not feel ashamed and know that it's not gonna get spread around… I appreciated having that relationship with a therapist. I truly felt like I could share any thought… I continued to seek treatment because I felt like my mental state was improving. (Paul, 27, gay)

Flexible Scheduling. About half of the participants shared that their therapists' ability to be flexible with scheduling appointments helped them stay engaged in treatment, since attending therapy was sometimes challenging due to long work hours, having to drive long distances, and often still trying to rebuild their lives. Seth (47, gay), for example, lived in a small rural town, far from where he used services in a small, rural town. By the time he got off work and drove to his doctor's office, the therapist and psychiatrist were usually gone for the day. Having a practitioner who was flexible with scheduling allowed him to access services more easily.

Therapeutic Style and Presence. Over half of the participants perceived their providers' therapeutic style helped them share their IPV experience and engage in psychotherapy. Providers' style helped participants build trusting, open relationships in therapeutic settings and more meaningfully engage with treatment. A major aspect of therapy for IPV included exploration of emotions: Paul (27, gay) recalled that, "She had taught me some coping strategies that I could manage… or be able to recognize certain emotions that I was feeling that I didn't

necessarily recognize on my own before." Ray (48, gay), recalled that, "They wanted you to be comfortable around your most sensitive memories."

Several participants noted that their therapists would try to incorporate humor and ensure that they left the session feeling better than when they entered. For instance, Dean's (25, gay) therapist was able to ensure he left session feeling good and would lighten heavy topics if she felt he needed it. If Seth's (47, gay) therapist sensed a topic was getting too intense, they would shift the topic of the session. Lastly, three participants noted that their therapists would ask them to write about their IPV experience. Jeffrey (27, gay) found it helpful that his therapist asked him exploratory questions, accurately reflected and summarized the content of his sessions, and gave him writing assignments to process his experience of IPV.

Participants also said that they stayed engaged in treatment because their therapist was non-judgmental and showed empathy for the experiences of sexual minority men. For instance, Mark (33, gay) noted that he did not feel judged as a gay male survivor, saying it was important to be in a space "without having anybody judge me for being okay. And for the underlying [that] you're a man, how could you have let this happen to you?" Mark felt connected to his therapist, observing their open body language and memory for details that Mark shared from session to session. Similarly, Sam (22, gay) noted both of his clinicians communicated it was a safe space to talk and were empathetic despite not having been in a same-sex relationship. Sam did not have to tone down what he experienced and perceived that his providers were invested in his recovery.

Physical Characteristics. Three participants noted that physical traits of their therapists made therapy easier. Some participants, for instance, found it easier to speak to female therapists. Others responded better when the therapist was not physically intimidating. Seth advises therapists:

> Be patient, don't appear threatening and… or appear as non-threatening as possible because even if you… even though you know you're there, to help him coming out of something [IPV], you just don't know. I still jump when people just come up and tap me on the shoulder. (Seth, 47, gay)

Participants in this study accessed a diverse assortment of mental health providers in response to the IPV they experienced. Typically, men in this sample saw at least one psychotherapist. Other participants attended psychiatry to receive talk therapy and/or medication management for mental health symptom reduction. Lastly, several participants spoke of needing crisis management services to reduce the impact of substance misuse and suicidal ideation that had developed in response to the IPV they experienced.

Summary of Findings

The experiences of 12 sexual minority men were analyzed to better understand their experiences of seeking help for IPV. Participants narrated how they moved from an abusive relationship to finding psychological resources to aid in their healing from IPV. All five parts of the help-seeking process (1) triggering events; (2) motivation to seek help; (3) searching for help; (4) getting help and sticking with the process are illustrated by the following composite of participants' narratives:

Each participant sought help either immediately or after several months after leaving their abusive relationships. Relationships were characterized by physical, psychological, sexual, HIV-related, financial, and stalking abuse. Participants described how they began experiencing IPV a few weeks to a few months into their relationship, with abuse occurring throughout the relationship. Some men left the relationship after one severe abuse incident, because of substance misuse by partners, or other relationship dynamics that indicated to participants that their physical safety and mental health was at stake.

Participants drew on a number of character strengths, which were critical to persevering in their search for help and facing barriers to finding help. For instance, several participants struggled with addiction, suicidal ideation, and rebuilding their lives after IPV. For many, grappling with the fact that they were in an abusive relationship was overwhelming. Several wanted to understand why the IPV happened to them and to tell their story to someone. Others

needed to be told they could heal and that they could make meaning of their experience. Participants desires, often paired with worsening mental health symptoms such as depression, anxiety, and trauma symptoms, fueled help-seeking.

Some participants found a therapist by telling their boss they needed someone to talk to. Other participants began searching for help quickly and found a resource through their connection to a university counseling center, their HIV care provider, or their primary care physician. Some participants found a clinician after a friend referred them. For other participants, using Internet search engines to locate a therapist was most efficient. Each of these avenues led to an eventual referral to attend therapy, psychiatry, or both to begin processing their experiences. The process to finding help could be painstaking. Some participants went through multiple therapists who were not understanding of their experience or blamed them for the abuse they experienced. Sometimes other concerns needed to be addressed throughout therapy such as substance misuse and suicidal ideation, which were exacerbated by IPV.

Participants saw their provider anywhere from a few weeks to several years to work through their psychological concerns resulting from IPV and to receive psychiatric medication. For several participants, finding their initial therapist was difficult and delayed. Some did not know where to look for a therapist, had to consider the cost of therapy and manage the driving distance, and change their work hours to accommodate appointment times.

Participants found support from important people in their lives and noticed the influence of their geographic location on findings services. Close friends or a work boss were important for connecting to a therapist. For others, friends provided important encouragement for them to seek out professional help when the trauma reactions to IPV were impacting participants' well-being.

Searching for help was often complicated by several barriers. For instance, participants might not know of any IPV-related resources to access in their geographic region, or they may have lacked financial resources. Multiple participants feared that providers would not be culturally competent to work with sexual minority male survivors. Having social support and character strengths facilitated participants persistence in the search for help. Strengths that included a drive to heal, wanting a better future, being resilient, and being open to going to therapy kept them motivated and engaged when encountering barriers to help-seeking.

Participants described several ways that their therapist and/or psychiatrist helped engage them in services. Clinicians would reassure participants they could heal from this experience and created a safe space for participants to disclose abuse. Clinicians would help identify participants' strengths and explore their emotional experiences. Overall, participants felt their provider was invested in their recovery. Participants perceived that their therapist was present and listening to them empathically when they asked open-ended questions that got them to recapitulate and reflect on their experience, remembered content between sessions, and used body language that communicated safety and respect. Practitioners communicated that they saw participants making progress as their work advanced. As practitioners work with sexual minority IPV survivors, participants advertise them to make their ability and willingness to work with this community known so that they are easier for sexual minority men to find.

The following chapter discusses limitations of the study and implications of the findings for future research and therapeutic practice.

Chapter Four: Discussion

All 12 participants in this study engaged in a help-seeking process that began with a triggering event, which led to either searching for help immediately or after a delayed period of time. They tapped into character strengths and other motivators to push past barriers and find professional psychological help for IPV. Upon finding help, several characteristics about the psychotherapy they received kept them engaged in the therapeutic process. The findings from this grounded theory qualitative study contributes to our knowledge about how sexual minority men seek and find psychological resources to address IPV.

Participants' lived experience of seeking help for IPV has implications for future research and clinical practice to address this major public health concern (CDC, 2018). Sexual minority men participating in this study described needing to seek out psychological help to recover from IPV. Attending psychotherapy led to perceived outcomes such as psychological well-being, healthier partners and relationships, and hope for their future. The following sections summarize findings about each step of the help-seeking process. I compare each step of the help-seeking process to previous findings about IPV in sexual minority men's relationships, explore clinical implications for each step of the process, and suggest future research directions to further explore each step of this process.

Step 1: Triggering Events

Participants in this study followed a linear help-seeking process. They initially experienced one or more triggering events that preceded help-seeking. IPV took several forms (i.e., physical, emotional, sexual, HIV-related, financial, stalking). These behaviors did not tend to occur at the beginning of the relationship. Partners would sometimes try to make amends for abuse, extending a survivor's length of time in the relationship before seeking help.

Previous Findings

An extensive body of research documents the types of IPV sexual minority men experience, the dynamics of IPV in their relationships, and, to a lesser extent, their reasons for leaving abusive relationships. Previous findings document that sexual minority men experience similar forms of abuse to those in this sample (i.e., physical, psychological, financial, sexual, HIV-related; Walters et al., 2013). Merrill and Wolfe (2000) note that violence does not often occur until several months into a relationship and may follow the Cycle of Violence model (Walker, 1979). The Cycle of Violence model was proposed as a model for heterosexual-identified women with abusive male partners. IPV episodes are thought to be followed by a "honeymoon phase" and violence subsequently escalates over time. Additionally, psychological abuse appeared to be a common form of abuse found in this sample (Pantalone et al., 2012; Stults et al., 2020). Participants also recalled that alcohol and drug use preceded and exacerbated abuse episodes, consistent with previous studies (e.g., Kelly et al. 2011; McClennen et al. 2002; Stall et al. 2003).

Clinical Implications

Findings about the influence of triggering events on help-seeking can inform professionals who work with sexual minority IPV survivors. Participants in this sample began help-seeking for multiple reasons and at different points in times after they experienced IPV. When working with clients in abusive relationships, it could be important to explore what keeps participants in their relationship and give them autonomy about choosing when to leave their partner, barring concerns about safety and risk. Some participants needed time before they were ready to take the critical step to leave an abusive relationship, while others were ready to immediately leave, seek help, and discuss IPV in their relationships. To effectively serve this

population, clinicians must be ready to flexibly respond to participants' needs when they disclose IPV in order to facilitate healing (Hancock, 2014).

Providers can also partner with sexual minority communities to focus on prevention efforts. Community efforts are critical to not only reducing IPV, but to provide opportunities for sexual minority men to find and access psychological resources. Prevention efforts can reduce IPV in sexual minority men's relationships, rather than treating survivors and batterers after abuse has occurred. Prevention research are scarce (Murray & Graybeal, 2007), but critical, as early prevention and interventions is likely less costly and, based on research with heterosexual couples, could improve well-being of survivors (Langhinrichsen-Rohling & Capaldi, 2012).

IPV prevention efforts could emphasize early education about early warning signs of abuse to help sexual minority men identify unhealthy relationship patterns (Pepler, 2012; Rohling & Turner, 2012). Such prevention efforts are warranted in light of findings suggesting sexual minority men do not often know they are in an abusive relationship (Donovan and Hester, 2008). Participants in this study either echoed this sentiment or did not imagine they would ever find themselves in an abusive relationship.

Future Research

No research to date focuses on prevention of IPV in sexual minority couples, as IPV prevention is often assumed to be a phenomenon in which heterosexual men abuse heterosexual women (Ehrensaft, 2008). Even within research on interpersonal violence in heterosexual relationships, evidence-based strategies for prevention are scarce. The Centers for Disease Control (CDC) provide some guidelines for IPV prevention, such as teaching healthy relationship skills to adolescents and young adults or intervening early with at risk youth (Niolon et al., 2017). The suggestions describe multiple empirically based programs and steps to consider

for preventing IPV; however, none of the specific recommendations mention fit or utility for sexual minority male survivors and communities.

