

THE IMPACT OF MINORITY STRESS ON LGBTQ INDIVIDUALS' INTENTIONS
TO SEEK HELP FOR INTIMATE PARTNER VIOLENCE

by

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Master of Arts
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DEDICATION

This project is dedicated to all those who have had difficulty seeking help for violence.

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LIST OF ABBREVIATIONS AND SYMBOLS

Analysis of variance.....	ANOVA
Chi-square.....	χ^2
Comparative fit index.....	CFI
Cronbach's alpha.....	α
Domestic violence.....	DV
F-test.....	F
General Help-Seeking Questionnaire.....	GHSQ
Heterosexist Harassment, Rejection, and Discrimination Scale.....	HHRD
Intimate partner violence.....	IPV
Internalized Homonegativity Scale.....	IHS
Lesbian, gay, bisexual, transgender, and queer.....	LGBTQ
Lesbian, Gay, Bisexual, Transgender and Queer Intentions to Seek Help for Intimate Partner Violence Scale.....	LGBTQ-ISH
Mean.....	M
Percent.....	%
P-value.....	p
Revised Conflict Tactics Scales.....	CTS-2
Root Mean Square Error of Approximation.....	RMSEA
Sample size.....	n
Standard deviation.....	SD

ABSTRACT

THE IMPACT OF MINORITY STRESS ON LGBTQ INDIVIDUALS' INTENTIONS TO SEEK HELP FOR INTIMATE PARTNER VIOLENCE

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Lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals experience rates of intimate partner violence (IPV) that are equal to or higher than rates reported by cisgender and heterosexual individuals; however, they do not seek help for IPV as often as heterosexual individuals; however, they do not seek help for IPV as often as heterosexual/cisgender survivors and they face population-specific barriers to help-seeking, such as a fear of discrimination from help sources. Although it is clear barriers to help-seeking exist, researchers and advocates do not have a clear or nuanced understanding of how, in which contexts, and to what degree they operate. This dissertation presents two studies that investigate intentions to seek help for IPV in a sample of 317 LGBTQ people. Study one examined the types of sources LGBTQ individuals are most likely to seek help from if they experience IPV in the future. Results indicated that LGBTQ people are most likely to seek help from friends, mental health professionals, and LGBTQ resource centers if they experience IPV. Additionally, intentions to seek help differed significantly based on participants' gender identity and IPV history. Study two investigated minority stress processes as barriers to help seeking for LGBTQ IPV from formal sources of support. Results indicated that discrimination and internalized

homo/transphobia are barriers to seeking help from mental health professionals, but these minority stress processes did not act as barriers to seeking help from other formal sources of support. In addition, participants' levels of outness did not serve as a barrier to seeking help from any of the formal sources of support.

STUDY ONE

Intimate partner violence (IPV) affects millions of individuals in the United States annually (Breiding et al., 2014). In recent years, more researchers have studied IPV among minority populations, including survivors who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ) (Edwards, Sylaska, & Neal, 2015). This research suggests LGBTQ individuals experience IPV at rates equal to or higher than rates reported by cisgender and heterosexual people (CDC, 2013; NCAVP, 2013). To cope with IPV, survivors use a variety of strategies, including seeking help (Abraham, 2000; Hamby, 2014). However, LGBTQ survivors do not seek help for IPV as often as straight and/or cisgender survivors (McClennan, 2005; Renzetti, 1992), suggesting that they may face population-specific barriers. Despite this discrepancy, quantitative research on how these barriers function is lacking.

Understanding the processes that prevent LGBTQ individuals from seeking help is critical to inform efforts to address them. Reviews of the LGBTQ IPV literature indicate that barriers include a lack of LGBTQ-affirming help sources and fear of discrimination (Calton & Cattaneo, 2015; Edwards, Sylaska, & Neal, 2015). However, the extent to which these factors prevent people from seeking help and the ways these barriers relate to different help sources have not been empirically examined (Calton & Cattaneo, 2015; Edwards, Sylaska, & Neal, 2015). These dynamics are difficult to

explore, because researchers often collect data at help sources (e.g., a medical clinic), likely missing those who face the greatest barriers to help seeking. To better understand barriers to seeking help for this vulnerable group, researchers need to examine intentions to seek help within the general LGBTQ community. Exploring individuals' intentions to seek help from different sources of support will tell IPV researchers and advocates where the greatest barriers to help-seeking might exist. This study contributes to this area by exploring whether the strength of LGBTQ peoples' intentions to seek help for IPV vary by subgroup and help source.

Seeking Help for IPV

Research in the general population has laid important groundwork for exploring help seeking in specific populations. First, research indicates that help seeking is one of many potential strategies that IPV survivors use to address abuse (Hamby, 2014). Second, research suggests that when survivors seek help, they are most likely to turn to informal sources (Donovan & Hester, 2008; McClennen, Summers, & Vaughan, 2002). Third, seeking help for IPV increases along with frequency and severity of violence. Finally, the most frequently used formal support is the justice system (Nurius, Macy, Nwabuzor, & Holt, 2011; Goodman, Dutton, Weinfurt, & Cook, 2003). This scholarship has also documented barriers to seeking help, including feelings of shame, fear of retaliation from a partner, a desire to keep IPV private, and fear of informal supports' reactions (Edwards et al., 2012; Walters, 2011).

In addition to those barriers, LGBTQ survivors face obstacles that are specific to their LGBTQ identity (for reviews see Calton, Cattaneo & Gebhard, 2015; Edwards,

Sylaska, & Neal, 2015). First and foremost, LGBTQ stigma¹ can make it more difficult for LGBTQ survivors to get help for IPV, both in terms of survivors' expectations and in terms of the responses of systems. For example, when seeking help from the police, some LGBTQ IPV survivors have reported that responding officers minimized the violence (Walters, 2011). Alhusen, Lucea, and Glass (2010) conducted interviews with LBT women who had used a range of formal services for same-sex IPV, and they reported pervasive homophobia within formal support systems. Stigma also manifests in the form of systemic inequities for LGBTQ survivors. There is a lack of formal IPV services tailored to LGBTQ survivors (Edwards, Sylaska, & Neal, 2015), and, within the services that are available, LGBTQ survivors are often subject to differential treatment. For example, LGBTQ survivors have reported being excluded by the justice system (e.g., being ineligible for protection orders; NCAVP, 2010) and domestic violence services (e.g., being turned away from IPV shelters because they identify as men, transgender, queer, lesbian, gay, and/or bisexual; NCAVP, 2012; Renzetti, 1996). Not surprisingly, knowledge of stigma prevents some LGBTQ individuals from asking for support (Carvalho, 2011, Renzetti, 1997; West, 1998).

Stigma may also feed hesitancy to report events that might portray the LGBTQ community negatively: Survivors have reported that IPV is silenced within the LGBTQ community for fear of further stigmatization (Walters, 2011). Also, related to the

¹ 'LGBTQ stigma' refers to society's negative regard for identities, relations, or communities that are not heterosexual or cis-gender (see Hendricks & Testa, 2012; Herek, 2004). This is often referred to as 'public stigma', and when it is internalized it is called 'self-stigma' (Corrigan, 2004). Both forms of stigma are elevated for LGBTQ individuals (e.g., Szymanski, Kashubeck-West, & Meyer, 2008) and may be barriers to help seeking for IPV.

existence of stigma, survivors' help-seeking decisions are influenced by whether they are open about their LGBTQ identity. Some LGBTQ survivors are afraid of being outed to their friends and family during the process of help seeking (Carvalho, 2011; West, 1998). Even if LGBTQ survivors are out with close friends and family, they may not feel comfortable disclosing their identity to a stranger. There is clear evidence that these barriers exist. However, researchers and providers do not have a clear or nuanced understanding of the contexts and the degree to which they operate.

In order to understand whether these barriers prevent LGBTQ individuals from seeking help for IPV, researchers can explore whether LGBTQ individuals who have and have not experienced IPV in the past have strong intentions to seek help for IPV if they experience abuse in the future. They can also examine whether these intentions vary across different sources of support. If LGBTQ individuals intend to seek help from some sources but not others, researchers will have a more nuanced understanding of where the greatest barriers to help-seeking behavior exist and where LGBTQ individuals feel most comfortable going in the aftermath of IPV.

