Lesbian, Gay, Bisexual, and Transgender Communities’ Readiness for Intimate Partner Violence Prevention

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Efforts to address intimate partner violence (IPV) in lesbian, gay, bisexual, and transgender (LGBT) communities often rely on identifying what service providers can do to better reach and serve these populations. However, assessing a community’s readiness in response to the issue of IPV in LGBT communities locates the issue where outcry is most likely to occur. Utilizing the Community Readiness Model in lesbian, gay, bisexual, and transgender communities in two rural and two urban communities, this study revealed a low level of community readiness to address IPV. Only vague awareness of IPV exists in these sexual orientation, gender identity, and geographic communities. The study suggests specific next steps tailored to raise LGBT communities’ readiness to address IPV from within their own communities, starting at the current low level.

KEYWORDS intimate partner violence, LGBT, community readiness, prevention

INTRODUCTION

Although intimate partner violence (IPV) in general is often written about from a heterosexist model, the prevalence of IPV in lesbian, gay,
bisexual, and transgender (LGBT) relationships has been well established.\(^1\) Over the past two decades and with varying frequencies, numerous studies have documented that IPV occurs in similar frequency to that which occurs in heterosexual relationships (Balsam & Szymanski, 2005; Burke & Follingstad, 1999; Coleman, 1990; Island & Letellier, 1991; Lie & Gentlewarrior, 1991; Lie, Schilit, Bush, Montagne, & Reyes, 1991; National Coalition of Anti-Violence Programs, 2010; Renzetti, 1992; Turell, 2000; Waldner-Haugrud & Gratch, 1997; Waldner-Haugrud, Gratch, & Magruder, 1997; Waterman, Dawson, & Bologna, 1989). Abuses in LGBT relationships cover the range of physical, emotional, and sexual behaviors (Koss et al., 1995). The prevalence of physical abuse is conservatively estimated at 1 in 3 same-sex couples (Turell, 2000), while sexual abuse occurs in approximately 1 in 10 (Turell, 2000). Emotional abuse may be present in the vast majority of same-sex couples, as multiple studies estimate its occurrence at more than 80% (Bologna, Waterman, & Dawson, 1987; Lie & Gentlewarrior, 1991; Lie et al., 1991; Lockhart, White, Causby, & Isaac, 1994; Turell, 2000).

Notably, several key differences exist between same-sex and heterosexual relationships with respect to IPV. These differences largely result from the sociocultural context of homophobia/heterosexism and the resultant embedded myths. First, heterosexist models focused on male-female relationships create difficulties for LGBT people attempting to label and define IPV outside the narrowly defined parameters of heterosexual relationships (Bornstein, Fawcett, Sullivan, Senturia, & Shiu-Thorton, 2006; Kulkin, Williams, Borne, de la Bretonne, & Laurendine, 2007; Marrujo & Kreger, 1996; McKenry, Serovich, Mason, & Mosack, 2006). The point is further illustrated by the lesbian women interviewed by Hassouneh and Glass (2008) who noted that many barriers to seeking help were created by the “hegemony of gender-based analysis of IPV” (p. 318). Second, many same-sex couples report that fear of discrimination keeps them from seeking help if they experience IPV (Kulkin et al., 2007; Renzetti, 1992; Turell, 2000). Third, a powerful myth believed by both service providers and batterers alike presumes the mutuality of abuse in relationships in which IPV may occur (Pattavina, Hirschel, Buzawa, Faggiani, & Bentley, 2007; Scherzer, 1998). Of the lesbians studied by Marrujo and Kreger (1996), 34% of clients in abusive relationships reported a pattern of “fighting back,” often confusing identification of the roles among primary aggressors, primary victims, and participants; service providers are similarly confused regarding these roles (Ristock, 2003). Lie and colleagues (1991) found that lesbians in particular were likely to describe use of aggression as mutual. Fourth, internalized homophobia can create reluctance to disclose IPV (Bornstein et al., 2006; McClellen, 2005). For LGBT people experiencing IPV, these four crucial differences, all arising from heterosexist and homophobic culture, create difficulties in seeking help. Finally, a fifth concern for LGBT people of color, if the batterer is a
member of their same racial/ethnic community, allegiance to that community may make disclosure feel like a betrayal (Kanuha, 1990; Turell, 2000).