Although no identifiable research has evaluated prevention efforts in sexual minority individuals, some authors have made recommendations for prevention that could be operationalized and tested. For instance, Ford and colleagues (2013) recommend providing IPV training specific to sexual minority individuals to multiple types of agencies who may have contact with this population. They furthermore suggest modifying services and resources to be sexual minority specific (i.e., intake forms and pamphlets). Lastly, the authors suggest shelters and safe houses be established for sexual minority survivors. Future research should seek to review a wide variety of IPV prevention literature and review potential feasibility and applicability to this population as a starting place for developing prevention efforts.

Subsequent studies should continue to explore the ways that sexual minority men understand when to seek help for IPV, which may include raising public awareness. The CDC provide multiple resources that serve as a starting place for raising awareness about what IPV is and for describing different forms of abuse. One document provides comprehensive and detailed descriptions about the many forms IPV can take within a relationship, including terminology related to this phenomenon and examples (Breiding et al., 2015). This document can serve as an excellent starting place for service providers to familiarize themselves with IPV terminology and as a tool for beginning to educate sexual minority communities about the multiple ways abusive behaviors can manifest. Future research must test the utility of such a tool for providers across multiple treatment settings for the purposes of not only detecting IPV, but subsequently being able to make a referral to additional services. Quantitatively asking sexual minority men and IPV

service providers to evaluate multiple educational materials would provide valuable insight about the transferability of such documents to IPV within men's same-sex relationships.

Another avenue for future research is to not only develop assessment tools for sexual minority men but also explore the validity and reliability of IPV screening developed and normed with heterosexual-identified women. Assessing IPV in sexual minority men often consists of asking questions about receipt of abusive behaviors or utilizes scales developed for heterosexual-identified women (e.g., Conflict Tactics Scale, short form; Straus et al., 1996). However, one study developed a short-form screening tool for assessing IPV with gay and bisexual men consisting of six yes/no questions (Stephenson et al., 2013). The questions assess exposure to several types of abusive behaviors, such as physical, emotional, and sexual abuse, as well as stalking and climate of the relationship. Although no research exists assessing its usefulness within a clinical setting, a follow-up study should obtain IPV service providers' reaction to how useful the measure would be if used in practice.

Previous findings explore what helps men leave abusive relationships and what needs to take place to recover from abuse. Oliffe and colleagues (2014) interviewed 14 gay men about their IPV experiences. Participants' reasons for leaving abusive relationships were seeing it as unsalvageable, over-reliance on substances to cope, or wanting to be a stronger person. To recover, participants recalled needing to let go of anger and resentment from the relationship, as well as talking to other people about their experience. Findings from Oliffe's study and the current study can be used to develop survey items about events and experiences that prompt sexual minority men to leave abusive relationships and seek help.

Step 2: Motivation to Seek Help

Sexual minority men may encounter, and overcome, multiple barriers to finding help in addition to grappling with the impact of IPV on their lives. Literature on IPV, and particularly same-sex IPV, focuses on why survivors stay in abusive relationships (e.g., Cruz, 2003), but little research explores motivations for leaving and seeking help. The current study begins to fill this gap. Participants in this sample described the consequences of IPV which included using substances to cope with abuse, as well as mental health symptoms (e.g., depressive, anxiety, and trauma symptoms). They also described character strengths that helped galvanize their motivation for help-seeking, such as hope for a better future, resilience, their will to live, and problem-solving capabilities. Participants were also motivated to avoid adverse consequences, and negative emotions including fears of failure. Participants also described wanting to seek help to learn more about why they experienced IPV, asking questions such as, “Why me?” They wanted to know if they were responsible for being abused, as some clinicians suggested, or to identify relational patterns that contributed to choosing unhealthy partners. Lastly, disclosing IPV to social supports in participants’ lives also played an important role in beginning their help-seeking process. For instance, participants responded to feedback from friends, family, and colleagues who saw they needed help and even gave them referrals.

Previous Findings

The reported impact of IPV by participants in this study are consistent with previous studies (Dickerson-Amaya & Coston, 2019; Miller & Irvin, 2017; Oliffe et al., 2014). For instance, Dickerson-Amaya and Coston (2019) surveyed LGB individuals about their IPV exposure and mental health, finding that IPV exposure increased the likelihood of diagnosis for depressive and anxiety disorders. The authors explored data provided by male sexual minority IPV survivors (n = 230), compared to their heterosexual-identified male counterparts (n = 3,623).

The authors found both groups were likely to experience Post-Traumatic Stress Disorder symptoms, and that sexual minority men were more likely to report poorer mental health and difficulty attending work or school because of the mental health impact of IPV. Participants in this sample reported depression, anxiety, and trauma symptoms, and these adverse outcomes of IPV served as strong motivators to seek help.

The character strengths of men in the current study were critical motivators to seeking help. Participants described important facets of their personality that motivated them. A qualitative study found that sexual minority men wanted to share their story to prevent other men from entering into and/or staying in abusive relationships and wanted to avoid abuse in the future (Oliffe et al., 2014). Similarly, the participants in the current study wanted to share their stories to help prevent future IPV. They also described their will to live as motivating and used their problem-solving skills to overcome barriers to seeking treatment.

Past research has documented characteristics of heterosexual-identified female survivors that facilitate their seeking help for IPV. Munoz and colleagues (2016) examined possible components of resilience and internal locus of control in 125 heterosexual-identified female IPV survivors. Hope was an important aspect of increasing internal locus of control, which was related to outcomes such as developing confidence and utilizing resources. Similar to heterosexual-identified women in this sample, sexual minority men in the current study described the will to live and hope for a better future as motivating them to seek out psychotherapy. These attitudinal strengths have been demonstrated as important factors for facilitating help-seeking in other demographic groups, including ethnic and racial minority young adults (McDermott et al., 2017).

Disclosure of IPV to social supports (i.e., friends and family) may also be related to help-seeking. For instance, initial disclosure of IPV to informal supports is a common way that sexual minority men seek help for IPV (McClennen, Summers, & Vaughan, 2002). Findings from the current study support that disclosing to informal supports is common and occurs at different points during help-seeking. Interestingly, participants in this study did not always disclose IPV to informal supports before seeking help. Some participants told friends about their experiences while already seeking out therapeutic resources. In this case, participants may have felt more comfortable disclosing to informal supports after they had more built in safety from using psychotherapy to process their IPV experience. Sometimes people in participants' lives noticed a shift in their personality due to IPV, which promoted encouragement to seek help.

Sometimes participants did not disclose IPV to people in their lives because they were not "out" about their sexual identity and same-sex relationship. This is consistent with findings indicating that IPV is exacerbated by minority stressors, such as sexual identity concealment (Meyer, 2003; Yuen-Ha et al., 2017). Concealing identity as a survivor of violence and as a sexual minority man can interfere with one's ability to access psychological help. Expectations of rejection, another minority stressor and barrier to seeking IPV resources in this population, was another concern that participants shared. Stigma consciousness (Carvalho et al., 2011), and expectations of rejection from service providers (Morgan et al., 2016) may inhibit disclosure of IPV. In one sample (Carvalho et al., 2011), gay men and lesbian survivors of IPV reported being more "out" and experiencing significant stigma consciousness, potentially based on possessing two marginalized identities. Increased stigma consciousness in this case may reduce the likelihood of disclosure to others about IPV victimization. Participants in the current study were concerned about disclosing their IPV identity to others, even if they were already out and had

supportive relationships; some participants were concerned about negative reactions from providers if they disclosed their sexual identities. Despite evidence that participants in this study experienced these minority stressors, recognizing the negative impact of IPV on their lives, a desire for insight, and their internal character strengths motivated them to seek help.

Clinical Implications

Understanding what motivates sexual minority men to seek help for IPV has considerable implications for violence prevention efforts. Participants describe several character strengths that allowed them to push past barriers to seeking and getting psychological help for IPV. Clinicians need to be aware that clients from this population bring biopsychosocial concerns into treatment and also a number of character strengths and resilience that can be marshalled. Clinicians could assess strengths by asking participants about what has helped clients make it through an abusive relationship or what aspects of their personality helped them reach the point of seeking help. Interventions from strengths-based approaches, such as Solution-Focused Therapy (De Shazer & Dolan, 2012) could be useful for eliciting how IPV survivors managed to survive and seek help despite experiencing IPV. Such approaches could help participants describe their desired future, help them set incremental goals toward rebuilding their lives after IPV. To help build hope for the future, clinicians can use interventions such as the Miracle Question, Scaling Questions, and Coping Questions. The aforementioned interventions may help survivors focus on how they have already managed to cope with IPV and how those character strengths can be leveraged to reach their goals. Solution-Focused Therapy has some evidence suggesting it is useful for working with intact heterosexual-identified couples (e.g., Oka & Whiting, 2011; Stith et al., 2004), however its utility with sexual minority couples or survivors is unknown at this point.

Strengths-based approaches to working with IPV survivors is still uncommon. Asay and colleagues (2016) interviewed survivors of IPV across 17 countries and found character strengths similar to those reported by participants in this study, such as having hope for a better future, survival skills, and problem-solving skills. Each of these characteristics of IPV survivors can be harnessed by clinicians to help clients bypass barriers to moving forward with their lives.

The influence of important social supports may also be an avenue for sexual minority male survivors to connect with psychological services for IPV. In this study, social supports and feedback from significant others helped participants realize the impact of IPV, obtain referrals, and seek psychotherapy. Indeed, mental health help-seeking seems to be aided by encouragement from social supports, as they can reduce the stigma around seeking help (Gulliver, Griffiths, Christenson, 2010). Clinicians could be involved in spreading awareness about same-sex IPV through consultation and advocacy efforts. Since social supports of survivors encouraged accessing resources for IPV, spreading information about same-sex IPV in ways that these supports may learn about this phenomenon is warranted. Speaking at LGBTQ events, posting information at venues catering to LGBTQ individuals, and working with community agencies serving this population could spread awareness about IPV and resources to access. Furthermore, therapists could explore with their clients how their social support networks can help them maintain gains in psychotherapy or help them rebuild their lives following IPV exposure.

Future Research

Future research should continue to examine what motivates sexual minority men to seek out psychological services for IPV. While previous research has begun to examine how the impacts of IPV can motivate survivors to leave an abusive relationship (e.g., Oliffe et al., 2014), we would benefit from knowing more about how to galvanize sexual minority men to seek out

psychological resources (and other services) for IPV. For instance, research on IPV help-seeking in sexual minority men frequently identifies law enforcement as a common resource for IPV (e.g., National Coalition of Anti-Violence Programs, 2012). In one study, sexual minority men expressed frustration about seeking law enforcement or criminal justice interventions for IPV, which is a commonly encountered barrier for this population (Guadalupe-Diaz, 2015; Pattavina et al., 2007). A follow-up qualitative study could ask to what extent law enforcement and criminal justice agency employees and experts know of and refer survivors in this population to culturally sensitive services to address IPV. Understanding what might help men seek out more resources to address IPV and rebuild their lives could help build more comprehensive services to address this public health concern.

Social supports were important for motivating help-seeking, and future research should establish concrete suggestions for how social support and feedback from others could influence prevention efforts. For instance, some participants noted how feedback from others had motivated their help-seeking. Future research should assess to when and how bystanders and important people in survivor's lives come to know about and respond to IPV in same-sex relationships. Understanding how and when bystanders and important people in survivor's lives recognize IPV is occurring would allow for more precise interventions targeted at raising awareness so these groups could intervene in survivors' lives sooner.