Considerations for LGBTQ IPV Research

Research exploring those questions needs to be guided by some special considerations. First, there is a growing emphasis within the LGBTQ literature on variance within the LGBTQ spectrum (Diamond, 2013; Rust, 2000). For example, the experience of a cisgender woman who identifies as a lesbian may be very different from than someone who identifies as genderqueer. These differences may be particularly salient in seeking help for IPV, as those who appear to be or identify as men may have a

more difficult time receiving IPV services than those who appear to be or identify as women. Researchers have called for studies that consider this variance (e.g., Edwards, Sylaska, & Neal, 2015); doing so requires diverse samples of LGBTQ people and careful attention to participants' identities in multiple domains.

In addition to needing diverse samples, it is important that researchers collect information from survivors who have not sought support for IPV in the past. Those who have never sought help despite experiencing IPV are likely facing the largest barriers to seeking help, and excluding their opinions would result in sampling bias. In order to collect a diverse sample that includes survivors who have never sought help for IPV, researchers are left with two options. Studies can ask about past help-seeking decisions among IPV survivors, or can investigate behavioral intentions among LGBTQ people in general. Both approaches may yield useful information, but the latter approach has the advantage of drawing the broadest sample: those who have a) experienced IPV and sought help, b) experienced IPV and not sought help, and c) never experienced IPV. All of these groups can report on their behavioral intentions if they were to experience IPV in the future.

The Current Study

Research suggests behavioral intentions are useful in studies where it is difficult to capture behavior, and that they are stronger predictors of behavior than attitudes (Ajzen, 1991; 2002; Armitage & Conner, 2001). They are not a proxy for behavior, given that meta-analyses indicate the mean correlation between behavioral intentions and behavior ranges from .4 to .6 (Armitage & Connor, 2001; McEachan et al., 2011).

However, the predictive validity of behavioral intentions increases when a measure of intentions is specific and the context is closely aligned with the context in which a person would carry out the actual behavior (Ajzen, 1991; Ajzen, 2002). Thus, in order to examine factors that influence LGBTQ individuals' behavioral intentions to seek help for IPV, researchers need a measure of intentions to seek help for IPV that is specific to both IPV and LGBTQ individuals. Such a measure has not been developed to date.

Wilson, Dean, and Ciarrochi (2005) developed the General Help-Seeking Questionnaire (GHSQ) to allow researchers to investigate intentions to seek help for specific problems. The GHSQ asks participants about their specific intentions to seek help from a variety of sources using a customizable stem. The current study adapted the GHSQ to assess intentions to seek help for LGBTQ IPV, with particular attention to variability across sources and along the LGBTQ spectrum. We also explore the possibility of differences according to the actual experience of IPV. Specifically, we examine the following research questions:

- 1) Which help sources are LGBTQ individuals most likely to use?
- 2) How strong are participants' intentions to seek help for IPV?
- 3) Are there significant differences in intentions based on participants' sexual orientation, gender identity, and IPV history?

Method

Participants

Participants' ($n = 317$) ages ranged from 18-66 ($M = 31$, $SD = 11.16$). Of these participants, 28.1% identified as men, 47.3% identified as women, and 24.6% identified

as transgender or non-binary. Thirty eight percent of the sample identified as gay/lesbian, 27% identified as bisexual, 25% identified as queer, 6% identified as other, and 4% identified as heterosexual and transgender. Additionally, 38% of the sample identified as White, 22% identified as Black, 19% identified as Asian, 12% identified as multi-racial, and 9% identified as Latino. Most participants were well educated, as 36% completed some college or technical school, 33% attained a 4-year college degree, and 23% completed a graduate program.

Procedure

This study is part of a larger investigation of sexual minorities' health and health-related behaviors, approved by The Virginia Commonwealth University Institutional Review Board. Flyers were posted on social networking websites including Facebook and Craigslist, and at community sites such as LGBTQ resource centers, health centers, and grocery stores. Interested participants emailed the study coordinator who ensured that participants were at least 18 years old, and that they identified as lesbian, gay, bisexual, transgender, or queer. Eligible individuals were emailed a link to the survey and a unique access code. Participants read the informed consent and completed a series of online questionnaires. Given the sensitive nature of some of the health-related measures, at the end of the survey, participants were given the phone numbers of a 24-hour National Treatment Referral Hotline and a Drug Counseling Hotline. Participants were paid \$15 via electronic Amazon gift card.

To safeguard against the high likelihood of obtaining false responses when conducting online research involving participant incentives, participants were

automatically deleted if they met the following criteria: a) there was indication of false responding, such as a completion time of less than 20 minutes or more than 24 hours, b) there were implausible response patterns, such as selecting the first response for every item on a scale, or c) if participants did not accurately respond to at least four of six accuracy checks (e.g., “Please select *disagree* for this item”).

Measures

Demographics. Participants reported their age, race/ethnicity, socioeconomic status, level of education, gender identity, and sexual orientation.

Intimate Partner Violence. In order to assess whether participants had been victims of IPV in their lifetimes, participants completed the Revised Conflict Tactics Scales (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). Participants responded to this measure on a Likert Scale from 1 (*once in the past year*) to 6 (*over 20 times in the past year*), with additional response options of 7 (*not in the past year, but it did happen before*) and 8 (*this has never happened*). Items were scored by creating several dichotomous variables that reflected whether participants had experienced any physical and/or sexual or psychological IPV in their lifetimes, as well as two dichotomous variables that reflected whether they had experienced any IPV overall over the course of their lifetimes or in the past year. The scale demonstrated adequate internal consistency ($\alpha = .87$) in this sample.

The Intentions to Seek Help for LGBTQ IPV (LGBTQ-ISH) Scale. We adapted the GHSQ (Wilson, Deane, & Ciarrocchi, 2005) to measure participants’ intentions to seek help for IPV from a variety of sources (see Appendix). When

customizing the measure, Wilson, Deane, and Ciarrocchi (2005) encourage researchers to adapt their more general stem to be problem-specific, to list informal and formal sources that are relevant to the problem type, and to include “no one” as an option. In the present study, participants were asked: “If you are the recipient (victim) of intimate partner violence in the future, how likely would you be to seek support from the following individuals/institutions?” Participants responded on a scale from 1 (*extremely unlikely*) to 7 (*extremely likely*) for 15 help sources, including formal sources (e.g., police), informal sources (e.g., friend), and LGBTQ-specific sources (e.g., LGBTQ health clinic). Our list of help sources includes the formal and informal sources in the GHSQ, as well as additional sources that are specific to IPV and LGBTQ individuals. We generated these additional sources by a) reviewing the literature (e.g., Goodman, Dutton, Weinfurt, & Cook, 2003; Krishnan, Hilbert, & VanLeeuwen, 2001), as well as b) using online search engines to identify additional types of community support (e.g., LGBTQ resource centers). The GHSQ has demonstrated adequate internal consistency, test-retest reliability, and predictive validity (Deane, Ciarrochi, Wilson, Rickwood, & Anderson, 2001; Wilson, Deane, & Ciarrocchi, 2005).

Data Analyses

Scoring the LGBTQ-ISH. In the GHSQ, internal consistency is reported and responses are summed to create a single score. However, a sum score may not accurately reflect whether a participant intends to seek help for IPV². Additionally, consistent with

² For example, if Participant A has strong intentions to seek help from just one source (score of 7) and low intentions to seek help from all others (scores of 1), then he/she would have a sum score of 20 (out of a possible 98), which may be incorrectly interpreted as a low intention to seek help overall. Contrastingly,

other scales that measure coping strategies for IPV (e.g., Goodman, Dutton, Weinfurt, & Cook, 2003), and with related literature (Abraham, 2000; Hamby, 2014), the endorsement of one help source on this adapted measure does not necessarily correlate with endorsement of another help source. The intent to seek help from friends, for example, does not suggest a willingness to call the police for help, as well. Consistent with an induced variable framework, each item represents separate intentions to seek help from different sources of support that all fall within the larger category of intentions to seek help for IPV. Because items are not expected to be correlated, factor analyses and measures of internal consistency are not the best psychometric approaches to scale validation (Bollen, 1989; Klem, 2000).