In spite of the influence these very important contextual differences may have on various aspects of the IPV equation, many studies focus on mainstream service providers when examining help-seeking for IPV by people in same-sex relationships. Sometimes, the studies examine barriers to seeking mainstream services, including receiving inferior or inadequate treatment (Bornstein et al., 2006; Hammond, 1988; Hassouneh & Glass, 2008; Lie & Gentlewarrior, 1991; McClellen, Summers, & Vaughan, 2002; Merrill & Wolfe, 2000; Renzetti, 1992; Scherzer, 1998; Simpson & Helfrich, 2005; Turell, 1999), while other studies focus on how to improve the services mainstream professionals provide for LGBT clients, assuming the significant problems often encountered by LGBT victim/survivors have been overcome (mental health: Alexander, 2002; Istar, 1996; McClellen, 2005; criminal justice: Pattavina et al., 2007; Rose, 2003; Younglove, Kerr, & Vitello, 2002; domestic violence agencies: Glass et al., 2008; Rose, 2003; medical: Pitt & Dolan-Soto, 2001). Based on a qualitative study, however, Turell and Herrmann (2008) concluded it was unlikely that victim/survivors would access mainstream community services and would be more likely to use options within the LGBT community for both initial outcry (telling someone about the IPV) and subsequent long-term support. Supporting the former point, a number of studies noted that police, providers of legal services, crisis lines, clergy, domestic violence agencies, and shelters are least utilized by same-sex IPV victim/survivors (Hammond, 1988; Letiellier, 1994; McClellen et al., 2002; Merrill & Wolfe, 2000; Renzetti, 1992; Scherzer, 1998; Turell, 2000).

If LGBT victim/survivors seek help at all, friends and therapist/counselors are primary sources of support (McClellen et al., 2002; Merrill & Wolfe, 2000; Renzetti, 1992; Scherzer, 1998; Turell, 1999). However, counseling can be problematic as a source of support because it focuses solely on the individual or couple as the source of the problem, thus potentially blaming the victim (Turell, 1999). Turell points out that this intrapsychic focus permits the IPV problem to continue in secret on a community level generally and urges a shift from intrapsychic to community-based intervention.

Although mainstream service providers are a possible resource to address same-sex IPV, interventions within LGBT communities would be ideal (McKenry et al., 2006). The participants in Bornstein and colleagues’ (2006) study did not support strategies designed to improve the cultural competence of mainstream services; rather, they strongly advocated for community-focused solutions. Kulkin and colleagues (2007) reached similar conclusions, advocating for specific targeting of LGBT communities regarding IPV. Other studies have focused on support within the LGBT community, but their recommendations typically combine all populations, ignoring differences in the lived experiences between lesbian, gay, bisexual, and transgender
people (Burke, Jordan, & Owen, 2002; Hamberger, 1996). One exception is Turell and Cornell-Swanson (2005), who analyzed help-seeking behaviors of people affected by same-sex IPV and found differences based on gender, sexual orientation, age, income, and ethnicity.

Sadusky and Obinna (2002) describe how underserved populations who experience IPV need support from peers within their community. Turell and Herrmann’s (2008) “diamond model” described the likelihood and order of possible intervention sources. They noted that initial outcry is most likely to be within the LGBT community. Bornstein and colleagues (2006) emphasized the importance of friendship and community networks to help identify abuse, educate the community, and hold batterers accountable. For instance, one study noted that the majority of older gay men (89%) turn to friends for support for “serious problems” (Beeler, Rawls, Herdt, & Cohler, 1999).

Isolation reduces access to the resources available to both victims and perpetrators (McKenry et al., 2006). Fortunately, community efforts are effective to break the isolation often experienced by LGBT IPV victim/survivors (Bornstein et al., 2006). IPV prevention education within the LGBT community has been studied. Participants in Bornstein and colleagues’ (2006) study emphasized the need for IPV-focused education within LGBT networks through community organizing and community building. McClellen (2005) noted that people in same-sex relationships need education and advocacy due to a lack of awareness of the existence and magnitude of IPV, supporting the earlier results of Turell (1999), who found that the most frequent reason LGBT people did not seek help was that they were unlikely to recognize the significance of the abuse. It appears that due to the heterosexist model for IPV, LGBT people may not recognize many forms of aggression in relationships as domestic violence (Girshick, 2002; Kulkin et al., 2007; Lie & Gentlewarrior, 1991; McKenry et al., 2006).

Unfortunately, same-sex IPV prevention education is inconsistently available; only one-third of the LGBT participants in Burke and colleagues’ (2002) had received information on same-sex IPV. Jacobs, Rasmussen, and Hohman (1999) surveyed LGBT people ages 50 and older in San Diego, and found that women were more likely than men to access services, and 31% of LGBT people over 50 were not able to find LGBT-specific services when in personal emotional crisis.