Findings from the current study suggest several hypotheses that might be tested with larger samples. Future quantitative research studies might test theories related to help-seeking constructs that traditionally are used with heterosexual populations (e.g., Theory of Planned Behavior (TPB; Ajzen, 1991; Edwards, Gidycz, & Murphy, 2015). For instance, a study of IPV help-seeking among heterosexual women found that personal beliefs about help-seeking (i.e.,

will the resource be useful) is linked to intention to seek out IPV resources (Fleming & Resick, 2017). These findings are consistent with findings in the current study in that perception of provider helpfulness and perceived ability to reach out for help enhanced persistence. As a next step, validating help-seeking constructs in sexual minority men who have experienced IPV would build on the current findings that personal beliefs about resources are important.

Step 3: Searching for Help

Participants in this study experienced similar challenges to help-seeking that other studies describe. Findings included concerns about finding a culturally competent provider (Bornstein et al., 2006; Ford et al., 2013), fear of or experiences of being judged by their clinician (Morgan et al., 2016), and financial concerns about the cost (Cruz, 2003). Several participants struggled to take time off work, had to drive long distances to attend psychotherapy, and had to search through lists of clinicians to locate one that felt trustworthy and safe. Living near a metropolitan area with more available resources made seeking help easier. For instance, five participants said living in a rural area made it difficult to either find or access psychotherapy for IPV. Conversely, living in or moving to a metropolitan area reportedly made it much easier to find and attend psychotherapy with a competent and affirmative therapist. Despite these barriers, participants in this study found clinicians through multiple means, such as a referral from a healthcare or HIV services provider, from a friend, or through internet searches.

The current study adds nuance to how we understand the lived experiences that precede help-seeking. No published study research has examined these lived experiences. Specifically, concerns about one's mental health, economic resources, knowledge of resources, hesitance to disclose IPV, and need to treat other comorbid symptoms all influenced the timing of help-

seeking for IPV in these sexual minority men. Participants in this study also reflected on how their physical location influenced their ability to seek help.

Previous Findings

Past research has explored fears, worries, and concerns of sexual minority male IPV survivors who are considering seeking help. Sexual minority survivors of IPV have shared concerns about the competency of their clinician to provide culturally sensitive care that is tailored to the experiences of being a sexual minority individual and IPV survivor (Donne et al., 2018; Pierre & Senn, 2010; Smith & Turrell, 2017). Participants in this study had similar concerns when searching for psychological help and described fears about being rejected or judged. They also shared concerns related to paying for services. Difficulty with finding the time off from work and financial concerns are consistent with previous qualitative findings about gay and bisexual sexual assault survivors (Donne et al., 2018).

The closest studies that document when help-seeking occurs for IPV found that not knowing of resources (Edwards et al., 2015) and concerns about clinician competency to work with sexual minority clients (Donne et al., 2018; St. Pierre & Senn, 2010) are potential reasons to delay seeking help. For instance, Edwards and colleagues (2015) surveyed over 200 LGBTQ identified college students about their knowledge of campus resources for LGBTQ IPV. Most of their sample reported not knowing of accessible campus resources or knowing those resources did not exist, hindering the possibility of seeking help for IPV. Donne and colleagues (2018) interviewed 18 sexual minority men about their experiences with seeking help for sexual assault and found participants felt discouraged from seeking help. Identifying as both a male and sexual minority survivor created a sense of shame about being sexually assaulted and fears that disclosing these experiences would lead to stigmatization of one’s identity and experience.

Similar to findings in this study, participants were unsure about their provider's ability to help them and their own ability to access help that was available (i.e., cost of treatment, insurance coverage, and difficulty scheduling appointments).

Previous research does not explore how sexual minority IPV survivors find psychological help for IPV, only that it is a common resource sought by this population (e.g., Scheer & Poteat, 2020). This could be because of the gendered lens that IPV is typically viewed through, suggesting it is a phenomenon that heterosexual-identified women experience in relationships with men (Girschick, 2002). As a result, heterosexual- and female-identified survivors may have access to more traditional forms of IPV help, such as shelters, leaving sexual minority men without formal options for intervention and treatment. Little is known about how psychological services are located prior to participants' accounts in this study. This study begins to expand our understand that finding a therapist happens through multiple channels, but most commonly comes from a referral from either a healthcare provider or one's social support network.

Research focusing on IPV in sexual minority men often recruit samples from metropolitan areas (e.g., Finneran & Stephenson, 2017). Participants in the current study who lived in rural areas noted the difficulties they experienced finding help as a result of their geographical location. Those who were on university campuses and those who had insurance were better able to access psychological services. To date, no other study documents how geographic location may influence experiences of seeking psychological help for IPV outside of convenience sampling from large, metropolitan areas. From a Minority Stress Theory perspective (Brooks, 1981; Meyer, 2003), participants from rural communities might be more reluctant to seek services because they assume that individuals in these communities hold prejudicial attitudes toward sexual minority men and their relationships. Hence, they might

conceal their identity for safety, anticipate negative reactions from providers, and fear overt discrimination. In this sense, help-seeking for IPV in rural contexts is different from seeking help in larger, metropolitan areas.

Lastly, participant's support systems acted as a source for referral and encouragement. Like other studies (e.g., Freedner et al., 2002), some participants found resources through their friends. Other participants confided in healthcare providers to obtain a referral to psychological resources. I located only one study suggesting that gay men benefit from talking to healthcare providers about their IPV experiences, possibly by receiving guidance about managing mental health symptoms that arose from IPV (Oliffe et al., 2014).

Clinical Implications

Healthcare providers are influential in connecting IPV survivors to psychological resources. Previous research suggests healthcare providers can prevent IPV through screenings (Ard & Mackadon, 2011; Bacchus et al., 2016). Bacchus and colleagues interviewed gay and bisexual male IPV survivors about screening for interpersonal violence. Their findings suggested that healthcare providers should strive to build strong rapport with patients to ask about and receive honest answers about IPV and be ready to provide relevant and useful resources to survivors. The frequency at which participants were bridged to services through their healthcare providers signifies the importance of making knowledgeable and appropriate referrals (Ard & Mackadon, 2011; Oliffe et al., 2014; Pierre & Senn, 2010). Furthermore, it is critical that they not only be well-versed in mental health resources for sexual minority male survivors, but also screen for IPV (Ard & Makadon, 2011; Bacchus et al., 2018).

Over one third of participants said advertising affirmative services for sexual minority men and survivors of IPV is crucial; they rarely knew of accessible, culturally competent

psychological services. Based on past findings, displaying cultural competence and advertising should be closely linked. For instance, Duke and Davidson (2009) note that providers must be trained in providing services to this community, intentionally advertise accessible services, coordinate services with other agencies (e.g., law enforcement, domestic violence shelters mental health providers, and healthcare providers), and have a list sexual minority affirmative resources ready to share and disseminate within the LGBTQ community. The aforementioned findings suggest that sexual minority men have little knowledge about IPV and subsequently do not know of accessible resources when they experience abuse in their relationships (Turrell et al., 2012). Information about culturally sensitive IPV service providers should be distributed to both providers and sexual minority community spaces (i.e., resource centers, bars).

Future Research

Findings in this study suggest ways that sexual minority IPV survivors look for and find psychological help for IPV, and more information about this process is needed. Continuing to learn about how sexual minority men locate psychological services for IPV can inform targeted advertising and strategies for increasing service accessibility. A future quantitative survey research study should address not only how sexual minority men seek out psychological services for IPV, but how they find a referral for services. Multiple pathways to finding a therapist were reported in this study, including searching online and eliciting referrals from healthcare providers and friends. The process of finding a therapist could better inform stakeholders about the need for referrals and the importance of clear, inclusive, and affirming advertising.

To address the specific needs of sexual minority IPV survivors from rural areas, qualitative researchers should ask sexual minority men from rural areas about their experiences with IPV and their process of finding help. Specific emphasis should be placed on the impact of

rural environments on this process. Furthermore, survey research could examine how rurality moderates help-seeking predictors such as knowledge of and perceived usefulness of resources.

Participants living in rural locations had difficulty finding and accessing resources for IPV, sometimes due to a lack of visible or safe psychotherapy resources to access. A useful next step would be testing sexual minority IPV survivors’ perceptions of advertising and recruitment efforts by mental health services. Specifically, using a Delphi poll could garner experts’ opinions and consensus about websites or advertising of clinicians who work with this population. Such feedback would help assess what clinicians do well already in their service advertisement and where improvements are needed. Such research is particularly needed given the already limited access to mental health resources in rural regions (e.g., Ziller, Anderson, & Coburn, 2010), suggesting that resources need to be visible, inclusive, and affirmative of sexual minority identities.

Step 4: Getting Help and Persisting with the Therapeutic Process

After searching for psychological help for IPV, participants in this study accessed psychotherapy and/or psychiatry; some participants used both resources to address mental health concerns related to IPV. Resources were accessed across a variety of settings and for varying time lengths, however participants overall reported that seeking psychological help for IPV helped them move on with their lives. In addition to receiving treatment for IPV, some participants recalled experiencing comorbid suicidal ideation and substance misuse in their efforts to cope with IPV. These clinically significant concerns needed to be addressed either before or during IPV psychotherapy. Lastly, participants recalled how specific aspects of their therapeutic experiences were helpful to their staying engaged in the therapeutic process. These aspects included therapists exuding a calm and competent therapeutic presence, meeting clients

where they were at, conveying empathy and a nonjudgmental stance, flexible scheduling, and even physical characteristics that made developing trust easier.

Previous Findings

Intimate partner violence is frequently associated with several adverse outcomes for survivors, such as increased substance use (Buller et al., 2014), decreased mental health (Miller & Irvin, 2017), and lower self-esteem (Oliffe et al., 2014). These consequences are consistent with participant experiences in this study and contextualize why sexual minority men relied on crisis intervention services to address suicidal ideation and substance use concerns either during or after their IPV trauma. Extant literature suggests substance use may be a potential coping strategy for survivors managing IPV (Freeland et al., 2018), however suicidal ideation and suicide related to IPV appears to have only been studied in heterosexual female-identified samples (Cavanaugh, et al., 2011; Devries et al., 2013). Frameworks such as Syndemic Theory (Stall et al., 2007) posit that IPV is associated with other inter-related adverse outcomes that can reciprocally exacerbate each other. Similarly, participants' experiences in this study did not occur in isolation from other pressing life challenges and concerns.

Like other findings, participants in this study accessed psychologists, therapists, and psychiatrists for IPV help (e.g., Houston & McKirnan, 2007; McClennnen et al., 2002; Scheer & Poteat, 2019). Despite mixed findings about the perceived usefulness of psychotherapy resources for sexual minority men (e.g., McClennen et al., 2002; Merrill & Wolfe, 2000), participants in this study reported therapeutic help was important to their recovering from IPV. Previous research does not explore in what ways psychotherapy is helpful, or unhelpful, to this population. The current study begins to contextualize how sexual minority men benefit from psychotherapy, such as having clinicians who seem genuinely invested in their recovery, provide an empathetic

and grounded presence to explore the impact of IPV, and are flexible with meeting participant's needs around scheduling and finances.

Lastly, this study addresses sexual minority men's experiences with therapy and explores what kept them engaged in services. Participants valued their clinicians when they perceived them to be knowledgeable enough to work with sexual minority clients, flexible in scheduling appointments, physically unintimidating, and fully present and empathic. Clinicians who had experience working with sexual minority men were perceived as understanding of the unique aspects of belonging to this community. Without this understanding, participants had difficulty connecting to their clinician. This could be fueled by shame of disclosing IPV and fear of disclosing one's sexual identity, particularly if men anticipate that a clinician will not be able to empathize with their experiences as a sexual minority survivor (Morgan et al., 2016).