Instead, we explored responses to the items in several ways. First, consistent with prior explorations of the GHSQ (e.g., Dean, Wilson, & Ciarrochi, 2001), we examined the mean, standard deviation, median, and mode for each item. We also conducted a repeated measures analysis of variance (ANOVA) to see if responses to items differed significantly. Then, we examined the inter-item correlations to determine whether responses to similar items (e.g. domestic violence shelter and domestic violence hotline) were highly correlated. We created categories where the data and logic suggested them, and summed within those categories. We also created a variable reflecting each participant's highest response (ranging from 1-7) to any item on the scale, excluding

Participant B could report low intentions to seek help from every source (by responding with a 2 to every item), resulting in a sum score of 28. Using these sum scores, participant B's intentions to seek help would be interpreted as higher than Participant A's.

“seek help from no one,” to explore the strength of participants’ intent to seek help from any source.

Differences in Responses to the Scale. To examine differences in responses to individual items and to categories of items based on gender, sexual orientation, and IPV history, we conducted three mixed-model analyses of variance (ANOVAs). The first ANOVA examined differences in intentions based on gender identity (man, woman, transgender/non-binary). The second ANOVA explored differences by sexual orientation (gay/lesbian, bisexual, heterosexual, and queer/other). Finally, the third ANOVA examined differences based on a history of IPV victimization (no history of IPV, lifetime history of psychological IPV, and lifetime history of sexual/physical IPV). We also examined whether there were differences in IPV history based on sexual orientation and gender identity, for descriptive purposes.

Results

Sample Description

Seventy-five percent of the sample reported being the victim of physical, sexual, or psychological IPV at some point in their lives, and 57% reported being the victim of physical, sexual, or psychological IPV in the past year. Specifically, 136 (42.9%) participants reported that they had experienced either physical IPV, sexual IPV, or both at some point in their lives, 98 (30.9%) participants reported that they had experienced psychological IPV at some point in their lives, and 83 (26.2%) participants had never experienced any form of IPV. We found no significant differences in participants’ lifetime history of IPV victimization based on their sexual orientation (whether they

identified as gay/lesbian, bisexual, heterosexual, or queer/other) ($\chi^2[3] = 2.35, p = .503$) or their gender (whether they identified as men, women, or transgender/non-binary) ($\chi^2[2] = 2.32, p = .314$). Similarly, there were no significant differences by gender for past year history of IPV victimization (history of experiencing physical, sexual, or emotional IPV versus no IPV history) ($\chi^2[2] = 2.20, p = .333$). However, participants' IPV victimization over the past year differed significantly according to their sexual orientation ($\chi^2[3] = 8.59, p = .035$), such that those who identified as bisexual experienced significantly more IPV in the past year (70.2%) than did those who identified as heterosexual (41.7%), gay or lesbian (54.9%), or queer (51.5%).

LGBTQ Individuals' Intentions to Seek Help for IPV

The following section describes the ways that we examined participants' intentions to seek help for IPV. First, we describe participants' responses to each item and identify the sources that participants were most and least likely to turn to for support if they experienced IPV. Second, we describe correlations among items and the resulting categorization system. Third, we detail participants' strength of intentions from any source. Finally, we describe differences in intentions to seek help across gender, sexual orientation, and IPV history.

Intentions to Seek Help from Each Source. Table 1 displays the mean, median, mode, and standard deviation for each item. On average, participants' responses to nearly every item indicated that they were somewhat unlikely to seek help (response of 3 on the Likert scale) or felt neutral about seeking help (response of 4) if they experienced IPV in the future. Only one source of support, a friend, received an average score that fell within

the “likely” range of responses (above 5). In descending order, the three sources that received the highest average scores were friends, mental health professionals, and LGBTQ resource centers; and the sources that received the lowest scores were general health clinic, parents, and co-worker (see Table 1).

Given that responses to several items were negatively skewed, the median and mode also provide meaningful information about participants’ responses. For example, the mode for a LGBTQ health clinic, the police, the court system, a domestic violence shelter, a sibling, a general health clinic, a parent, and a co-worker was 1, suggesting many participants were extremely unlikely to seek help from over half of the sources of support listed on the measure. Similarly, the median was very low for domestic violence shelter, a sibling, a parent, a general health clinic, and a co-worker. However, the mode for a friend and a mental health professional was 7, suggesting most participants had high intentions to seek help from these sources of support. Combined, these item-level results suggest participants’ intentions vary by source. Supporting this conclusion, results of a repeated measures ANOVA indicated there were significant differences among responses to items ($F[14, 4424] = 71.20, p < .001$). Post-hoc analyses using Tukey adjustment for multiple comparisons produced pairwise comparisons that indicated many items differed significantly (means are displayed in Table 1). For example, intentions to seek help from a friend (received the highest average score) were significantly higher than intentions to seek help from all of the other sources of support, including other informal sources of support, such as a parent ($p < .001$) or a co-worker ($p < .001$). Intentions to seek help from a mental health professional (which received the second highest average score)

differed significantly from intentions to seek help from many other sources of support, including other formal sources like a domestic violence shelter ($p = .013$). In addition, intentions to seek help from some the LGBTQ-specific sources differed significantly from intentions to seek help from non-LGBTQ sources. For example, intentions to seek help from a LGBTQ health clinic differed from intentions to seek help from a co-worker ($p = .014$), and intentions to seek help from a LGBTQ resource center differed significantly from intentions to seek help from a domestic violence shelter ($p = .015$).

Categorizing Sources of Support for LGBTQ Individuals. In the interest of parsimony, we aimed to combine sources into categories supported by data and theory. Typically, the help seeking literature differentiates between formal and informal sources of help (e.g., Liang, Goodman, Tummala-Narra, & Weintraub, 2005). However, in our sample, intentions to seek help from various formal sources differed significantly from each other, as did intentions to seek help from different informal sources. A fuller review of the correlations among items (see Table 2) revealed that sources that provide similar services or are part of the same system (e.g., the police and the courts are both part of the justice system) were highly correlated. As a result, we derived the following categories: the justice system (police and the court system), medical professionals (medical doctor and general health clinic), domestic violence services (domestic violence network, domestic violence shelter and domestic violence phone hotline), family (parent and sibling), and LGBTQ sources (LGBTQ resource center and LGBTQ health clinic). Mental health professional, friend, co-worker and no-one were not highly related to other sources and/or were theoretically dissimilar from the other sources. As a result, these

items stand alone. The mean response to each newly formed category (see Table 1) indicated participants' intentions to seek help from LGBTQ sources were only slightly less than their intentions to seek help from friends and mental health professionals, and their intentions to seek help from family were nearly as low as their intentions to seek help from co-workers.

Strength of Participants' Intentions to Seek Help for IPV. Despite the fact that participants' intentions differed across different types of sources, when we examined participants' highest response across all items (i.e., how willing participants were to seek help from someone), we found that the average highest response was 6.30 out of 7 ($SD = 1.22$). Nearly all participants reported that they were 'extremely likely' ($n = 199$) or 'likely' ($n = 66$) to seek help from at least one source. As such, the mode and median highest responses were both 7. Only 6 participants reported they were extremely unlikely to seek help from all of the sources (i.e., their highest score was 1)³.

Differences in Participants' Intentions to Seek Help for IPV. We examined whether there were differences in intentions to seek help for IPV by sexual orientation, gender, and IPV history in two ways. First, we explored whether there were differences in intentions across individual items on the LGBTQ-ISH based on sexual orientation, gender, and IPV history. Second we examined whether there were differences in intentions across categories of sources and items that were not categorized based on sexual orientation, gender, and IPV history.

³ We examined the gender identity of participants who reported that they would not seek help from anyone to see if they all identified as transgender/non-binary, given that transgender and queer identified individuals experience high rates of stigma from the general community. Results indicated that these participants were one man, three women, and two transgender/non-binary individuals.

Sexual orientation. The results of the mixed-model ANOVA with sexual orientation as the between-subjects variable and each item as the within subjects variable, Mauchly's Test of Sphericity indicated that the assumption of sphericity had been violated, $\chi^2(104) = 1480.02, p < .001$. As such, we used a Greenhouse-Geisser correction to adjust the degrees of freedom for the averaged tests of significance. Results indicated that there was a significant main effect of item (each source) on intentions to seek help for IPV, $F(8.32, 2604.84) = 30.35, p < .001$. However, there was no significant main effect of sexual orientation ($F[3, 313] = 0.09, p = .967$) or interaction between sexual orientation and source ($F[24.97, 2604.84] = 1.14, p = .291$), which suggests there were no significant differences across responses to items based on sexual orientation.