Options may exist for LGBT people in urban areas that are unheard of for people who live in rural areas (Alexander, 2002). If services are not readily available in a large city, one wonders about the lack of services for LGBT people living in rural areas. Cruz and Firestone (1998) noted that gay male IPV survivors need more education and options, and cautioned that one must note the “similarities and differences in experiences based on the structural context in which the abuse takes place” (p. 170).

Clearly, research regarding intervention and prevention of same-sex IPV needs to focus within the LGBT community. In addition, the examination
needs to include the assumption of both similarities and differences between the LGBT communities, to take the structural context, as noted by Cruz and Firestone (1998), into account. Too often, lesbians, gay men, bisexual men and women, and transgender people are viewed as one homogeneous community (Ristock, 2003). To truly address lesbian, gay, bisexual, and transgender community preparedness to address IPV, these communities needed to be assessed separately (Greenwood et al., 2002).

Thoughtful examination of IPV awareness and help-seeking behaviors within and among LGBT communities is crucial to developing support after IPV occurs; such examination is also important to the development of prevention programs. When studying IPV, both the similarities and differences among the LGBT communities regarding identity group membership; characteristics of gender, class, and age; and geographic locale must be examined.

The need to engage LGBT communities rather than mainstream service providers lends itself to the utilization of the Community Readiness Model (CRM) developed by the Tri-Ethnic Center for Prevention Research in Colorado (Plested, Edwards, & Jumper-Thurman, 2005). This model has been used to determine community readiness to address a variety of health and social issues across widely varying populations. (Refer to Plested et al., 2005, for a list of references.) Although not previously used to examine LGBT IPV, this approach was particularly well matched to this project for several reasons. First, it allowed for each identity group, or community, to be addressed separately. Second, it engaged the community in the process to inform readiness by relying on interviews of both community members and those connected to community. Finally, the model paired readiness levels with strategies that can be most effective for a community at each level. A description of each dimension of readiness and of each stage of community readiness as developed by the Tri-Ethnic Center for Prevention Research can be found in the Appendix I.

METHODS

An advisory committee to assist with the project was convened by an upper Midwest, statewide, nonprofit organization whose mission is the healthy development of LGBT people. The committee was comprised of LGBT people from rural and urban communities. The first step in customizing the CRM for LGBT IPV was to define the issue to be addressed. In consultation with the advisory committee, IPV was defined as any type of domestic violence, including sexual, emotional, physical, psychological, and financial abuse, within a dating or long-term relationship. IPV did not include hate crimes, bashing, or violence perpetrated by individuals not intimately connected to the victim/survivor. It also excluded childhood abuse.
The model required that multiple communities be considered separately and encouraged narrow definitions. Since past research efforts in IPV have focused more on lesbian and bisexual women than on men or transgender people, the decision, again involving input from the advisory committee, was to divide the larger LGBT population into 16 communities. Lesbian, gay male, bisexual males and females, and transgender individuals were each considered a separate community, as well as each of 4 geographic regions (2 urban, 2 rural)—creating a $4 \times 4$ plan. The two urban areas had populations of 300,000 or greater; the rural areas had populations of less than 70,000. All participants lived in the same state in the upper Midwest. For example, lesbians in one rural area were a separate community from transgender people in that same area, and transgender people in that area were defined as a community separate from transgender people in an urban region.

Once the issue and communities were defined, an approach for interviews was determined. According to the model, four to seven interviews in each community are needed to assess readiness. Participants need not identify as L, G, B, or T; rather, they need to have knowledge of IPV efforts in the community. Two of the authors served as the interviewers, conducting at least 5 interviews in each community for a total of 81 interviews.

The Interviews

Enlisting the assistance of personal and professional contacts, the interviewers began by identifying people connected to or members of LGBT communities in each geographic area. They contacted each of the identified individuals by phone or e-mail to request an interview; then, using a snowball approach, they asked the initial contacts for recommendations of additional people to interview. This method proved successful and resulted in interviews with 79 individuals for a total of 81 interviews. The model allowed for individuals to be interviewed for more than one community if they were knowledgeable in multiple communities, which explains the discrepancy in the number of individuals and interviews.

As suggested by the model, all interviews were conducted via phone, which increased flexibility for scheduling interviews. Interviews were conducted over a six-month time period with the majority of interviews occurring in the first three months. Even with the flexibility of interviewing people by phone, there were still some challenges in scheduling, including “no-shows” and individuals needing to reschedule multiple times. Most interviews lasted 60 minutes, with a range of 20 to 90 minutes.