Participants in this study did not often recall specific interventions employed by their therapist, however, they remembered how they felt in psychotherapy. Therapists' ability to develop rapport and create a safe holding environment to process IPV is consistent with findings from common factors research. For instance, findings suggest developing the therapeutic alliance is critical to success in psychotherapy (Flückiger et al., 2018; Horvath et al., 2011). Findings from the current study about participants' recalling their therapists being nonjudgmental and creating a sense of safety to process IPV suggests that building a strong therapeutic alliance is critical to processing sexual minority men's experiences of relationship violence. In previous research, empathy, groundedness, openness, cognitive complexity, awareness of personal biases, resourcefulness, and unconditional positive regard were reported by clinicians as ways to build therapeutic alliance with sexual minority IPV survivors (Hancock, 2014). Participants in this study similarly recalled how exploring emotions, empathy, a non-judgmental stance, and

knowledge of same-sex relationships were essential to their feeling connected with their therapist.

Prior research on IPV in sexual minority men does not explore the importance of therapist characteristics; however, in related research, matching race and ethnicity has been found to be important in heterosexual female survivor-therapist dyads (Horst et al., 2012). Sexual minority men may feel less judged by a female provider, as opposed to male medical providers (Bacchus et a., 2016). Disclosing victimization to a male provider may elicit stigma consciousness because it violates masculine norms that men cannot be victims of abuse (e.g., Kay & Jeffries, 2010). As a next step, researchers should ask sexual minority men about how male-identified clinicians can create safety in psychotherapy spaces, particularly for those who have experienced interpersonal violence. An analogue research design could provide sexual minority IPV survivors with therapeutic intervention prompts delivered by either a male- or female-identified therapist. Participants could rate therapists based on their perceived experience working with IPV survivors, sexual minority men, and the degree of empathy expressed. The condition of revealing the gender identity of clinicians to participants could be used to assess sexual minority male survivors' preference for male or female clinicians. Future research could also assess therapy process and outcomes with male-identified clinicians and sexual minority male counseling dyads.

This study, and previous research, suggests that showing empathy and knowledge of the sexual minority community is important, but it is also important to acknowledge and address the specific, immediate individual needs of a client who has experienced IPV. Clinicians should take a trauma informed approach (Abuse, 2014) to give clients power over how much they share at any given point and when they need to take a break from discussing traumatic events. Based on

some participants accounts, building in levity to sessions when content is heavy can be useful, reflecting findings that laughter and soothing activities are antithetical to traumatic stress responses (Black, 2006).

Lastly, previous literature suggests that finances are a common barrier to leaving an abusive relationship (Woodyatt & Stephenson, 2016). The current study suggests it is a barrier to accessing therapy. Finances and/or lack of insurance, combined with difficulty getting time off work to see a therapist, including travel time, were barriers for participants. Indeed, some evidence suggests money for even basic needs can be difficult to obtain when experiencing IPV in same-sex relationships (Kubicek et al., 2015).

Clinical Implications

Findings from Step 4 have several implications for training mental health professionals to work in a culturally competent manner with sexual minority male IPV survivors. Based on participant experiences, a significant aspect of cultural competence in working with this population is the quality of the therapeutic relationship. The following sections review how findings about this help-seeking step can inform psychological practice with this population.

When asked about how to best serve this population, many participants expressed the need for clinicians to strive for understanding the experiences of being both a sexual minority male and an IPV survivor. One way for clinicians to communicate understanding of this community is knowing relevant terminology (e.g., bear, otter, leather) and understanding how abuse looks different in same-sex relationships compared to heterosexual relationships. Clinicians should regularly review recent changes in terminology within the LGBTQ community to ensure their clients do not have to educate them during psychotherapy. Furthermore, clinicians should be well versed in research about same-sex IPV to understand the unique ways abuse can

manifest in sexual minority male relationships. This knowledge can be particularly useful in helping clinicians challenge their assumptions about who can be abused and what forms abuse can take in a relationship. One participant said that it was important to have knowledge of how IPV operates in same-sex relationships and noted how much more awareness there is about helping heterosexual-identified female survivors. This observation mirrors the lack of awareness and concrete ways to assist other populations who survive IPV, including sexual minority men, despite high prevalence rates (Stiles-Shields & Carroll, 2015).

Another way to communicate cultural competence and to build the therapeutic alliance with this population is to demonstrate knowledge of additional community resources this population could access. Past research suggests sexual minority survivors believe IPV service providers should be knowledgeable about resources in the community that are accessible and safe to access (Pierre & Senn, 2010). Multiple participants in this study found therapy through their HIV services provider or healthcare provider, suggesting a need for providers to know other culturally competent providers to make referrals to. Lastly, participants in this study described how flexible scheduling and sliding scale psychotherapy fees were critical to accessing therapeutic resources. Clinicians can communicate understanding the impact IPV has on survivors' lives by flexibly meeting their client's time and financial needs, particularly immediately following leaving an abusive relationship.

Clinicians should advertise relevant training they have received or research they have conducted related to this population. This can be done through posting on their personal website, LinkedIn page, or other venues where services are listed. Several clients said this information helped them assess the fit of a clinician before making an appointment and finding time to attend it. Some clients may already be coping with the trauma outcomes of IPV and working to find

new housing, and jobs. Communicating clinical services through multiple channels and striving to ensure community awareness of services could save survivors time and energy in finding services, while mitigating fears about cultural competence.

Another concern in working with sexual minority male survivors of IPV is the heightened rates of suicidal ideation and substance misuse that could constitute a form of coping with abuse. Previous research has documented that substance misuse is related to IPV victimization, which can exacerbate suicidal ideation/attempts (Houston & McKirnan, 2007; Relf et al., 2004). Several participants experienced suicidal ideation during and after experiencing IPV. Heterosexual-identified women in different sex relationships have reported high rates of suicidal ideation as an outcome of IPV victimization (e.g., Pico-Alfonso et al., 2006). A robust body of research documents an association between sexual minority identity and suicidal ideation and/or attempts. Suicidal ideation and/or attempts in this population could be related to the presence of minority stressors (Meyer, Frost, & Nezhad, 2015), which are associated with IPV and may act as barriers to help-seeking (e.g., Gillum & DiFulvio, 2012). Therapists should assess for both substance misuse and suicidal ideation when serving this population, particularly because clients in this study reported needing to address these concerns in addition to the IPV they experienced.

Future Research

Future research should examine survivors' experience with therapeutic process as well as the outcomes of clinical interventions. Several participants recalled feeling supported by their therapists, even if they could not remember specific interventions or coping skills provided. Common factors research centers the therapeutic alliance as critical to success in psychotherapy and is important to psychotherapy process and outcome research specific to IPV in sexual minority men. Future qualitative research could ask about both sexual minority survivors' and

therapists' experiences in therapy for IPV exposure to learn more about building a strong therapeutic alliance. Therapeutic process studies could examine how therapists engage sexual minority men in treatment while also creating and evaluate specific affirmative therapeutic approaches for IPV with sexual minority men that support positive coping (instead of self-medication).

Some research explores sexual minority women's perceptions of service provider competency (Alhusen et al., 2010), but little is known about how sexual minority men view their psychotherapy experiences. Researchers should next interview sexual minority men who are currently in psychotherapy for IPV to learn specifically about what interventions are useful for their recovery and help facilitate a trusting and collaborative relationships; such findings would be particularly crucial for IPV service providers to reduce the likelihood of attrition and increase positive outcomes for this population.

Outcome research is also needed to assess the utility of psychological approaches for supporting sexual minority male IPV survivors' lives. Follow-up research could explore sexual minority men's experiences after being in therapy to understand how they have made meaning of their IPV experience and their long-term mental health. Large-scale multi-site health survey research could explore therapeutic alliance, severity of symptoms, time in therapy, and other factors related sexual minority male survivors' outcomes as a result of therapeutic services. Understanding the effectiveness of therapy targeting IPV-related mental health symptoms will be critical to improving therapeutic services.

Little research has documented a connection between IPV and suicidal ideation and/or attempts, and what exists does not untangle the influence of other factors that could increase IPV risk and impact on mental health (Mimiaga et al., 2015). Since several participants in this study

struggled with suicidal ideation, an important future study should seek to answer prevalence rates of suicidal ideation and/or attempts in this population. Furthermore, researchers need to explore to what extent IPV risk assessments are integrated into suicide risk assessments within this population in order to highlight the need for attending to this severe mental health concern.

Strengths and Limitations

This is one of few studies about help-seeking for IPV in sexual minority men that recruited a sample diverse in sexual identity and age. Also notable is that the sample included participants from rural regions known to be low resourced in terms of available services. This sample stands in contrast to studies sampling from large, metropolitan areas with large sexual minority populations (e.g., Atlanta, New York City; Stephenson & Finneran, 2017; Williams et al., 2015).

Another notable strength of this study is its in-depth exploration of lived experiences seeking help in the aftermath of IPV. Frequently, research on IPV help-seeking in this population has focused on barriers to getting help for IPV and coping strategies, rather than exploring how the help-seeking process unfolds. Studying lived experience provides a complex picture of the ways that sexual minority men must navigate seeking and getting professional psychological help, such as lacking awareness of competent services and fearing potential stigma from services providers (e.g., Calton, Cattaneo, & Gebhard, 2016; Freeland, Goldenberg, & Stephenson, 2018). For instance, this study builds on prior knowledge that HIV services, healthcare providers, and psychological resources are all commonly sought by this population (e.g., Felix et al., 2020), yet no previous study documents the methods by which sexual minority men access and use these resources to improve their quality of life after IPV.

The current study sample lacked racial diversity, as only one participant identified as a Hispanic man and the rest identified as White men. Future studies need to address the unique

experiences men of color face as they seek help for IPV. Recruiting sexual minority men of color is particularly critical. Past studies have on occasion recruited more diverse samples of sexual minority male survivors (e.g., Freeland et al., 2018), and other have not (e.g., Bartholomew et al., 2008). Freeland and colleagues (2018) collected their sample from a major metropolitan city with a high concentration of gay and bisexual men and had access to a diverse population based on race, education level, and relationship type (i.e. monogamous, open relationships). For understanding the experiences of sexual minority men of color, it may be crucial to sample from large cities with dense LGBTQ populations. Little is known about sexual minority men of color's experiences finding and accessing psychological resources of any kind, and their experiences likely differ from White members of the sexual minority community. For instance, some literature documents Black sexual minority men's experiences of racism within sexual minority communities as well as in larger society, which may inhibit help-seeking and further increase negative mental health outcomes for this subgroup of the population (e.g., Cascalheira & Smith, 2020; Wade & Harper, 2019). Although prior research suggests that sexual minority men may seek help more often, identifying as a person of color may limit help-seeking (e.g., Parent et al., 2018). Evidence also suggests that people of color may be more reluctant to seek out therapeutic services specifically (Gonzalez et al., 2010), possibly due to expectations that therapy will not be useful, or clinicians will harm rather than help them.

Conclusion

Intimate partner violence is a traumatic experience that frequently leads to a multitude of harmful and persistent outcomes (Miller & Irvin, 2017). For sexual minority men, adverse outcomes of IPV, compounded by a perceived lack of resources often paint a bleak picture in the extant sexual minority IPV literature. This study contributes new understandings of the steps that sexual minority men engage in to obtain help for IPV. Recognition of strengths, motivations, and

the ability to persevere in the face of IPV and recognition of the importance of additional systemic changes that increase affirmative therapeutic services and access to services aligns with counseling psychology’s values and commitments to fostering health in marginalized populations.