For the results of the second mixed-model ANOVA with sexual orientation as the between-subjects variable and each category of sources/individual item as the within subjects variable, Mauchly's Test of Sphericity indicated that the assumption of sphericity had been violated, $\chi^2(27) = 242.99, p < .001$, so we used a Greenhouse-Geisser correction, as well. Similarly, results indicated that there was a significant main effect of each category of source on intentions to seek help for IPV, $F(5.80, 1813.72) = 57.53, p < .001$. However, there was no significant main effect of sexual orientation ($F[3, 313] = 0.13, p = .946$) or interaction between sexual orientation and category ($F[17.38, 1813.72] = 1.19, p = .291$), which suggests there were no significant differences across responses to categories of sources based on sexual orientation.

Gender. When we conducted a mixed-model ANOVA with gender as the between-subjects variable and each item as the within subjects variable, Mauchly's Test

of Sphericity indicated that the assumption of sphericity had been violated, $\chi^2(104) = 1499.65, p < .001$. As such, we used a Greenhouse-Geisser correction to adjust the degrees of freedom for the averaged tests of significance. There was a significant main effect of item (each source) on intentions to seek help for IPV, $F(8.33, 2614.44) = 61.58, p < .001$, but there was no significant main effect of gender, $F(2, 314) = 2.40, p = .092$. However, the interaction between gender and source was significant ($F[16.65, 2614.44] = 3.17, p < .001$), suggesting differences across items differ significantly by gender identity. The mean and standard deviation of each item and category and the nature of the differences between them displayed in Table 3. Results indicated that intentions to seek help from friends ($F[2, 314] = 4.27, p = .015$), coworkers ($F[2, 314] = 3.29, p = .038$), a medical doctor ($F[2, 314] = 3.32, p = .037$), mental health professionals ($F[2, 314] = 4.89, p = .008$), a domestic violence network ($F[2, 314] = 3.40, p = .034$), a domestic violence hotline ($F[2, 314] = 6.68, p = .001$), a general health clinic ($F[2, 314] = 3.76, p = .024$), and no one ($F[2, 314] = 6.27, p = .002$) differed significantly by gender identity. However, intentions to seek help from parents ($F[2, 314] = 1.85, p = .158$), siblings ($F[2, 314] = 1.74, p = .177$), the police ($F[2, 314] = 2.23, p = .109$), the court system ($F[2, 314] = 0.78, p = .458$), a domestic violence shelter ($F[2, 314] = 1.54, p = .215$), a LGBTQ resource center ($F[2, 314] = 0.14, p = .872$), and a LGBTQ health clinic ($F[2, 314] = 0.65, p = .522$) did not differ significantly based on gender.

Specifically, women had significantly higher intentions to seek help from friends than men ($p = .010$), but these intentions were not significantly higher than those reported by transgender and non-binary individuals ($p = .475$). Similarly, women had significantly

higher intentions to seek help from a mental health professionals than men ($p = .013$) but not transgender and non-binary individuals ($p = .066$). Women had significantly higher intentions to seek help from a medical doctor than transgender and non-binary individuals ($p = .038$), but not men ($p = .987$). Comparably, women were also significantly more likely to seek help from a domestic violence network than transgender/non-binary individuals ($p = .030$), but not men ($p = .920$). Women were also significantly more likely to seek help from a domestic violence hotline than transgender/non-binary individuals ($p = .001$) but not men ($p = .375$). Additionally, men reported significantly higher intentions to seek help from coworkers than transgender and non-binary individuals ($p = .032$), but these intentions were not significantly higher than those of women ($p = .191$). Finally, men had significantly higher intentions to seek help from no one than women ($p = .009$) but not transgender individuals ($p = .999$), and transgender/non-binary individuals also reported significantly higher intentions to seek help from women ($p = .012$).

In addition, when we conducted a mixed-model ANOVA with gender as the between-subjects variable and each category of sources as the within subjects variable, Mauchly's Test of Sphericity indicated that the assumption of sphericity had been violated, $\chi^2(27) = 249.46, p < .001$. As such, we used a Greenhouse-Geisser correction for this analysis, too. Similarly, we found a significant main effect of category on intentions to seek help for IPV, $F(5.77, 1813.11) = 10.88, p < .001$, but there was no significant main effect of gender, $F(2, 314) = 2.67, p = .070$. However, the interaction between gender and category was significant ($F[11.55, 1813.11] = 3.26, p < .001$), suggesting differences across categories of sources also differ significantly by gender

identity. . Results indicated that intentions to seek help from co-workers ($F[2, 314] = 4.89, p = .008$), domestic violence services ($F[2, 314] = 4.24, p = .015$), friends ($F[2, 314] = 4.27, p = .015$), medical professionals ($F[2, 314] = 4.19, p = .016$), mental health professionals ($F[2, 314] = 4.89, p = .008$), and no one ($F[2, 314] = 6.27, p = .002$) significantly differed by gender identity; however, intentions to seek help from family ($F[2, 314] = 2.00, p = .137$), the justice system ($F[2, 314] = 1.54, p = .216$) and LGBTQ sources ($F[2, 314] = 0.06, p = .945$) did not differ significantly based on gender.

More specifically, women had significantly higher intentions to seek help from medical professionals than transgender and non-binary individuals ($p = .014$), but these intentions were not significantly higher than those reported by men ($p = .907$). The difference between men and transgender/non-binary individuals' intentions to seek help from medical professionals approached significance ($p = .076$). Women also reported significantly higher intentions to seek help from domestic violence services than transgender and non-binary individuals ($p = .011$), but these intentions were not significantly higher than those of men ($p = .616$). Women had significantly higher intentions to seek help from mental health professionals than men ($p = .013$) but not transgender and non-binary individuals ($p = .066$). Similarly, women were also significantly more likely to seek help from friends than men ($p = .010$) but not transgender/non-binary individuals ($p = .475$). In addition, men were significantly more likely to seek help from a co-worker than transgender individuals ($p = .032$), but not women ($p = .191$). Finally, men had significantly higher intentions to seek help from no one than women ($p = .009$) but not transgender individuals ($p = .999$), and

transgender/non-binary individuals also reported significantly higher intentions to seek help from women ($p = .012$).

IPV history. We also conducted a mixed model ANOVA with type of IPV history as the between-subjects variable and each item as the within subjects variable. Mauchly's Test of Sphericity indicated that the assumption of sphericity had been violated, $\chi^2(104) = 1482.34$, $p < .001$, and so we also used a Greenhouse-Geisser correction in this analysis. Results indicated that there was a significant main effect of item on intentions to seek help for IPV $F(8.31, 2610.10) = 69.25$, $p < .001$, as well as a significant main effect of IPV history, $F(2, 314) = 6.13$, $p = .002$. Additionally, the interaction between IPV history and source type was significant ($F[16.63, 2610.10] = 2.40$, $p = .001$), indicating that there were significant differences in the mean responses to items based on IPV history. The mean and standard deviation of each item and category and the nature of the differences between them displayed in Table 4. Results indicated that intentions to seek help from friends ($F[2, 314] = 3.70$, $p = .026$), parents ($F[2, 314] = 13.272$, $p < .001$), siblings ($F[2, 314] = 8.02$, $p < .001$), a medical doctor ($F[2, 314] = 3.36$, $p = .036$), a domestic violence network ($F[2, 314] = 3.14$, $p = .044$), a domestic violence shelter ($F[2, 314] = 4.25$, $p = .015$), and a general health clinic ($F[2, 314] = 5.38$, $p = .005$) differed significantly by IPV history. However, intentions to seek help from coworkers ($F[2, 314] = 9.12$, $p = .403$), the police ($F[2, 314] = 2.599$, $p = .076$), the court system ($F[2, 314] = 1.03$, $p = .358$), mental health professionals ($F[2, 314] = 2.80$, $p = .062$), a domestic violence hotline ($F[2, 314] = 2.17$, $p = .115$), a LGBTQ resource center ($F[2, 314] =$

1.35, $p = .261$), a LGBTQ health clinic ($F[2, 314] = 1.64, p = .195$), and no one ($F[2, 314] = 1.28, p = .279$) did not differ significantly based on IPV history.