Interviewers provided a brief description of the project when they initially contacted participants. This included explaining the purpose of the project, identifying what the interview would include and exclude, and
setting an interview appointment time. Participants were told that they would not be asked about their own experience with IPV nor would they be expected to be experts in this issue. Once an interview was scheduled, interviewers began by calling the participant, verifying identity, and reading a short consent statement. Next, interviewers read the questions from the CRM, each customized for IPV and the community defined by identity and geographic area (Appendix II). For example, “What services or efforts are available in the bisexual community in Rural A Community to address IPV?” would be asked for each community and each population. Per the CRM, participant responses were typed verbatim as they were answered. The interviewers added a couple of questions that asked about outcry: to whom a person would first turn, and why, if she or he were experiencing IPV. This addition supplemented previous research on the outcry needs of LGBT people experiencing IPV.

Scoring

A scoring team of four members underwent training by one of the CRM founders, Robert Foley. Operating in teams of two, every interview transcript was scored by both members of the team, who then compared their scores and discussed discrepancies until consensus was reached, using the criteria built into the CRM. Each element of community readiness was scored separately. These scores were subsequently combined to create an overall readiness score for each interview. As instructed by the CRM, scores are always rounded down (2.9 rounded to 2.0) to reflect that communities that have not reached the next level of readiness are simply not ready for that level of corresponding interventions.

RESULTS

Individual interview scores were combined to create a community score for each of the 16 communities. Community readiness scores were also calculated for each identity group, regardless of geographic area, and for each geographic group, regardless of identity. These scores appear in Table 1.

<table>
<thead>
<tr>
<th>Regional Community</th>
<th>Lesbian (CR = 3)</th>
<th>Gay Men (CR = 3)</th>
<th>Bisexual (CR = 3)</th>
<th>Transgender (CR = 3)</th>
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<tbody>
<tr>
<td>Rural A (CR = 3)</td>
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<td>Rural B (CR = 2)</td>
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As Table 1 shows, the overall readiness of all communities in the project is 3, or “Vague Awareness” (Appendix I). Vague awareness indicates that most people believe that there is a local concern, but there is no immediate motivation to do anything about it. Across the 16 communities, 2 communities scored a readiness level of 2, or “Denial/Resistance,” signaling that at least some community members recognize that it is a concern, but there is little recognition that it might be occurring locally. Three communities scored a readiness level of 4, or “Preplanning.” At this level, there is clear recognition that something must be done, and there may even be a group addressing the problem. However, efforts are not focused or detailed. All 11 remaining communities scored a 3. When communities were consolidated into identity-based communities and into geographic communities, only one grouping of communities (Rural B—all identities) scored a 2, while the others scored a 3.

Further score analyses uncovered variations by dimension as well. Across communities, the dimensions of Community Knowledge of Efforts (prevention and services related to IPV), Community Climate (receptiveness to address IPV), and Community Knowledge of the Issue (IPV) scored lowest—at 2. Meanwhile, averaged across communities, Existing Community Efforts scored highest—at 5.

DISCUSSION

The average of a “vague awareness” level of readiness of the communities in this study is consistent with those found in previous studies that listen to the voices of LGBT people. For example, the participants in Bornstein and colleagues’ (2006) study focused on solutions that organize and build community, as did those in Beeler and colleagues’ (1999) study. Likewise, McClellen (2005) concluded that “same-gender persons are in need of education and advocacy as many are unaware of the existence, let alone the magnitude, of lesbian and gay-male IPV” (p. 152). To be effective, community-based solutions to domestic violence (DV), which include helping to define the problem and provide models for healthy relationships, need to be tailored to the level of readiness.

Both interviewer/authors identified themes from the interviews conducted, sharing these and direct quotations with the other authors and the advisory committee comprised of representative LGBT people in the region, who in turn offered their own explanations of the scores based on experiences in their own communities. The following describes the more common themes, with a sampling of supporting quotations, and their links with existing literature.
Bisexual Men and Women

The prevailing theme among bisexual communities was the question of whether a bisexual community actually exists. Several participants discussed their experiences of feeling neither a part of gay/lesbian or straight communities. Others felt disconnected from other bisexual people in that there was no visible community.

It's not really a community. An undercover community. Many people don't want to consider themselves bisexuals. (Urban B)

But, bi leadership in the community, I'm not sure there are any. There are gay male or lesbian leaders. They may be there, but no one really identifies as bi in leadership roles. The leaders of bi community are not out as “bi.” They either seem to be straight or gay/lesbians. Especially as adults. For youths, it's much more fluid to identify as bi. (Rural B)

Some bisexual people also were unsure if mainstream services were for them.