Appendix A. Study Flyer

RECRUITING GAY, BISEXUAL, AND QUEER MEN FOR A RESEARCH STUDY ON GETTING PSYCHOLOGICAL HELP FOR INTIMATE PARTNER VIOLENCE VICTIMIZATION

YOU ARE ELIGIBLE IF YOU:

- **IDENTIFY AS A GAY, BISEXUAL, OR QUEER MAN**
- **HAVE BEEN A VICTIM OF INTIMATE PARTNER**
- **VIOLENCE IN A SAME-SEX RELATIONSHIP**
- **HAVE SOUGHT PSYCHOLOGICAL HELP FOR**
- **INTIMATE PARTNER VIOLENCE**
- **ARE 18 YEARS OF AGE OR OLDER**

If interested and eligible, contact me, Todd Ryser-Oatman, at jtry222@uky.edu or read more about this study at: http://rebrand.ly/gbipv

You will be eligible for a $50.00 gift card if you qualify for an interview to thank you for your time.

Appendix B. Interview Screening Survey

Thank you for your interest in our study! We want to talk to sexual minority men (gay, bisexual, queer) who have gotten help for intimate partner violence that happened in a same-sex relationship. Specifically, we hope to better understand what your experience was like when seeking professional psychological help in the southeastern United States. The purpose of this survey is to determine if you are eligible to participate in an individual interview to learn more about your experiences with seeking professional psychological help for intimate partner violence. If you are eligible for and participate in an individual interview, you will be given a $50 gift card for your time.

This is a confidential study. If you are at least 18 years old and have had experiences with intimate partner violence in a same-sex relationship and sought professional help in response, and are willing to talk about your experience, please answer the following questions about the professional help that you sought.

If you have any questions, please feel free to contact Todd Ryser-Oatman at jtry222@uky.edu.

In what state did you seek professional psychological help for intimate partner violence?

From whom did you receive professional psychological help:

- Therapist or counselor
- Psychologist
- Social worker
- Pastoral counseling
- Healthcare professional
- A different resource professional resource to help with IPV:

In what year did you receive this professional psychological help?

How did you learn about this study?

Do you have any questions or comments?

Thank for your time answering these questions! If you are willing to be interviewed about your experience, please leave your first name and either your email or phone number so I can contact you about your possible participation in the interview! Thank you again, if you have any questions or comments, you can contact me at jtry222@uky.edu

First name
Email

Appendix C. Interview Protocol

Thank you for taking time to talk with me about your experiences with intimate partner violence. The purpose of this study is to better understand the lived experiences of sexual minority men who have sought and gotten professional psychological help for intimate partner violence in a same-sex relationship.

Interview Questions

The following questions will explore your lived experiences with intimate partner violence, what resources you used to get help, and what pushed you to get help.

Please answer these questions honestly and with as much detail as possible, because everything you share will likely be new and useful information. If any of my questions are confusing, let me know and I will clarify. Remember that all of your responses will remain confidential.

Demographics

How do you describe your sexual orientation or identity?

How old are you?

What state do you currently live in? Is this the same state you sought help for IPV in?

IPV Exposure

- Tell me about your experience with intimate partner violence.
  - What kinds of abuse did you experience? Were there any specific behaviors or events that stand out?
  - How long did the abuse go on for?
- How did the intimate partner violence start?
  - Tell me about the progression? Start suddenly, build up.
- How did it affect you? Were there other ways you were affected?

- What other parts about your experience with IPV feel relevant to let me know?

Facilitators to Help-Seeking

- What are your experiences with seeking and getting professional psychological help for intimate partner violence?
    - What professional resource(s) did you access?
    - Were there resources you didn't access but knew of?
        - What prevented you from accessing this resource?
    - How did you find this/these resource(s)?
    - How long after the IPV did you access this resource?
        - Did you access it during the IPV?
- What motivated you to get help for the intimate partner violence you experienced?
    - Was there a particular moment that made it clear it was time to get help?
- What got in the way of you getting help?
- What inside you told you it was time to get help for the violence?
    - What are some of your strengths that helped you?
    - What helped you push past any barriers or challenges (name barriers they mentioned)?
    - What other things about you as a person facilitated you seeking help?
- Tell me about your support network (prompt: family, friends, sexual minority community)?
- If you told these people about the intimate partner violence / if they found out about the intimate partner violence…
    - How did they show support?

- Tell me about how they influenced you to get help?
- How else were they helpful to you?

- What about your environment made it easier to seek help for IPV?
  - Tell me about the resources you know about for IPV around where you live.
  - How did knowing about these resources effect your getting help.
  - Tell me about how your environment made it easier to seek help based on all this?
    - Readily available resources, LGBT community, area where you live… word of mouth of helpful resources?
- What, if anything, about your relationship that made it easier to get help?
- How did your relationship contribute to your getting help?
    - X number incidents of violence?
    - Severity of violence?
    - Partner encouraged your getting help?

- If I didn't touch on something else, what other things facilitated you seeking psychological help?
- What helped you continue to use the resource that you did (what got you hooked in?)?
- What was helpful about the professional help you got?
  - What advice would you give to helping professionals who are working with gay and bisexual men who are experiencing intimate partner violence?
  - How have these experiences shaped you as a person? What have you learned from your experience?
    - Prompt for positive things if they do not mention.

- Is there anything that you might not have thought about before that occurred to you during the interview?
- May I follow up with you to give feedback on my preliminary findings and check that they reflect your experience?
- May I follow up if I have questions or need clarification on a part of your experience?

Appendix D. Self-Care Resources for Participants

1. Practice deep breathing: learn how by trying a breathing app or search Youtube for "breathing exercises"
2. Make your favorite warm drink and snuggle up under a cozy blanket
3. Read a book for fun
4. Write a letter to someone you love
5. Go for a walk outside
6. Write in your journal
7. Color: Google "free coloring pages for adults" for plenty of print-at-home options or purchase a coloring book.
8. List 10 things you are grateful for: or make it a daily practice. Keep a journal by your bed and write one thing daily.
9. Write down 5 things you love/like about yourself
10. Meditate: There are several free apps that will walk you through a guided meditation
11. Take a bubble bath
12. Light a scented candle
13. Go cloud watching—lie on your back and watch the sky
14. Do one small thing on your to-do list
15. Watch or read something that will make you laugh
16. Take a power nap
17. Find a small way to help someone today: hold a door, smile and say "hello" to someone, say "thank you" to someone.
18. Exercise a signature strength: think of something you are good at and find a way to put it into action.
19. Spend time alone doing something you enjoy: reading, exercising, crafting, watching a movie building, etc.
20. Journal negative thoughts: spend 15 minutes writing about what is bothering you, then burn it or throw it in the trash and let it go
21. Play with playdough: purchase or make your own. Roll it around and squish it in your hands or use cookie cutters to make something fun.
22. Sit in the sun for 10 minutes
23. Go to the movies
24. Cook a new recipe
25. Listen to your favorite music
26. Work in the garden: get your hands in the dirt!
27. Watch the sunrise/sunset
28. Listen to an inspiring podcast
29. Go out to eat
30. Watch funny Youtube videos
31. Meet friends for coffee or a drink

32. Sing along to your favorite song at the top of your lungs
33. Go for a drive—destination not required
34. Make your favorite dessert
35. Go to bed early or sleep in late
36. Research something that interests you just to learn more about it
37. Get a massage
38. Write a letter/email to an old friend
39. Eat something healthy
40. Play a game: an app, card or board game
41. Go for a hike
42. Find an inspiring quote and put it up somewhere you can see it
43. Take pictures of things that make you smile
44. Watch baby animal videos
45. Have dinner with friends
46. Join a support group: online or in person!
47. Try something new: something you have always wanted to do or maybe something you have always been scared to try
48. Find a community event to attend
49. Create a self-care tool box: make a list of your favorite self-care ideas or fill a small box with your favorite self-care ideas and/or self-care items (lotion, candle, pictures, quotes, etc.)
50. Thank someone: whether you write to a good friend or simply thank someone for excellent customer service, express your appreciation.
51. Sew, garden, crochet, sculpt, build—do something with your hands
52. Rearrange your furniture: try something new in your living space
53. Write a poem: free verse, limerick, or haiku - it is all fun.
54. Declutter your wardrobe: get rid of/donate items that you haven't worn in a year or are stained, ripped or otherwise unwearable.
55. Make a list of the three most important tasks you need to complete today and do them
56. Make a music playlist based on your current mood
57. Ask three friends to give you positive feedback. Write it down and put it somewhere you can see it daily
58. Set photos of someone or something you love as your phone background or computer screensaver
59. Clean up your work area
60. Look at yourself in the mirror and imagine you are your best friend: What would you tell you right now?
61. Drink more water
62. Scream, pound pillows, tear paper, shake your body to move the energy out

63. Buy or cut flowers from your garden: Put them where you can see and smell them often.
64. Reach out to three good friends and tell them something you appreciate about them
65. Do some creative writing: get lost in telling a story
66. Allow yourself to cry if you need to
67. Go for a drive and turn your favorite music up
68. Plan a night out (or in) with your favorite people
69. Build a blanket fort—watch a movie inside!
70. Write a letter to your future self and put it away for later
71. Take a selfie
72. Sit and listen to one of your favorite songs: just sit and listen, close your eyes and don't multitask
73. Exercise: run, walk, bike, lift weights. If you regularly exercise try something new.
74. Write down a mistake and verbally forgive yourself
75. Take a moment to put on some nice smelling lotion: take your time and pay extra attention to the feeling and smell.

Talking Resources:

- National Domestic Violence Hotline:
  1-800-799-7233

- National Alliance on Mental Illness (NAMI) Hotline:
  1-800-950-6264

- National Suicide Prevention Lifeline
  1-800-273-8255

Inspirational Podcasts:

- The Life Coach School
- Happier
- Let's Discuss
- The Lively Show

Appendix E. Consent to Participate in a Research Study

KEY INFORMATION FOR *Sexual Minority Men's Narratives about Getting Help for IPV*:

We are asking you to choose whether or not to volunteer for a research study about your experiences with getting professional psychological help (e.g., psychologist, social worker, counsellor) for intimate partner violence in a same-sex relationship. We are interviewing sexual minority men about their experiences with getting psychological help with intimate partner violence. This page is to give you key information to help you decide whether to participate in this interview. We have included detailed information after this page. If you have questions about this interview procedure, the contact information for the research investigator in charge of the study is below.

WHAT IS THE STUDY ABOUT AND HOW LONG WILL IT LAST?

We want to interview sexual minority men about their experiences with getting professional psychological help (e.g., psychologist, social worker, counsellor) for intimate partner violence in a same-sex relationship. You will be asked questions about your experience with intimate partner violence, what personal, interpersonal, and environmental characteristics influenced your getting help, and your experience with accessing professional resources. Your participation in this interview will last between an hour and an hour and a half. After we examine your responses, we will reach out again to ask if you agree with how your responses were transcribed and see if you have any more information to add to your interview. All interviews will be recorded by the principal investigator and kept on a password protected jump drive that only he has access to.

WHAT ARE KEY REASONS YOU MIGHT CHOOSE TO VOLUNTEER FOR THIS STUDY?

You should participate in this study if you wish to tell us about your experience getting professional psychological help (e.g., psychologist, social worker, counsellor) for intimate partner violence in a same-sex relationship. You may find benefit from reflecting on this experience and sharing your story to better help us understand more about what it is like to get help; your interview may aid professional psychological service providers to better assist sexual minority men experiencing intimate partner violence in the future. Additionally, you will be awarded $50 for your time if you decided to participate in this interview. For a complete description of benefits and/or rewards, refer to the Detailed Consent.