Specifically, those with a history of psychological IPV victimization had significantly higher intentions to seek help from a friend than those who reported a history of physical/sexual IPV victimization ($p = .022$), but not those who had never experienced IPV ($p = .625$). In addition, those who had a history of psychological IPV victimization also reported significantly higher intentions to seek help from a parent than those who had a history of physical/sexual IPV victimization ($p < .001$), but their intentions did not differ significantly from those who had never experienced IPV ($p = .630$). Similarly, those who experienced psychological IPV reported significantly higher intentions to seek help from a sibling than those who had experienced physical/sexual IPV ($p = .025$), but their intentions were not significantly higher than participants who had never experienced IPV ($p = .430$). Those who experienced psychological IPV reported significantly higher intentions to seek help from a medical doctor than those who had experienced physical/sexual IPV ($p = .031$), but their intentions were not significantly higher than participants who had never experienced IPV ($p = .194$). Additionally, participants who had experienced psychological IPV reported significantly higher intentions to seek help from a domestic violence shelter than those who had experienced physical/sexual IPV ($p = .017$), but their intentions were not significantly higher than those who had never experienced any form of IPV ($p = .810$). Participants who had experienced psychological IPV also reported significantly higher intentions to seek help from a domestic violence network than those who had experienced

physical/sexual IPV ($p = .035$), but their intentions were not significantly higher than those who had never experienced any form of IPV ($p = .569$). Finally, participants who had experienced psychological IPV reported significantly higher intentions to seek help from a general health clinic than those who had experienced physical/sexual IPV ($p = .007$), but their intentions were not significantly higher than those who had never experienced any form of IPV ($p = .852$).

Similarly, when we conducted a mixed-model ANOVA with IPV history as the between-subjects variable and each category of sources as the within subjects variable, Mauchly's Test of Sphericity indicated that the assumption of sphericity had been violated, $\chi^2(27) = 251.25, p < .001$. As such, we used a Greenhouse-Geisser correction for this analysis, too. We found a significant main effect of category on intentions to seek help for IPV, $F(5.75, 1806.22) = 119.88, p < .001$, a significant main effect of IPV history, $F(2, 314) = 6.12, p = .002$, and a significant interaction between IPV history and category ($F[11.51, 1806.22] = 2.33, p = .007$). These results suggest differences across categories of sources differ significantly by IPV history. . Results indicated that intentions to seek help from family ($F[2, 314] = 13.69, p < .001$), friends ($F[2, 314] = 3.70, p = .025$), medical professionals ($F[2, 314] = 4.71, p = .010$) and domestic violence services ($F[2, 314] = 3.71, p = .025$) differed significantly by IPV history, but intentions to seek help from co-workers ($F[2, 314] = 0.91, p = .403$), LGBTQ sources ($F[2, 314] = 1.65, p = .192$), the justice system ($F[2, 314] = 1.80, p = .168$), and mental health professionals ($F[2, 314] = 2.79, p = .062$) did not differ significantly by IPV history.

More specifically, those with a history of psychological IPV victimization had significantly higher intentions to seek help from medical professionals than those who reported a history of physical/sexual IPV victimization ($p = .007$), but not those who had never experienced IPV ($p = .421$). In addition, those who had a history of psychological IPV victimization reported significantly higher intentions to seek help from domestic violence services than those who had a history of physical/sexual IPV victimization ($p = .021$), but their intentions did not differ significantly from those who had never experienced IPV ($p = .629$). Similarly, those who experienced psychological IPV reported significantly higher intentions to seek help from a friend than those who had experienced physical/sexual IPV ($p = .022$), but their intentions were not significantly higher than participants who had never experienced IPV ($p = .625$). Finally, participants who had experienced psychological IPV reported significantly higher intentions to seek help from family members than those who had experienced physical/sexual IPV ($p = .001$), but not those who had never experienced any form of IPV ($p = .432$).

Discussion

This study explored LGBTQ individuals' intentions to seek help for IPV if they experience IPV in the future. Nearly 85% of the sample reported that they were likely or extremely likely to seek help from at least one source of support if they experience IPV in the future. However, intentions greatly differed according to help source and the strength of participants' intention to seek help overall was driven by intentions to seek help from only a few sources: friends, mental health professionals, and LGBTQ resource centers. Participants reported low intentions to seek help from many other sources of support,

including domestic violence shelters, medical professionals, the justice system, their families, and their co-workers. In addition, there was wide variance in participants' opinions about each potential source of support ($SD \sim 2$ for most items). This variance suggests great individual difference in how LGBTQ people feel about each particular source, which is consistent with prior research that has documented large differences in how people feel about seeking help from different types of sources (Wilson, Deane, & Ciarrochi, 2005).

Intentions to Seek Help from Friends, Counselors, and LGBTQ Centers

Participants said they would be most likely to turn to friends if they experienced IPV, and women had significantly higher intentions to seek help from friends than men. The fact that participants would intend to go to friends for help is consistent with literature that indicates people who are struggling with problems, such as IPV and depression, would rather go to informal sources than formal sources when they need help (e.g., Baldero & Fallon, 1995; Goodman et al., 2003). This finding is also consistent with research that suggests LGBTQ IPV survivors often disclose IPV to friends (Donovan & Hester, 2008; McClennen, Summers, & Vaughan, 2002; Sylaska & Edwards, 2014). Thus, the behavioral intentions of this sample are similar to how IPV survivors have acted in the aftermath of IPV.

The fact that women had higher intentions to turn to friends than men may be a product of gender roles, given that traditional masculine gender roles indicate that men should be more stoic, dominant, and able to handle problems on their own (Mahalik, Cournoyer, DeFranc, Cherry, Napolitano, 1998). Men may fear that they will be

stigmatized for victimization, given the stereotype that men cannot be IPV victims because they are usually physically large and/or strong (Allen-Collinson, 2009). Also, men and transgender participants had significantly higher intentions to not seek help from anyone than women, which is consistent with research on help-seeking behavior that indicates that men seek help less often than women for a variety of health-related problems (Moller-Leimkuhler, 2002). This finding adds to our knowledge about how the behavioral intentions of transgender individuals compare to those of men and women, by suggesting they may be more likely than women to seek help for IPV. Similarly, participants who had experienced psychological abuse in the past had significantly higher intentions to turn to friends than those who had experienced physical/sexual IPV. Some survivors may feel less comfortable disclosing physical and sexual IPV to friends, because these types of IPV are less common (CDC, 2013) and, as a result, they may be more stigmatized than psychological IPV.

Participants also reported fairly high intentions to seek help from mental health professionals and LGBTQ sources if they experience IPV in the future.. Survivors may feel most comfortable seeking help from mental health professionals and LGBTQ sources of support if they experience IPV because these types of formal sources have special training in how to provide sensitive care. In addition, in counseling, the fact that sessions are confidential may help LGBTQ people to feel comfortable talking about their identity and IPV without the risk of exposure. Women in our sample were significantly more likely to seek help from mental health professionals than men, which is consistent with research that indicates LGBTQ individuals, particularly lesbian women, often seek help

from counselors after IPV (Renzetti, 1988; Ristock, 2002). Women may feel more comfortable seeking support from counselors because they are socialized to express emotions and seek support for difficulties (Mahalik et al., 2005).

Similarly, LGBTQ sources may be easier to approach than other sources, because survivors are unlikely to be the only LGBTQ-identified person in these contexts. In addition, LGBTQ-specific sources have specialized knowledge of and experience with LGBTQ needs and resources, which has been cited as particularly helpful to LGB survivors who have sought support for IPV (Oswald, Fonseca, & Hardesty, 2010; St. Pierre & Senn, 2010). Participants' intentions to seek help from a LGBTQ resource centers were higher than their intentions to seek help from a LGBTQ health clinic. Resource centers may seem like more helpful options because they are likely to provide information about a plethora of resources for LGBTQ people (such as domestic violence services, legal financial services, child-care services, and LGBTQ-specific services), many of which may be helpful for survivors who are preparing to leave a partner.