... in the LGBT community not much that supports IPV there, usually have to go outside to local DV shelter because we don't have anything specifically for bisexual. (Rural A)

Both themes support ideas in previous literature. Balsam and Szymanski (2005) discuss how the identity of bisexual creates minority stress for those women who so identify, largely through negative stereotypes about bisexuality and tensions between bisexual women and lesbians. Minority stress results from stigmatization and marginalization. Bornstein and colleagues’ (2006) study of LBT female victim/survivors of IPV also noted the marginalization of bi- and trans- people within the LBT communities. While Bornstein and colleagues (2006) found different patterns of the experience of abuse between bisexual and lesbian women, the impact on seeking and obtaining support for IPV is not addressed in either article, which further supports the lack of inclusion of bisexual people within the LGT communities. Girschick (2002) noted the difficulty of community accountability when bisexual people have significantly different experiences from gay men and/or heterosexual transgender people.

Gay Men

Themes that emerged across gay male populations nearly all related to being male, not to being a gay male. One prominent theme was that gay men would not tell about IPV they were experiencing; this would be too embarrassing
and unmanly to admit being a victim of abuse, a violation of traditional masculinity. This is consistent with many previous publications that point to the salience of gender roles over sexual orientation as it relates to the ability to self-label as “victim” (Bailey & Zucker, 1995; Brown, 2008; Letellier, 1994; McKenry et al., 2006; Seelau, Seelau, & Poorman, 2003; Waldner-Haugrud & Gratch, 1997). Gay male inability to transcend male gender roles regarding being a victim of IPV has been documented to occur as early as in adolescence (Halpern, Young, Waller, Martin, & Kupper, 2004). When asked to whom a gay male victim would turn, this participant said,

Um, friends. And he would not look for support in structured services because of stigma. (Rural A)

Another participant stated:

There is an assumption by gay male community that this does not occur in gay male community, only lesbian. . . . Because it does not seem very “manly.” I am sure there needs to be work around acknowledging, normalizing, that gay male IPV occurs. (Urban B)

And another:

I think the attitude is one of stigmatizing and not taking it seriously. (Urban B)

Another perspective:

People see what they want to see. If someone shows up with a shiner, people are not going to say right away, but might think about it. (Rural A)

Many people interviewed for the gay male community, consistent with a lower level of readiness, expressed little knowledge about whether IPV occurred in their community. This confirms the conclusions of many studies, most recently that of Kulkin and colleagues (2007).

As a gay male in the area I am not very familiar with statistics and I think I am aware of services and am active in the community. (Urban B)

And I am not aware of too many couples having this problem but I am aware it is a problem in the community. (Urban B)

There is a stereotype that male-to-male violence doesn’t exist. Believe that men can protect themselves against violence, even if that’s not the
Men also frequently acknowledged a lack of IPV services for men. As with lesbians (Girshick, 2002; Turell & Herrmann, 2008), gay men are more likely to seek help from friends first (Beeler et al., 1999).

You know I think about outreach campaigns in a women’s restroom in nowhere (town) there are signs in restrooms and with little tear-offs. But again it is not a ... it’s a gender-specific bathroom. I would put money down that those are not in men’s bathrooms. How do resources discriminate against men? (Rural A)

Many services can’t do as much for men. (Urban B)

Lesbians

In some communities there was a sense that IPV either does not happen in lesbian relationships or would not be tolerated. The myth of a lesbian utopia has been discussed in previous publications (Girshick, 2002; Hassouneh & Glass, 2008).

I think it’s a “don’t ask, don’t tell.” Easy for people, especially lesbians, to deny it happens. Women don’t do this to women, they believe. (Urban A)

“Not tolerated and not discussed.” (Rural A)

Conversely, as much as participants recognized that there were lesbians involved in IPV work and in social advocacy work in their communities, there was still often a sense that lesbians lacked knowledge or acknowledgment of IPV. Again, this is congruent with persistent myths about egalitarianism in all lesbian relationships, gender role stereotypes that women aren’t violent, or that violence between women is just a “catfight” (Brown, 2008; Burke & Follingstad, 1999; Hassouneh & Glass, 2008).