WHAT ARE KEY REASONS YOU MIGHT CHOOSE NOT TO VOLUNTEER FOR THIS STUDY?

The only reasons you should not take part in this study is if you are not at least 18 years of age, not a sexual minority male, if you have not experienced intimate partner violence in a same-sex relationship, or if you have not sought professional psychological help for intimate partner violence. You may feel some discomfort talking about your experiences with intimate partner violence during this interview. For a complete description of risks, refer to the Detailed Consent.

DO YOU HAVE TO TAKE PART IN THE STUDY?

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any services, benefits, or rights you would normally have if you choose not to volunteer.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS OR CONCERNS?

The person in charge of this study is Todd Ryser-Oatman of the University of Kentucky, Department of Educational, School, and Counseling Psychology. He is being supervised by Dr. Sharon Rostosky of the University of Kentucky, Department of Educational, School, and Counseling Psychology. If you have questions, suggestions, or concerns regarding this study or you want to withdraw from the study his contact information is: jtry222@uky.edu

If you have any questions, suggestions or concerns about your rights as a volunteer in this research, contact staff in the University of Kentucky (UK) Office of Research Integrity (ORI) between the business hours of 8am and 5pm EST, Monday-Friday at 859-257-9428 or toll free at 1-866-400-9428.

DETAILED CONSENT:

ARE THERE REASONS WHY YOU WOULD NOT QUALIFY FOR THIS STUDY?

You should not participate in this study if you are under 18 years of age, if you do not identify as a sexual minority male, if you have no experienced intimate partner violence in a same-sex relationship, and if you have never received professional psychological services (e.g., psychologist, social worker, counsellor) for intimate partner violence.

WHERE WILL THE STUDY TAKE PLACE AND WHAT IS THE TOTAL AMOUNT OF TIME INVOLVED?

This interview will be conducted either over a phone call or using Zoom video conferencing software. The interview is expected to last between an hour and an hour and a half.

WHAT WILL YOU BE ASKED TO DO?

This interview protocol consists of questions about your experiences with intimate partner violence, your experiences with getting professional psychological help for intimate partner violence, and the personal, interpersonal, and environmental characteristics that enabled you to get help. We will ask you to provide as much detail as you possibly can, as it will likely be new information to better help us understand the process sexual minority men go through as they seek and get help for intimate partner violence.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

To our knowledge, there are no known risks to participating in this individual interview. You could possibly feel some discomfort answering questions related to your experiences with intimate partner violence or recalling getting psychological help for intimate partner violence.

In addition to risks described in this consent, you may experience a previously unknown risk or side effect.

WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?

We do not know if you will get any benefit from taking part in this study. However, some people have experienced relief or insight when getting to talk about their experiences with intimate partner violence. Additionally, if you take part in this study, information learned may help professional psychological service providers who work with sexual minority men who are experiencing intimate partner violence.

IF YOU DON'T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?

If you do not want to be in the study, there are no other choices except not to take part in the study.

WHAT WILL IT COST YOU TO PARTICIPATE?

There are no costs associated with taking part in this study.

WHO WILL SEE THE INFORMATION THAT YOU GIVE?

When we write about or share the results from the study, we will write about the combined information we receive from participant. We will keep your name and other identifying information private.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. All individual interviews will be audio recorded and transcribed for analysis. All audio files and interview transcriptions will be stored on a password protected jump drive with all identifying information removed.

You should know that there are some circumstances in which we may have to show your information to other people because you talk about harming yourself, harming another person, or if you disclose any child, elder, or dependent adult being abused.

Officials from the University of Kentucky may see or copy pertinent study information which could identify a subject for the purpose of making sure the research project was carried out correctly.

CAN YOU CHOOSE TO WITHDRAW FROM THE STUDY EARLY?

You can choose to leave the study at any time. You will not be treated differently if you decide to stop taking part in the study.

WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?

You will receive $50 for taking part in this study in the individual interview. If you do not want to complete the entire interview for any reason, you will still be rewarded $50 for your time.

WILL YOU BE GIVEN INDIVIDUAL RESULTS FROM THE RESEARCH TESTS/SURVEYS?

If you choose to participate in this individual interview, you will be sent the transcription of your individual interview so that you can provide feedback on its accuracy and tell us any new information you thought of that we initially did not discuss during the interview.

WHAT ELSE DO YOU NEED TO KNOW?

If you volunteer to take part in this study, you will be one of about 15 people to do so.

The PI is Todd Ryser-Oatman, a doctoral student in the Counseling Psychology program at the University of Kentucky. He is being guided in this research by Dr. Sharon Rostosky, Ph.D. There may be other people on the research team assisting at different times during the study.

WILL YOUR INFORMATION BE USED FOR FUTURE RESEARCH?

Your information collected for this study will NOT be used or shared for future research studies, even if we remove the identifiable information like your name, clinical record number, or date of birth.

References

Abuse, S. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach.

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, *50*(2), 179-211.

Alhusen, J. L., Lucea, M. B., & Glass, N. (2010). Perceptions of and experience with system responses to female same-sex intimate partner violence. *Partner Abuse*, *1*(4), 443-462.

American Psychological Association. (2012). Guidelines for psychological practice with lesbian, gay, and bisexual clients. *The American Psychologist*, *67*(1), 10.

Ard, K. L., & Makadon, H. J. (2011). Addressing intimate partner violence in lesbian, gay, bisexual, and transgender patients. *Journal of General Internal Medicine*, *26*(8), 930-933.

Asay, S., DeFrain, J., Metzger, M., & Moyer, B. (2016). Implementing a strengths-based approach to intimate partner violence worldwide. *Journal of Family Violence*, *31*(3), 349-360.

Bacchus, L. J., Buller, A. M., Ferrari, G., Brzank, P., & Feder, G. (2018). "It's Always Good to Ask": a mixed methods study on the perceived role of sexual health practitioners asking gay and bisexual men about experiences of domestic violence and abuse. *Journal of Mixed Methods Research*, *12*(2), 221-243.

Barrett, B. J., Peirone, A., & Cheung, C. H. (2020). Help seeking experiences of survivors of intimate partner violence in Canada: The role of gender, violence severity, and social belonging. *Journal of Family Violence*, *35*(1), 15-28.

Bartholomew, K., Regan, K. V., Oram, D., & White, M. A. (2008). Correlates of partner abuse in male same-sex relationships. *Violence and Victims*, *23*(3), 344-360. doi:10.1891/0886-6708.23.3.344

Biello, K. B., Mimiaga, M. J., Santostefano, C. M., Novak, D. S., & Mayer, K. H. (2018). MSM at Highest Risk for HIV Acquisition Express Greatest Interest and Preference for Injectable Antiretroviral PrEP Compared to Daily, Oral Medication. *AIDS and Behavior*, *22*(4), 1158-1164. doi:10.1007/s10461-017-1972-6

Black, T. G. (2006). Teaching trauma without traumatizing: Principles of trauma treatment in the training of graduate counselors. *Traumatology*, *12*(4), 266-271.

Blosnich, J. R., & Bossarte, R. M. (2009). Comparisons of intimate partner violence among partners in same-sex and opposite-sex relationships in the United States. *American Journal of Public Health*, *99*(12), 2182-2184.

Bornstein, D., Fawcett, J., Sullivan, M., Senturia, K., & Shiu-Thornton, S. (2006). Understanding the Experiences of Lesbian, Bisexual and Trans Survivors of Domestic Violence. *Journal of Homosexuality, 51*(1), 159-181.

Breiding, M., Basile, K. C., Smith, S. G., Black, M. C., & Mahendra, R. R. (2015). *Intimate partner violence surveillance: Uniform definitions and recommended data elements*. Version 2.0.

Brooks, VR. *Minority stress and lesbian women*. Lexington, MA: Lexington Books; 1981

Buller, Ana Maria, Devries, Karen M, Howard, Louise M, & Bacchus, Loraine J. (2014). Associations between intimate partner violence and health among men who have sex with men: A systematic review and meta-analysis. *PLoS Medicine, 11*(3), E1001609.

Burke, L. K., & Follingstad, D. R. (1999). Violence in lesbian and gay relationships: Theory, prevalence, and correlational factors. *Clinical Psychology Review*, *19*(5), 487-512.

Burke, T. W., Jordan, M. L., & Owen, S. S. (2002). A cross-national comparison of gay and lesbian domestic violence. *Journal of Contemporary Criminal Justice*, *18*(3), 231-257.

Calton, J. M., Cattaneo, L. B., & Gebhard, K. T. (2016). Barriers to help seeking for lesbian, gay, bisexual, transgender, and queer survivors of intimate partner violence. *Trauma, Violence, & Abuse*, *17*(5), 585-600. doi:10.1177/1524838015585318

Carvalho, A., Lewis, R., Derlega, V., Winstead, B., & Viggiano, C. (2011). Internalized sexual minority stressors and same-sex intimate partner violence. *Journal of Family Violence*, *26*(7), 501-509. doi:10.1007/s10896-011-9384-2

Cascalheira, C. J., & Smith, B. A. (2019). Hierarchy of desire: Partner preferences and social identities of men who have sex with men on geosocial networks. *Sexuality & Culture*, 1-19.

Cavanaugh, C. E., Messing, J. T., Del-Colle, M., O'Sullivan, C., & Campbell, J. C. (2011). Prevalence and correlates of suicidal behavior among adult female victims of intimate partner violence. *Suicide and Life-Threatening Behavior*, *41*(4), 372-383.

Charmaz, K. (2014). *Constructing grounded theory*. Sage.

Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training*, *41*(4), 412.

Craft, S. M., & J. M. Serovich. 2005. "Family-of-origin factors and partner violence in the intimate relationships of gay men who are HIV positive." *Journal of Interpersonal Violence*, *20* (7), 777–791.

Cruz, J. M. (2003). "Why doesn't he just leave?": Gay male domestic violence and the reasons victims stay. *The Journal of Men's Studies, 11*(3), 309-323.

Cruz, J. M., & Firestone, J. M. (1998). Exploring violence and abuse in gay male relationships. *Violence and Victims*, *13*(2), 159.

Davis, A., Kaighobadi, F., Stephenson, R., Rael, C., & Sandfort, T. (2016). Associations between alcohol use and intimate partner violence among men who have sex with men. *LGBT Health*, *3*(6), 400-406.

De Shazer, S., & Dolan, Y. (2012). *More than miracles: The state of the art of solution-focused brief therapy*. Routledge.

Devries, K. M., Mak, J. Y., Bacchus, L. J., Child, J. C., Falder, G., Petzold, M., ... & Watts, C. H. (2013). Intimate partner violence and incident depressive symptoms and suicide attempts: a systematic review of longitudinal studies. *PLoS Med*, *10*(5), e1001439.

Dickerson-Amaya, N., & Coston, B. M. (2019). Invisibility Is Not Invincibility: The Impact of Intimate Partner Violence on Gay, Bisexual, and Straight Men's Mental Health. *American Journal of Men's Health*, *13*(3), 1557988319849734.

Donne, M. D., DeLuca, J., Pleskach, P., Bromson, C., Mosley, M. P., Perez, E. T., ... & Frye, V. (2018). Barriers to and facilitators of help-seeking behavior among men who experience sexual violence. *American Journal of Men's Health*, *12*(2), 189-201.

Donovan, C., & Hester, M. (2014). *Domestic violence and sexuality: What's love got to do with it?* Bristol; Chicago, IL: Policy Press.