Low Intentions to Seek Help from Justice Systems and Shelters

Research with heterosexual and cisgender survivors suggests they often turn to the justice system for formal support (Goodman, Dutton, Weinfurt, & Cook, 2003); however, participants in our sample reported low intentions to seek help from police officers and the courts if they experienced IPV in the future. It is possible that LGBTQ individuals feel less safe approaching these sources for help than other sources given that the justice system has historically been dismissive of and discriminatory toward LGBTQ people (Grant et al., 2011; Walters, 2011). Similarly, it is possible that participants

reported having low intentions to seek help from medical professionals and domestic violence shelters because LGBTQ individuals have historically been discriminated against by medical providers and been denied access to beds in domestic violence shelters (NCAVP, 2012). Participants who reported a history of psychological IPV were significantly more likely to intend to seek help from a shelter than those who had experienced physical or sexual IPV in the past. Although it is not clear why this difference emerged, one possibility is that participants who have experienced physical and sexual IPV have prior experience seeking help from these formal sources of support that is impacting their intentions. For example, those that have encountered discrimination in the context of seeking help may be unlikely to use the same resources again.

Although intentions to seek help from these sources were fairly low, they were higher than participants' intentions to seek help from many of the informal sources of support, including family members and co-workers. The fact that participants reported the low intentions to seek help from the family is contrary to Sylaska and Edward's (2014) finding that LGBTQ survivors often disclosed abuse to female family members. However, we did not collect information about the gender of potential help sources, so it is possible that participants would have reported higher intentions to seek help from female friends and family, but that these differences were not captured by our questions. However, there were no gender differences in intentions to seek help from family in this sample, suggesting that the gender of the survivor may not have a large impact on whether people intend to seek help from parents and siblings. In addition, we found that

participants who had never experienced IPV had significantly higher intentions to seek help from family than those who had experienced psychological and physical/sexual IPV. It is possible that those who have never experienced IPV have a more limited understanding of how difficult it may be to disclose such a stigmatized event to family members, resulting in a more optimistic view about the likelihood that they would disclose the IPV to their parents and siblings. Those who experienced psychological IPV were more likely to report it to family than those that experienced physical and/or sexual IPV, suggesting that participants who have experienced serious IPV may be more ashamed of it or worried about the effects of disclosing it to close family.

Implications for Practice

Given that friends may be the first to learn about IPV and to provide critical support, it is important for the public to be well-informed about the resources that are available for IPV survivors within their communities. Research with IPV survivors suggests if friends are able to be empathetic, warm, and non-judgmental when listening to disclosures of IPV, their support is often very helpful for survivors (Sylaska & Edwards, 2014). Survivors' friends should also be sensitive to their LGBTQ-specific needs, such as the fact that some survivors may feel more comfortable seeking help from certain supports over others. For example, it may be adaptive for some LGBTQ survivors to avoid seeking help from sources that have historically discriminated against them or the LGBTQ community. As such, informal supports should ask survivors about their level of comfort seeking help from different formal sources of support and assist them in weighing the benefits and drawbacks of seeking help from various sources.

It is also vital that mental health professionals and LGBTQ resource centers are prepared to meet LGBTQ IPV survivors' needs, given that participants in our sample reported the highest intentions to seek help from these sources of all formal sources. Prior research indicates that LGBTQ individuals may not seek help from counselors who do not seem to be LGBTQ affirming (Ristock, 2002). To provide sensitive care, mental health providers should have an understanding of how power and control issues that are specific to LGBTQ identity can function within abusive relationships, and they should work with clients to identify these harmful dynamics. For example, one partner may threaten to out the other partner (i.e., disclose his/her/their LGBTQ identity) if the partner tries to end the relationship. Counselors can reference the LGBTQ Power and Control Wheel (Pence & Paymar, 1993) in working with clients to identify these dynamics, and training is available to professionals that are unprepared identify LGBTQ IPV or to work with LGBTQ IPV survivors (e.g., FORGE offers monthly training webinars; FORGE, 2016).

Implications for Future Research

Future investigations should also examine the connection between specific barriers to help seeking and intentions to seek help from different types of sources. It is possible that some of the wide variance in the strength of participants' intentions and the types of help sources that participants would seek help from is attributable to barriers, such as levels of outness and past experiences with discrimination. In related studies of help seeking for stigmatized problems, researchers have found significant negative correlations between barriers to help seeking and intentions to seek help for problems,

such as suicidal thoughts (Wilson, Dean, & Ciarochi, 2005). Given that LGBTQ identities and IPV are stigmatized, stigma may greatly influence survivors' intentions to seek help for IPV. Researchers should investigate stigma as a barrier to seeking help from medical professionals, domestic violence shelters, and the justice system, in particular, because many LGBTQ individuals in our sample reported fairly low intentions to seek help from these formal sources and it is unclear why these intentions are low. If researchers and professionals within these formal support systems know why LGBTQ individuals do not intend to seek help from them, they may be able to adapt services to best meet LGBTQ peoples' needs.

Given that participants' intentions to seek help from similar types of sources were highly correlated, future researchers that use this measure can take the average of scores on similar items to assess intentions to seek help from different categories of sources. We suggest using the following categories: medical professionals, LGBTQ sources, justice system, family, and domestic violence services, and then using the other items separately (co-worker, friend, mental health professional and no-one). In addition, it would be useful to survey participants over time to determine if those with high intentions at an initial time-point seek help if they experience IPV at a later time point. Future studies should explore the utility of this measure by comparing behavioral intentions to subsequent help-seeking behavior.

Limitations

Several key limitations frame our findings. First, not all participants had a history of or were currently experiencing IPV. As a result, some participants may not have a

sense of what it is like to cope with IPV. However, many participants (75%) had experienced IPV at some point in their lives, and over half (57%) had experienced IPV in the past year. Furthermore, of those who reported experiencing IPV in their lifetimes, nearly 70% reported that they had experienced severe forms of IPV: sexual or physical violence. It is possible that these participants reflected on their prior experiences with IPV when responding to items. However, we did not measure how participants coped with IPV in the past and, therefore, do not have a way of comparing their intentions to any previous help-seeking behavior. Future research should explore whether prior help seeking from one source predicts intentions to seek help from another type of source.

Another key limitation is that we did not ask participants any additional information about their intentions to seek help. For example, we did not ask them to tell us why they reported high or low intentions to seek help from certain sources. Our results indicated that there was a lot of variability in intentions to seek help, which may be predicted by a variety of factors, including known barriers to seeking help for IPV. Future research should explore the reasons survivors seek help from certain sources, which would provide insight into help-seeking decisions.

Conclusion

This study examined LGBTQ individuals' intentions to seek help for IPV if they experienced IPV in the future. Results suggest that if LGBTQ individuals experience IPV they intend to seek help from at least one source of support and they are most likely to seek help from a friend. When considering seeking help from formal sources of support, LGBTQ individuals intend to seek help from mental health professionals and LGBTQ

resource centers, but have low intentions to seek help from family, general health clinics and co-workers. Future work should examine the relation between barriers to help seeking for LGBTQ individuals and behavioral intentions to seek help for IPV, in order to understand the factors that influence these intentions.

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Table 1

Intention to Seek Help from Each Source and Category of Support

Source	Mean	Median	Mode	SD
Item				
A friend	5.57	6	7	1.79
A mental health professional	4.51	5	7	2.01
A LGBTQ resource center	4.22	5	6	2.05
A domestic violence network	4.15	4	5	2.09
A domestic violence phone hotline	4.06	4	5	2.14
A LGBTQ health clinic	4.01	4	1	2.10
A medical doctor	3.90	4	5	2.06
The police	3.71	4	1	2.12
The court system	3.63	4	1	2.11
A domestic violence shelter	3.49	3	1	2.11
A sibling	3.29	2	1	2.16
A general health clinic	3.28	3	1	1.98
A parent or former legal guardian	3.06	2	1	2.16
No one	2.46	1	1	1.97
A coworker	2.37	2	1	1.75
Category				
LGBTQ Sources	4.11	4.5	1	1.96
Domestic Violence Services	3.90	4	1	1.93
Justice System	3.67	3.5	1	2.03
Medical Professionals	3.59	3.5	1	1.85
Family	3.17	3	1	1.90

Note. Response options ranged from 1 (*extremely unlikely*) to 7 (*extremely likely*). Response option ‘No one’ was followed by (i.e., I would not seek support from anyone) for clarification.