I think most lesbians in this city just chalk it up as bad relationships happen. (Urban B)

I know a dozen women I would call for advice about DV, but whether they are geared into DV and the lesbian community, I can’t tell you. (Urban A)

No one [lesbian leadership] out there saying “this is a critical issue happening to lesbians.” (Urban A)
Lesbian community is isolated as it is and don’t want to address the issues. Not see it in own relationships, and with interconnectedness among friends, it gets nasty to see it in others’ relationships. (Rural B)

Transgender Individuals

A common theme among transgender individuals was isolation, particularly in rural areas, both from LGB individuals and from one another in some cases. As mentioned earlier, Bornstein and colleagues (2006) noted the marginalization of both bi- and trans- people within the LGB communities.

I am a transsexual . . . so not accepted by gays or lesbians, not as men or women. (Rural A)

Transgender people often mentioned other issues being much more urgent in their lives than IPV. These would include not only the marginalization mentioned but also discrimination and violence in the broader social context.

I would probably say that it’s ranked pretty low unless happening to you. There are more immediate needs, such as depression and drug issues, pain and shame. (Urban A)

[trans] people are more concerned with hate crimes and being free to walk the streets . . . (Rural B)

Additional Themes

There were other themes that crossed identity groups. Some of these themes appeared to be specific to one area, while others spanned both urban and rural.

Activism Fatigue in Rural B

Participants in Rural B noted community fatigue after the state’s constitutional amendment to ban gay marriage passed. Individuals in that region frequently cited this defeat as a reason that LGBT communities were less likely to get involved in any sort of movement. Interviews in this region were conducted just a year after the amendment passed.

What we’ve seen lately, since the marriage amendment vote, a lot of folks put time and money into that effort and a burnout factor in this community. Agencies that are volunteer driven, have been struggling. A depression has set in. They think “this state sucks and I’m going to stay
home and watch TV.” People got tired. Lower turnout lately. People are burned out. To ask a community to do one more thing in addition to what they already are doing could be a challenge. With the exception of allies and youth; they are not as burned out. (Rural B)

MAINSTREAM INTEGRATION IN URBAN A

One characteristic of Urban A’s LGB (not as true for transgender populations) communities is significant integration of nonheterosexual people into the mainstream community. Urban A is generally reputed to be a “gay-friendly” city, and as a result, people interviewed were less likely to feel isolated from the majority population.

We are a blessed community in that we have been out of the intellectual, legal ghetto longer than many communities, but we are self-involved, navel gazers. We are not filling our ranks of activists with younger people. Much more stratification and withdrawal that comes with increased privilege. (Urban A)

NOT ME, THEN NOT INVOLVED

Several participants across identity groups said they believe people are only concerned about IPV if it is happening to them or someone they know. This is consistent with Kulkin and colleagues (2007), who noted that if the issue is not related directly to them, many gay men and lesbians ignore it.

The general level would be low but if someone was in an abusive or have friend in an abusive relationship they will be more aware. If not, I don’t think they even think about it. (Rural A)

CONCLUSIONS

The findings of this project lead to the development of several strategies (noted next) that best match communities at the Vague Awareness (3) level of readiness; however, to recognize that some communities scored lower than a 3, strategies that work at the Denial/Resistance (2) level are also included. All strategies focus on enhancing community readiness to deal effectively with IPV.

The objective of strategies for Level 2, Denial and Resistance, is to raise awareness that the problem exists in the community. According to the CRM, specific ideas include the following:

- visiting one-on-one with community leaders;
- discussing and describing local IPV incidents;
• using local media as available;
• engaging local educational/health outreach programs to assist with flyers, posters, and brochures;
• publishing articles about same-sex IPV in bulletins of houses of worship, local newsletters, etc.;
• and presenting information to local related community groups.

As communities move into Level 3, Vague Awareness, the goal shifts to raising awareness that the community can do something to address IPV. Many of the same strategies for Level 2 are relevant, such as posting flyers and posters, as is publishing articles in local newspapers and newsletters. Level 3 strategies also include the following:

• initiating events, such as potlucks, to present information on the issue, and
• asking for time on local groups’ meeting agendas to discuss the topic.

Given the inclusion of both urban and rural areas in this study, including one urban area known as one of the most LGBT friendly in the United States, we believe these suggestions are generalizable for most, if not all, LGBT communities in the United States. In fact, given the low levels of readiness found in this study, strategies implemented in some larger cities across the United States, ones that assume much higher levels of readiness are likely too premature to have full effectiveness. Implementing more advanced interventions than warranted by a community’s level of readiness can do more damage than good. Communities would do well to assume lower levels of readiness than presumed and to implement strategies needed to raise readiness levels; once levels of readiness are raised, LGBT people will be able to more fully take advantage of the advanced interventions available.