Duke, A., & Davidson, M. M. (2009). Same-sex intimate partner violence: Lesbian, gay, and bisexual affirmative outreach and advocacy. *Journal of Aggression, Maltreatment & Trauma*, *18*(8), 795-816. doi:10.1080/10926770903291787

Dworkin, S. L. (2012). Sample size policy for qualitative studies using in-depth interviews. *Archives of Sexual Behavior, 41*(6), 1319-1320.

Edwards, K. M., Gidycz, C. A., & Murphy, M. J. (2015). Leaving an abusive dating relationship: A prospective analysis of the investment model and theory of planned behavior. *Journal of Interpersonal Violence*, *30*(16), 2908-2927.

Edwards, K. M., Sylaska, K. M., & Neal, A. M. (2015). Intimate partner violence among sexual minority populations: A critical review of the literature and agenda for future research. *Psychology of Violence*, *5*(2), 112-121. doi:10.1037/a0038656

Ehrensaft, M. K. (2008). Intimate partner violence: Persistence of myths and implications for intervention. *Children and Youth Services Review*, *30*, 276–286.

Felix, S., Daigle, L. E., Hawk, S. R., and Policastro, C. (2020). Lesbian, gay, and bisexual victims' reporting behaviors to informal and formal sources. *Sexuality Research and Social Policy.*

Finneran, C., & Stephenson, R. (2014). Intimate partner violence, minority stress, and sexual risk-taking among US men who have sex with men. *Journal of Homosexuality*, *61*(2), 288-306.

Fleming, C. E., & Resick, P. A. (2017). Help-seeking behavior in survivors of intimate partner violence: Toward an integrated behavioral model of individual factors. *Violence and Victims*, *32*(2), 195-209.

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, *55*(4), 316.

Foran, H. M., & O'Leary, K. D. (2008). Alcohol and intimate partner violence: a meta-analytic review. *Clinical Psychology Review*, *28*(7), 1222-1234. doi:10.1016/j.cpr.2008.05.001

Ford, C. L., Slavin, T., Hilton, K. L., & Holt, S. L. (2013). Intimate partner violence prevention services and resources in Los Angeles: Issues, needs, and challenges for assisting lesbian,

gay, bisexual, and transgender clients. *Health Promotion Practice*, *14*(6), 841-849. doi:10.1177/1524839912467645

Freedner, N., Freed, L. H., Yang, Y. W., & Austin, S. B. (2002). Dating violence among gay, lesbian, and bisexual adolescents: Results from a community survey. *Journal of Adolescent Health*, *31*, 469–474. http://dx.doi.org/10.1016/S1054-139X(02)00407-X

Freeland, R., Goldenberg, T., & Stephenson, R. (2018). Perceptions of informal and formal coping strategies for intimate partner violence among gay and bisexual men. *American Journal of Men's Health*, *12*(2), 302-312.

Gillum, T. L., & DiFulvio, G. (2012). 'There's so much at stake': Sexual minority youth discuss dating violence. *Violence Against Women*, *18*(7), 725-745. doi:10.1177/1077801212455164

Girshick, L. B. (2009). *Woman-to-woman sexual violence: Does she call it rape?* UPNE.

Glaser, B. G. A. L. (1978). Strauss (1967): The Discovery of Grounded Theory: Strategies for Qualitative Research. *London: Wiedenfeld and Nicholson*, *81*, 86.

Goldenberg, T., Stephenson, R., Freeland, R., Finneran, C., & Hadley, C. (2016). 'Struggling to be the alpha': Sources of tension and intimate partner violence in same-sex relationships between men. *Culture, Health & Sexuality*, *18*(8), 875-889. doi:10.1080/13691058.2016.1144791

Gonzalez, H. M., Vega, W. A., Williams, D. R., Tarraf, W., West, B. T., & Neighbors, H. W. (2010). Depression care in the United States: too little for too few. *Archives of General Psychiatry*, *67*(1), 37-46.

Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional psychology: Research and practice*, *21*(5), 372.

Guadalupe-Diaz, X. (2016). Disclosure of same-sex intimate partner violence to police among lesbians, gays, and bisexuals. *Social Currents*, *3*(2), 160-171.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, *18*(1), 59-82.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC Psychiatry*, *10*(1), 113.

Hancock, R. D. (2014). Positive counsellor characteristics with sexual minority intimate partner violence victims. *Canadian Journal of Counselling and Psychotherapy*, *48*(2), 153-170.

Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist*, *25*, 517–572.

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology*, *52*(2), 196.

Horst, K., Mendez, M., Culver-Turner, R., Amanor-Boadu, Y., Minner, B., Cook, J., ... & McCollum, E. (2012). The importance of therapist/client ethnic/racial matching in couples treatment for domestic violence. *Contemporary Family Therapy*, *34*(1), 57-71.

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy*, *48*(1), 9.

Houston, E., & McKirnan, D. J. (2007). Intimate partner abuse among gay and bisexual men: risk correlates and health outcomes. *Journal of Urban Health: Bulletin of The New York Academy of Medicine*, *84*(5), 681-690.

Island, D., & Letellier, P. (1991). Men who beat the men who love them. Binghamton, NY: Haworth Press.

Kelly, B. C., Izienicki, H., Bimbi, D. S., & Parson, J. T. (2011). The intersection of mutual partner violence and substance use among urban gays, lesbians, and bisexuals. *Deviant Behavior*, 32, 379–404.

Kimmes, J. G., Mallory, A. B., Spencer, C., Beck, A. R., Cafferky, B., & Stith, S. M. (2019). A meta-analysis of risk markers for intimate partner violence in same-sex relationships. *Trauma, Violence, & Abuse*, *20*(3), 374-384.

Kubicek, K., McNeeley, M., & Collins, S. (2015). Same-Sex Relationship in a Straight World. *Journal of Interpersonal Violence, 30*(1), 83-109.

Kubicek, K., McNeeley, M., & Collins, S. (2016). Young men who have sex with men's experiences with intimate partner violence. *Journal of Adolescent Research*, *31*(2), 143-175. doi:10.1177/0743558415584011

Langhinrichsen-Rohling, J., & Capaldi, D. M. (2012). Clearly we've only just begun: Developing effective prevention programs for intimate partner violence. *Prevention Science*, *13*(4), 410-414.

Lelaurain, S., Graziani, P., & Monaco, GL (2017). Intimate Partner Violence and Help-Seeking. *European Psychologist*.

Lothstein, L. M. (2013). Group therapy for intimate partner violence (IPV). *International Journal of Group Psychotherapy*, *63*(3), 449-452. doi:10.1521/ijgp.2013.63.3.449

Madera, S. R., & Toro-Alfonso, J. (2005). Description of a domestic violence measure for Puerto Rican gay males. *Journal of Homosexuality*, *50*(1), 155-173.

Mahalik, J. R. (2000b, August). A model of masculine gender role conformity. Symposium—Masculine gender role conformity: Examining theory, research, and practice. Paper presented at the 108th Annual Convention of the American Psychological Association, Washington DC.

McClennen, J. C., Summers, A. B., & Vaughan, C. (2002). Gay men's domestic violence: Dynamics, help-seeking behaviors, and correlates. *Journal of Gay & Lesbian Social Services*, *14*(1), 23-49.

McDermott, R. C., Cheng, H. L., Wong, J., Booth, N., Jones, Z., & Sevig, T. (2017). Hope for help-seeking: A positive psychology perspective of psychological help-seeking intentions. *The Counseling Psychologist*, *45*(2), 237-265.

McKenry, P. C., Serovich, J. M., Mason, T. L., & Mosack, K. (2006). Perpetration of gay and lesbian partner violence: A disempowerment perspective. *Journal of Family Violence*, *21*(4), 233-243. doi:10.1007/s10896-006-9020-8

McRae, L., Daire, A. P., Abel, E. M., & Lambie, G. W. (2017). A social learning perspective on childhood trauma and same-sex intimate partner violence. *Journal of Counseling & Development*, *95*(3), 332-338.

Merrill, G. S., & Wolfe, V. A. (2000). Battered gay men: An exploration of abuse, help seeking, and why they stay. *Journal of Homosexuality*, *39*(2), 1-30.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674-697. doi:10.1037/0033-2909.129.5.674

Meyer, I. H., Frost, D. M., & Nezhad, S. (2015). Minority stress and suicide in lesbians, gay men, and bisexuals. *Youth Suicide and Bullying: Challenges and Strategies for Prevention and Intervention*, 177-187.

Miller, B., & Irvin, J. (2017). Invisible scars: Comparing the mental health of LGB and heterosexual intimate partner violence survivors. *Journal of Homosexuality*, *64*(9), 1180-1195. doi:10.1080/00918369.2016.1242334

Mimiaga, M. J., Biello, K. B., Robertson, A. M., Oldenburg, C. E., Rosenberger, J. G., O'Cleirigh, C., ... & Safren, S. A. (2015). High prevalence of multiple syndemic conditions associated with sexual risk behavior and HIV infection among a large sample of Spanish-and Portuguese-speaking men who have sex with men in Latin America. *Archives of Sexual Behavior*, *44*(7), 1869-1878.

Morgan, K., Buller, A. M., Evans, M., Trevillion, K., Williamson, E., & Malpass, A. (2016). The role of gender, sexuality and context upon help-seeking for intimate partner violence: A synthesis of data across five studies. *Aggression and Violent Behavior*, *31*, 136-146. doi:10.1016/j.avb.2016.09.001

Morrow, S. L. (2005). Quality and Trustworthiness in Qualitative Research in Counseling Psychology. *Journal of Counseling Psychology, 52*(2), 250-260.

Moskowitz, K., Richmond, K., & Michniewicz, K. (2020). Caught in a bad romance: Endorsement of traditional romantic ideology, internalized heterosexism, and intimate partner violence experiences among sexual minority individuals. *Psychology of Sexual Orientation and Gender Diversity*.

Munoz, R. T., Brady, S., & Brown, V. (2017). The psychology of resilience: A model of the relationship of locus of control to hope among survivors of intimate partner violence. *Traumatology*, *23*(1), 102.

Murray, C. E., & Graybeal, J. (2007). Methodological review of intimate partner violence prevention research. *Journal of Interpersonal Violence*, *22*(10), 1250-1269.

Murray, C. E., Mobley, A. K., Buford, A. P., & Seaman-DeJohn, M. M. (2007). Same-sex intimate partner violence: Dynamics, social context, and counseling implications. *Journal of LGBT Issues in Counseling*, *1*(4), 7-30.

Nguyen-Feng, V. N., Frazier, P. A., Greer, C. S., Howard, K., Paulsen, J. A., Meredith, L., & Kim, S. (2015). A randomized controlled trial of a web-based intervention to reduce distress among students with a history of interpersonal violence. *Psychology of Violence*, *5*, 444-454. http://dx.doi.org/ 10.1037/a0039596

Niolon, P. H., & Centers for Disease Control and Prevention. (2017). *Preventing intimate partner violence across the lifespan: A technical package of programs, policies, and practices*. Government Printing Office.

Oka, M., & Whiting, J. B. (2011). Contemporary MFT theories and intimate partner violence: A review of systemic treatments. *Journal of Couple & Relationship Therapy*, *10*(1), 34-52.