Table 2

Correlations Between Items

Items	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1.														
2.	.26**													
3.	.30**	.55**												
4.	.17**	.33**	.33**											
5.	.15**	.24**	.26**	.24**										
6.	.12**	.25**	.22**	.27**	.84**									
7.	.23**	.27**	.28**	.24**	.56**	.59**								
8.	.31**	.27**	.26**	.15**	.37**	.35**	.57**							
9.	.29**	.26**	.27**	.22**	.38**	.43**	.54**	.61**						
10.	.24**	.24**	.24**	.19**	.30**	.34**	.47**	.56**	.87**					
11.	.17**	.32**	.29**	.32**	.34**	.40**	.42**	.40**	.66**	.71**				
12.	.27**	.21**	.27**	.21**	.30**	.34**	.44**	.44**	.64**	.64**	.64**			
13.	.25**	.38**	.33**	.31**	.45**	.49**	.69**	.54**	.56**	.51**	.61**	.54**		
14.	.28**	.30**	.32**	.25**	.29**	.34**	.56**	.52**	.57**	.56**	.57**	.79**	.67**	
15.	-.44**	-.13*	-.23**	-.02	-.26**	-.22**	-.26**	-.32**	-.29**	-.25**	-.09	-.22**	-.18**	-.20**

Note. The following abbreviations were used: DV = domestic violence.* = $p < .05$, ** $p < .01$.

Table 3

Differences in Responses to the LGBTQ-ISH Based on Gender Identity

	Gender Identity			<i>Difference^b</i>
	Men	Women	Trans/Non-binary ^a	
<i>N</i>	89	150	78	
	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	
Item				
1. Friend	5.15 (1.9)	5.84 (1.64)	5.55 (1.88)	W > M
2. Sibling	3.58 (2.15)	3.29 (2.23)	2.95 (2.02)	
3. Parent	3.43 (2.18)	2.89 (2.16)	2.95 (2.1)	
4. Coworker	2.73 (1.83)	2.33 (1.74)	2.05 (1.6)	M > T
5. Police	3.76 (1.99)	3.9 (2.23)	3.28 (2.02)	
6. Court System	3.65 (1.93)	3.75 (2.22)	3.38 (2.11)	
7. Medical Doc.	4.04 (2)	4.09 (2.15)	3.38 (1.89)	W > T
8. Mental Health	4.12 (2)	4.88 (2.01)	4.26 (1.95)	W > M, T
9. DV Network	4.26 (2.04)	4.37 (2.12)	3.63 (2.03)	W > T
10. DV Hotline	4.06(2.17)	4.43 (2.11)	3.36 (2.01)	W > T
11. DV Shelter	3.45 (2.08)	3.68 (2.15)	3.17 (2.06)	
12. LGBTQ Cen.	4.12 (2.14)	4.27 (2.03)	4.23 (2.01)	
13. Health Clin.	3.35 (2)	3.51 (2.05)	2.77 (1.72)	W > T
14. LGBTQ Clin.	4.21 (2.16)	3.89 (2.11)	4.00 (2.02)	
15. No One	2.82 (1.96)	2.05 (1.82)	2.83 (2.14)	M, T > W
Category				
1. Family	3.50 (1.96)	3.09 (1.87)	2.95 (1.87)	
2. Justice Sys	3.71 (1.86)	3.83 (2.14)	3.33 (1.99)	
3. Medical Prof.	3.70 (1.78)	3.80 (1.97)	3.08 (1.97)	W > T
4. DV Services	3.92 (1.88)	4.16 (1.94)	3.38 (1.89)	W > M
5. LGBTQ	4.17 (2.02)	4.08 (1.96)	4.12 (1.96)	

Note. The following abbreviations were used: Cen. = Center, Clin. = Clinic, Doc = doctor, DV = domestic violence, Prof. = Professionals. ^a = Trans/non-binary category includes those who identified as transmen, transwomen, non-binary, and other. ^b = Difference column describes which groups means significantly differ on the item. In this column, M = men, W = women, and T =transgender/non-binary.

Table 4

Differences in Responses to the LGBTQ-ISH Based on IPV History

	Type of IPV Experienced			<i>Differences</i>
	Physical/ Sexual	Psych- ological	None	
<i>N</i>	136	98	83	
	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	
<i>Item</i>				
1. Friend	5.28 (1.81)	5.91 (1.57)	5.66 (1.96)	P > PS
2. Sibling	2.76 (1.85)	3.50 (2.30)	3.89 (2.29)	N > PS; P > PS N > PS,P;P >
3. Parent	2.38 (1.72)	3.44 (2.39)	3.72 (2.21)	PS
4. Coworker	2.35 (1.64)	2.55 (2.05)	2.20 (1.51)	
5. Police	3.46 (2.00)	4.09 (2.16)	3.67 (2.23)	
6. Court System	3.54 (2.09)	3.89 (2.20)	3.49 (2.05)	
7. Medical Doctor	3.65 (1.91)	4.34 (2.18)	3.81 (2.10)	P > PS
8. Mental Health	4.38 (1.87)	4.91 (2.01)	4.28 (2.20)	
9. DV Network	3.85 (1.93)	4.53 (2.19)	4.22 (2.16)	P > PS
10. DV Hotline	3.80 (2.04)	4.39 (2.22)	4.11 (2.19)	
11. DV Shelter	3.10 (1.99)	3.87 (2.17)	3.67 (2.16)	P > PS
12. LGBTQ Cen.	4.00 (1.99)	4.40 (2.17)	4.26 (2.00)	
13. Health Clin.	2.88 (1.78)	3.60 (2.09)	3.51 (2.05)	P > PS
14. LGBTQ Clin.	3.77 (2.02)	4.26 (2.14)	4.11 (2.16)	
15. No One	2.62 (1.86)	2.20 (1.97)	2.51 (2.17)	
<i>Category</i>				
1. Family	2.57 (1.54)	4.33 (2.09)	3.81 (1.93)	
2. Justice System	3.49 (1.95)	3.99 (2.08)	3.58 (2.09)	
3. Medical Prof.	3.26 (1.63)	4.00 (1.97)	3.66 (1.98)	P > PS
4. DV Services	3.58 (1.75)	4.26 (1.99)	4.00 (2.07)	P > PS
5. LGBTQ	3.89 (1.84)	4.33 (2.09)	4.23 (1.99)	

Note. Cen. = Center, Clin. = Clinic, DV = domestic violence, Prof. = Professionals. ^a =

Differences column describes which groups means' significantly differ on the item. In this column, PS =physical/sexual/both physical and sexual abuse, P = only psychological abuse, and N = no abuse.

APPENDIX

Intentions to Seek Help for LGBTQ IPV Scale

Instructions:

If you are the recipient of intimate partner violence in the future, how likely would you be to seek support from the following individuals/institutions?

Rate your response on a scale from 1 (extremely unlikely) to 7 (extremely likely).

Items:

- 1) A friend
- 2) A parent or former legal guardian
- 3) A sibling or other non-parental family member
- 4) A co-worker
- 5) The police
- 6) The court system (e.g., file for a civil protection order)
- 7) A medical doctor
- 8) A mental health professional
- 9) A domestic violence network
- 10) A domestic violence phone hotline
- 11) A domestic violence shelter
- 12) A LGBTQ resource center
- 13) A general health clinic
- 14) A LGBTQ health clinic
- 15) No one (i.e., I would not seek support from anyone)

STUDY TWO

Intimate partner violence (IPV) affects millions of individuals in the United States annually (Breiding et al., 2014). However, research on the prevalence and effects of IPV has historically utilized samples of IPV survivors and perpetrators that identify (or are assumed by researchers to identify) as cisgender⁴ and/or heterosexual, excluding the experiences of those who identify as lesbian, gay, bisexual, transgender⁵, or queer⁶ (LGBTQ) (Edwards, Sylaska, & Neal, 2015). This lacuna in the research on IPV is alarming, given research that suggests LGBTQ individuals, particularly those who identify as transgender or queer, are at greater risk for experiencing IPV (CDC, 2013; NCAVP, 2011) and face additional barriers to help seeking for IPV (Calton, Cattaneo, & Gebhard, & 2015; Edwards et al., 2015).