To span Levels 2 and 3 of readiness and to recognize communities’ desires to get services within their LGBT communities, a three-part approach is warranted to increase LGBT community readiness to address IPV and to prepare resources for this increased readiness. The first strategy is to build awareness within LGBT communities regarding IPV. One effective way to begin increasing LGBT awareness of IPV is to distribute and share results of the findings in this study.

Even with awareness, there is no guarantee that LGBT organizations will be ready to assist effectively with this issue. Therefore, the second strategy is to develop the capacity of LGBT organizations, groups, and individual leaders (assuming they exist in a given community), to respond to IPV within LGBT communities. As a foundation to capacity-building, the existing capacity of LGBT individuals and groups to respond to IPV should be determined. Evidence of capacity includes the existence of current relationships with IPV providers and the LGBT organizations and current best practices and/or evidence-based approaches of existing LGBT
Finally, partnerships need to be developed for the purpose of increasing response to IPV within LGBT communities. Local LGBT leaders can meet regularly with LGBT community centers and other groups to discuss how to implement services both within the community and with mainstream IPV service providers. This last strategy includes increasing the cultural competency of IPV services regarding LGBT IPV and continuing partnerships for infrastructure development with IPV providers and LGBT organizations, groups, and individual leaders.

One limitation of this study is that our definition of “communities” remained somewhat broad. For example, community parameters were not sufficiently refined to include ethnicity as a variable (for example, gay African-American male community or Latina lesbian community). As awareness of same-sex IPV is raised within LGBT communities, one must also assess and then design programs inclusive of the potentially unique needs of LGBT people of color (Méndez, 1996; Waldron, 1996). Also, we included both male and female bisexual people in one bisexual community. Separate community readiness needs to be conducted for each bisexual community. Ultimately, community readiness should be assessed and strategies developed for the multiplicity and intersectionality of communities with LGBT people of all ethnicities, gender expressions, sexual orientations, and ages.

Creating awareness in LGBT communities is not easy. The heterosexist model of IPV, gender roles, and myths remain the norm. Another complicating dynamic is the urge to focus on barriers to and programs of mainstream service providers, rather than on gaps within LGBT communities (Turell & Herrmann, 2008). For women in particular, focusing on women as potential perpetrators means acknowledging that no space is truly safe, even women-only spaces (Girshick, 2002). Certainly structural barriers to communicating with LGBT people in both urban and rural areas exist as well. The digital divide persists for many people, and few LGBT media outlets exist. Furthermore, much of existent community-level print materials focus on socializing and lighter fare—a limitation that challenges dissemination of information on weightier issues such as IPV.

For most LGBT communities, laying the groundwork of interventions at a “vague awareness” readiness level is necessary before moving into other types of programming. Although much of the literature recommends community education and interventions for LGBT IPV, these recommendations may not be effective if they presume a more advanced level of community readiness than exists. Given our results, we believe that implementing strategies beyond the levels of Denial/Resistance and/or Vague Awareness will not yield the intended results, as LGBT communities do not appear to be ready for strategies beyond building awareness. After increasing awareness of the issue’s existence and that something can be done about IPV in LGBT
communities, the next steps (Level 4) can include raising awareness of concrete ideas to combat challenging problems. Building community readiness is a worthwhile effort to ensure the effective use of resources, both in terms of prevention efforts and to break isolation, so that when victim/survivors seek support and help, they receive rapid and effective intervention.

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NOTE

1. The terms LGBT and same-sex relationships are used interchangeably throughout this article, although reluctantly, and we acknowledge, not always accurately. The authors recognize that some bisexual and transgender people are in relationships that appear heterosexual to those who do not know each person’s gender/sexual identity. However, for the sake of consistency with past research and parsimony in this article, we use these terms to include the range of relationships for L, G, B, and T people.

REFERENCES


**APPENDIX I:**

**STAGES OF COMMUNITY READINESS**

1. **No Awareness**

   Issue is not generally recognized by the community or leaders as a problem (or it may truly not be an issue).

   Intervention or activity example: Make one-on-one visits with community leaders/members.

2. **Denial/Resistance**

   At least some community members recognize that it is a concern, but there is little recognition that it might be occurring locally.

   Intervention or activity example: Discuss descriptive local incidents related to the issue.

3. **Vague Awareness**

   Most feel that there is a local concern, but there is no immediate motivation to do anything about it.

   Intervention or activity example: Post flyers, posters, and billboards.
4. Preplanning
There is clear recognition that something must be done, and there may even be a group addressing it. However, efforts are not focused or detailed.

   Intervention or activity example: Visit community leaders to encourage them to invest in the cause.