Oringher, J., & Samuelson, K. W. (2011). Intimate partner violence and the role of masculinity in male same-sex relationships. *Traumatology*, *17*(2), 68-74. doi:10.1177/1534765610395620

Pantalone, D. W., Schneider, K. L., Valentine, S. E., & Simoni, J. M. (2012). Investigating partner abuse among HIV positive men who have sex with men. *AIDS and Behavior*, *16*, 1031-1043. doi:10.1007/s10461-011-0011-2

Parent, M. C., Hammer, J. H., Bradstreet, T. C., Schwartz, E. N., & Jobe, T. (2018). Men's mental health help-seeking behaviors: An intersectional analysis. *American Journal of Men's Health*, *12*(1), 64-73.

Pattavina, A., Hirschel, D., Buzawa, E., Faggiani, D., & Bentley, H. (2007). A comparison of the police response to heterosexual versus same-sex intimate partner violence. *Violence Against Women*, *13*(4), 374-394.

Peterman, L. M., & Dixon, C. G. (2003). Domestic Violence Between Same-Sex Partners: Implications for Counseling. *Journal of Counseling & Development*, *81*(1), 40.

Pico-Alfonso, M.A., Garcia-Linares, M. I., Celda-Navarro, N., Blasco-Ros, C., Echeburúa, E., & Martinez, M. (2006). The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: Depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. *Journal of Women's Health*, *15*, 599–611, http://dx.doi.org/10.1089/jwh.2006.15.599.

Pitt, E., & Dolan-Soto, D. (2001). Clinical considerations in working with victims of same-sex domestic violence. *Journal of The Gay & Lesbian Medical Assn*, *5*(4), 163-169. doi:10.1023/A:1014266212280

Randell, K. A., Bledsoe, L. K., Shroff, P. L., & Pierce, M. C. (2012). Mothers' motivations for intimate partner violence help-seeking. *Journal of Family Violence*, *27*(1), 55-62.

Relf, M. V., Huang, B., Campbell, J., & Catania, J. (2004). Gay identity, interpersonal violence, and HIV risk behaviors: An empirical test of theoretical relationships among a probability-based sample of urban men who have sex with men. *Journal of the Association of Nurses in AIDS Care*, *15*(2), 14-26.

Rhodes, S. D., McCoy, T. P., Wilkin, A. M., & Wolfson, M. (2009). Behavioral risk disparities in a random sample of self-identifying gay and non-gay male university students. *Journal of Homosexuality*, *56*(8), 1083-1100.

Ristock, J. & Timbang, N. (2005). Relationship violence in lesbian, gay, bisexual, transgender, queer (LGBTQ) communities: Moving beyond a gender-based framework. Retrieved from: www.mincava.umn.edu/documents/lgbtqviolence

Rivara, F. P., Anderson, M. L., Fishman, P., Bonomi, A. E., Reid, R. J., Carrell, D., & Thompson, R. S. (2007). Healthcare utilization and costs for women with a history of intimate partner violence. *American Journal of Preventive Medicine*, *32*, 89-96.

Salter, M., Robinson, K., Ullman, J., Denson, N., Ovenden, G., Noonan, K., ... & Huppatz, K. (2020). Gay, Bisexual, and Queer Men's Attitudes and Understandings of Intimate Partner Violence and Sexual Assault. *Journal of Interpersonal Violence*, 0886260519898433.

Saltzman, L. E., Fanslow, J. L, McMahon, P. M., & Shelley, G. A. (2002). Intimate partner violence surveillance: Uniform definitions and recommended data elements (Vol. 1). Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Scheer, J. R., & Baams, L. (2019). Help-seeking patterns among LGBTQ young adults exposed to intimate partner violence victimization. *Journal of Interpersonal Violence*, 0886260519848785.

Scheer, J. R., & Poteat, V. P. (2018). Trauma-informed care and health among LGBTQ intimate partner violence survivors. *Journal of Interpersonal Violence*, 0886260518820688.

Simpson, E. K., & Helfrich, C. A. (2005). Lesbian Survivors of Intimate Partner Violence: Provider Perspectives on Barriers to Accessing Services. *Journal of Gay & Lesbian Social Services*, *18*(2), 39-59. doi:10.1300/J041v18n0203

Smith, S. K., & Turell, S. C. (2017). Perceptions of healthcare experiences: Relational and communicative competencies to improve care for LGBT people. *Journal of Social Issues*, *73*(3), 637-657.

St. Pierre, M., & Senn, C. Y. (2010). External barriers to help-seeking encountered by Canadian gay and lesbian victims of intimate partner abuse: An application of The Barriers Model. *Violence and Victims*, *25*(4), 536-552. doi:10.1891/0886-6708.25.4.536

Stall, R., Friedman, M., & Catania, J. A. (2008). Interacting epidemics and gay men's health: a theory of syndemic production among urban gay men. *Unequal Opportunity: Health Disparities Affecting Gay and Bisexual Men in the United States*, *1*, 251-274.

Stall, R., Mills, T. C., Williamson, J., Hart, T., Greenwood, G., Paul, J., et al. (2003). Association of co-occurring psychosocial health problems and increased vulnerability to HIV/AIDS among urban men who have sex with men. *American Journal of Public Health*, *93*, 939–942.

Stephenson, R., Hall, C. D., Williams, W., Sato, K., & Finneran, C. (2013). Towards the development of an intimate partner violence screening tool for gay and bisexual men. *Western Journal of Emergency Medicine*, *14*(4), 390.

Stephenson, R., & Finneran, C. (2017). Receipt and Perpetration of Intimate Partner Violence and Condomless Anal Intercourse Among Gay and Bisexual Men in Atlanta. *AIDS and Behavior*, *21*(8), 2253-2260. doi:10.1007/s10461-017-1709-6

Stephenson, R., Khosropour, C., & Sullivan, P. (2010). Reporting of intimate partner violence among men who have sex with men in an online survey. *Western Journal of Emergency Medicine*, *11*(3), 242.

Stiles-Shields, C., & Carroll, R. A. (2015). Same-sex domestic violence: Prevalence, unique aspects, and clinical implications. *Journal of Sex & Marital Therapy*, *41*(6), 636-648. doi:10.1080/0092623X.2014.958792

Stith, S. M., Rosen, H., McCollum, E. E., & Thomsen, C. J. (2004). Treating intimate partner violence within intact couple relationships: Outcomes of multi-couple versus individual couple therapy. *Journal of Marital and Family Therapy*, *30*(3), 305-318.

Strayed, C. (2012). *Wild: From lost to found on the Pacific Crest Trail*. Vintage.

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues*, *17*, 283-316.

Stults, C. B., Brandt, S. A., Hale, J. F., Rogers, N., Kreienberg, A. E., & Griffin, M. (2020). A qualitative study of intimate partner violence among young gay and bisexual men. *Journal of Interpersonal Violence*, 0886260520936365.

Stults, C. B., Javdani, S., Greenbaum, C. A., Kapadia, F., & Halkitis, P. N. (2016). Intimate partner violence and sex among young men who have sex with men. *Journal of Adolescent Health*, *58*(2), 215-222.

Sylaska, K. M., & Edwards, K. M. (2014). Disclosure of intimate partner violence to informal social support network members: A review of the literature. *Trauma, Violence, & Abuse*, *15*(1), 3-21.

Tirado-Muñoz, J., Gilchrist, G., Farré, M., Hegarty, K., & Torrens, M. (2014). The efficacy of cognitive behavioral therapy and advocacy interventions for women who have experienced intimate partner violence: A systematic review and meta-analysis. *Annals of medicine*, *46*(8), 567-586.

Trujillo, O., Cantu, J. I., & Charak, R. (2020). Unique and cumulative effects of intimate partner cybervictimization types on alcohol use in lesbian, gay, and bisexual emerging adults. *Cyberpsychology, Behavior, and Social Networking*.

Tully, C. (2000). Lesbians, gays, and the empowerment perspective. New York: Columbia University Press.

Turell, S. C., & Cornell-Swanson, L. V. (2005). Not all alike: Within-group differences in seeking help for same-sex relationship abuses. *Journal of Gay & Lesbian Social Services*, *18*(1), 71-88.

Turell, S., Herrmann, M., Hollander, G., & Galletly, C. (2012). Lesbian, gay, bisexual, and transgender communities' readiness for intimate partner violence prevention. *Journal of Gay & Lesbian Social Services*, *24*(3), 289-310.

Wade, R. M., & Harper, G. W. (2020). Racialized sexual discrimination (RSD) in the age of online sexual networking: Are young Black gay/bisexual men (YBGBM) at elevated risk for adverse psychological health? *American Journal of Community Psychology*, *65*(3-4), 504-523.

Walker, L. E. (1979). The battered woman. New York, NY: Harper Perennial.

Williams, J. K., Wilton, L., Magnus, M., Wang, L., Wang, J., Dyer, T. P., ... & Stephenson, R. (2015). Relation of childhood sexual abuse, intimate partner violence, and depression to

risk factors for HIV among black men who have sex with men in 6 US cities. *American Journal of Public Health*, *105*(12), 2473-2481.

Wise, A. J., & Bowman, S. L. (1997). Comparison of beginning counselors' responses to lesbian vs. heterosexual partner abuse. *Violence and Victims*, *12*(2), 127-135.

Wong, J. Y. H., Choi, E. P. H., Lo, H. H. M., Wong, W., Chio, J. H. M., Choi, A. W. M., & Fong, D. Y. T. (2017). Dating violence, quality of life and mental health in sexual minority populations: A path analysis. *Quality of Life Research*, *26*(4), 959-968.

Woodyatt, C. R., & Stephenson, R. (2016). Emotional intimate partner violence experienced by men in same-sex relationships. *Culture, Health & Sexuality*, *18*(10), 1137-1149.

Wu, E., El-Bassel, N., McVinney, L. D., Hess, L., Fopeano, M. V., Hwang, H. G., & ... Mansergh, G. (2015). The association between substance use and intimate partner violence within Black male same-sex relationships. *Journal of Interpersonal Violence*, *30*(5), 762-781. doi:10.1177/0886260514536277

Ziller, E. C., Anderson, N. J., & Coburn, A. F. (2010). "Access to rural mental health services: service use and out-of-pocket costs." *The Journal of Rural Health* 26.3*,* 214-224.

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CLINICAL EXPERIENCE

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August 2017- **University of Kentucky-Counseling Psychology Program**, Lexington, KY April 2019 *Supervisor of Masters Student* (Supervised Doctoral Training)

August 2018- June 2019 **Bluegrass.org Community Mental Health Center, Lexington, KY**
Psychology Practicum Student (Supervised Doctoral Training)

August 2017- May 2018 **Graham Office of Career Management**, Lexington, KY
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August 2016- May 2018 **University of Kentucky-Counseling Center**, Lexington, KY
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August 2015- May 2016 **Greenhouse 17 Domestic Violence Shelter**, Lexington, KY
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PEER REVIEWED PUBLICATIONS

Brown, H., Reese, R., Rostosky, S., Toland, M.**,** Kwok, C., **Ryser-Oatman, T.** (2019). Blessing or BS? Examining the therapy experiences of transgender and gender nonconforming clients obtaining referral letters for gender affirming medical treatment. *Professional Psychology: Research and Practice*.

Abreu, R. L., Rosenkrantz, D. E., Ryser-Oatman, J. T., Rostosky, S. S., & Riggle, E. D. (2019). Parental reactions to transgender and gender diverse children: A literature review. *Journal of GLBT Family Studies*, 1-25.

Clements, A., Dschaak, Z., Hargons, C. N., Kwok, C., Meiller, C., Ryser-Oatman, T., & Spiker, D. (2018). Humanity in Homelessness: A Social Justice Consultation Course for Counseling Psychology Students. *Journal for Social Action in Counseling & Psychology*, *10*(2), 34-48. [authors presented in alphabetical order]

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