5. Preparation
Active leaders begin planning in earnest. Community offers modest support for efforts.

   Intervention or activity example: Sponsor a community picnic to kick off the effort.

6. Initiation
Enough information is available to justify efforts. Activities are underway.

   Intervention or activity example: Conduct consumer interviews to identify service gaps, improve existing services, and identify key places to post information.

7. Stabilization
Activities are supported by administrators or community decision makers. Staff are trained and experienced.

   Intervention or activity example: Prepare and submit newspaper articles detailing progress and future plans.

8. Confirmation/Expansion
Efforts are in place. Community members feel comfortable using services and support expansions. Local data are regularly obtained.

   Intervention or activity example: Develop a local speaker's bureau.

9. High Level of Community Ownership
Detailed and sophisticated knowledge exists about prevalence, causes, and consequences. Effective evaluation guides new directions. Model is applied to other issues.

   Intervention or activity example: Diversify funding resources.
I am going to read you several questions about the Bisexual community in Rural A Community and Intimate Partner Violence they might experience. I will refer to intimate partner violence as IPV. When I use this term, I am referring to physical, sexual, and emotional abuse that can occur while bisexual people date and between bisexual people who are in committed relationships. When I use the term community, I am referring to the bisexual community in Rural A Community.

Your answers and ideas are very important and I want to accurately record them. Therefore, I will be typing your answers as we talk. I may need to ask you to pause for a moment from time to time to give me time to record what you are saying. Your name will not appear at all on this transcript.

Do you have any questions before we begin?

Rural A—Bisexual People

A. Community Efforts and B. Community Knowledge of Efforts

1. Using a scale from 1–10, how much of a concern is intimate partner violence (IPV) for bisexual people in Rural A Community, with 1 being “not at all” and 10 being “a very great concern”? Please explain.

2. What services or efforts are available in the bisexual community in Rural A Community to address IPV?

3. What are the strengths of these services?

4. What are the weaknesses of these services?

5. How can bisexual people in Rural A Community access these services (i.e., referrals, waiting lists, criteria)?

6. How long have these services been in existence for bisexual people in Rural A Community?

7. How have these services been supported by bisexual people in Rural A Community?

8. Generally, do the bisexual people in Rural A Community use these services? Please explain.

9. Using a scale from 1–10, how aware are bisexual people in Rural A Community of the efforts to provide services for IPV? (1 = “no awareness” and 10 = “very aware”). Please explain.

C. Leadership

10. Who are leaders specific to IPV in the bisexual community in Rural A Community?
11. Using a scale from 1–10, how much of a concern is bisexual IPV to the bisexual leadership in Rural A Community (with 1 = not at all and 10 = of great concern)? Please explain.
12. How do the leaders in the bisexual community in Rural A Community support current efforts related to bisexual IPV? Please explain.
13. Please explain how the leaders are actively involved in the efforts.
14. Would the leadership support additional efforts? Please explain.

D. COMMUNITY CLIMATE
15. Describe the bisexual community in Rural A Community.
16. What are the attitudes of the bisexual people in Rural A Community about bisexual IPV?
17. How supportive would bisexual people in Rural A Community be in creating or expanding efforts to address bisexual IPV?
18. What are the primary obstacles to obtaining services about IPV in the bisexual community in Rural A Community?

E. KNOWLEDGE ABOUT THE ISSUE
19. How knowledgeable are bisexual people in Rural A Community about bisexual IPV? Please explain (i.e., signs, symptoms, local stats, etc.).
20. For bisexual people in Rural A Community, what type of information is available about bisexual IPV prevention?
21. Is local data on bisexual IPV available for bisexual people in Rural A Community? If so, from where?
22. How do bisexual people in Rural A Community obtain this information?

F. RESOURCES FOR PREVENTION EFFORTS (TIME, MONEY, PEOPLE, SPACE, ETC.)
23. If a bisexual person in Rural A Community was affected by IPV, to whom would s/he first turn for help? Why?
24. On a scale from 1–10, what level of knowledge related to bisexual IPV do those “first responders” have? (1 = very low and 10 = very high)
25. What is the attitude of bisexual people in Rural A Community about supporting bisexual IPV prevention efforts with people volunteering time, making financial donations, and providing space?
26. Are you aware of any proposals or action plans that have been written to address bisexual IPV in Rural A Community?
27. Do you know if there is any evaluation of the efforts? If yes, on a scale of 1–10, how sophisticated is the evaluation effort (with 1 = not at all and 10 = very sophisticated)?
28. Anything else you’d like to add that we haven’t discussed?