This study aims to address this gap in the literature by examining the relation between minority stress and intentions to seek help for IPV in this vulnerable subpopulation. We begin by detailing the prevalence of LGBTQ IPV and the importance of studying intentions to seek help in this context. We then describe minority stress processes as key predictors of intentions to seek help for LGBTQ IPV and discuss the

⁴ 'Cisgender' refers to individuals whose gender identity and assigned-at-birth gender are consistent.

⁵ The term 'transgender' describes anyone whose gender identity is different from the gender they/she/he were assigned at birth. "Trans*" is used to describe persons who identify across the gender spectrum, including those who identify as transgender, transsexual, genderqueer, and two-spirit (e.g., Johnson, 2013).

⁶ 'Queer' refers to a rejection of fixed identity categories (Halberstam, 2011), and can be used to refer to sexual orientation or gender identity.

ways in which connection to the LGBTQ community and social support might attenuate those relationships.

LGBTQ IPV Prevalence

In the past 15 years research on LGBTQ IPV has increased, including several major reviews and large-scale studies that describe the extent of the problem (e.g., Edwards, Sylaska, & Neal, 2015). For example, one study that utilized a nationally representative dataset found 44% of lesbian women and 61% of bisexual women reported having experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime. In the same study, 26% of gay men and 37% of bisexual men reported having these experiences (Centers for Disease Control, 2013). In addition, large studies have shown significantly greater risk of IPV among trans* and queer people (e.g., NCAVP, 2011). For example, Langenderfer-Magruder, Whitfield, Walls, Kattari, and Ramos (2014) found 51.7% of trans* respondents reported a lifetime history of IPV, as compared to 34.2% of cisgender respondents. Results of these studies indicate that although IPV prevalence estimates vary depending on identity, LGBTQ people experience rates of IPV that are equal to or higher than those of cisgender, heterosexual participants (e.g., Edwards, Sylaska, & Neal, 2015; Murray & Mobley, 2009; Ristock, 2005; Turell, 2000).

Given these rates of IPV, it is particularly important that LGBTQ survivors have the option of seeking help for IPV if they need it. However, many LGBTQ survivors do not seek formal help for IPV despite experiencing severe abuse (McClennan, 2005). To

address this issue, researchers need to examine key factors that decrease the likelihood that LGBTQ survivors will seek help for IPV.

Barriers to Help Seeking for LGBTQ IPV

Prior research about help seeking for IPV suggests populations that vary from the general narrative about domestic violence victims (i.e., victims are middle class, White, heterosexual, women; Sokolof et al., 2005) have reported difficulties seeking help because of factors directly related to their identity (e.g., Cook, 2009; Latta & Goodman, 2005; McCart et al., 2010). The few studies on LGBTQ survivors suggest they believe mainstream domestic violence services are not for them and fear being marginalized or misunderstood by a help source (Alhusen, Lucea, & Glass, 2010; Cruz & Firestone, 1998; Renzetti, 1996). This body of research suggests IPV survivors' intentions to seek help for IPV are affected by variables related to their social identity, which are imperative to examine in order to understand barriers to seeking support. The minority stress literature provides evidence for the importance of several specific variables.

Minority Stress Model

Minority stress is defined as psychological stress that develops in minority individuals as a result of living in a social environment in which the dominant culture stigmatizes and discriminates against minority groups (Brooks, 1981; Meyer, 1995; Meyer, 2003). Meyer's (2003) Minority Stress Model proposes several factors relevant to struggles of minority individuals, including experiencing discrimination, concealing one's minority identity, and internalizing stigma. These factors have been associated with depression, anxiety, anger, shame, and symptoms of post-traumatic stress disorder in

studies with samples of LGB participants (Bird, Khuns, & Garafalo, 2012; Herek et al., 1999; Lewis et al., 2002; Meyer, 1995; Szymanski, 1995). Although far less research has been conducted on minority stress processes in transgender and gender queer individuals, Gamarel and colleagues (2014) found transgender-related discrimination was associated with increased risk of depression among transgender women. Only one study has examined whether minority stress impacts decisions related to seeking help. McGregor and colleagues (2001) found that internalized homophobia predicted less frequent medical visits and less participation in health-related examinations during visits in lesbian women diagnosed with breast cancer (McGregor et al., 2001), which suggests minority stress may impact decisions related to help seeking for IPV.

Experiences with LGBTQ rejection and discrimination are common among the LGBTQ population (see meta-analysis by Katz-Wise & Hyde, 2012; review by Stotzer, 2009). Prejudiced events that occurred in the past have the power to influence a person's expectations of future discrimination. The few studies on LGBTQ help seeking for IPV suggest such fears are warranted (Renzetti, 1996; Walters, 2011). For example, one transgender woman reported that domestic violence shelter staff asked her a set of grueling questions about her body including, 'What is between your legs?' After this humiliating treatment, they denied her shelter because they decided that she was really a man (GLBT Domestic Violence Coalition and Jane Doe, Inc., 2005). Other survivors have reported that the violence they experienced was simply dismissed and/or minimized by potential help sources, such as the police and health care providers (e.g., Alhusen, Lucea, & Glass, 2010; Walters, 2011). When LGBTQ IPV survivors consider seeking

help, these experiences with discrimination may decrease their proclivity for pursuing support.

Internalized Homophobia/Transphobia and Concealment of Identity.

Internalized homophobia/transphobia is a form of self-hatred that occurs when LGBTQ individuals direct negative social attitudes homosexuality and non-traditional forms of gender identity toward themselves (Hendricks & Testa, 2012; Kashubeck-West, Szymanski, & Meyer, 2008; Locke, 1998; Meyer & Dean, 2008; Meyer, 1995; Sophie, 1987)⁷. When minority individuals internalize homophobia and transphobia, they may perceive themselves as inferior to members of dominant culture, which can impact behavior (Meyers, 2003). The self-devaluation that can occur with internalized homophobia or transphobia may lead to IPV victims questioning whether they deserve help (Garnets et al., 1999), thus reducing their likelihood of seeking help.

Whether a LGBTQ individual is open about their identity may also explain part of the relation between experiences with discrimination and intentions to seek help for IPV. Of all minority groups, LGBTQ people are perhaps most likely to experience concerns related to disclosure and concealment during the help seeking process. LGBTQ identities are brought to the forefront of the interpersonal interaction during help seeking for IPV, because survivors are asked to discuss their romantic relations. Discussing the unhealthy aspects of a relationship is difficult for anyone, but it is even more challenging for survivors if their relationships are already stigmatized. Furthermore, because minority sexual orientation and gender identity are often concealable (Quinn & Earnshaw, 2013), a

⁷ We use the term 'homo/transphobia' to refer to both homophobia and transphobia.

survivor may not have discussed their LGBTQ identity with anyone prior to seeking help. The sudden requirement to come out in the process of seeking help is likely to produce additional minority stress. As such, the anticipation of having to focus on an aspect of identity that is otherwise concealable may elicit additional hesitance to seek help for LGBTQ survivors.

This distress may be compounded by the fact that LGBTQ survivors may risk outing themselves to others beyond the help provider, such as their friends, family, or the public, as part of the help seeking process (Ristock, 2002, 2005). LGBTQ survivors may fear their loved ones will abandon them, they will lose their jobs, or they will experience discrimination as a result of being open about their identity (Renzetti, 1997; Russo, 1999). Trans* individuals may have these concerns both pre and post change in their gender role (Zimman, 2009). Given these concerns, the risk of outing oneself may not be worth the potential benefits of receiving support for IPV and may lower LGBTQ individuals' intentions to seek support.

The Current Study

Building on the literature just described, the current study explores the relation between three minority stress processes (experiences with LGBTQ discrimination, internalized homophobia and transphobia, and outness) and LGBTQ individuals' intentions to seek help for IPV. Specifically, we tested the following hypotheses:

- 1) Greater experiences with discrimination, higher levels of internalized heterosexism, and lower levels of outness will be associated with lower intentions to seek help for IPV.

2) Internalized heterosexism will partially mediate the relationship between heterosexist discrimination and LGBTQ survivors' intentions to seek help for IPV.

3) Outness will partially mediate the relationship between heterosexist discrimination and LGBTQ survivors' intentions to seek help for IPV.

In addition to examining these hypotheses, we explored whether there were any differences in the proposed outcomes based on sexual orientation, gender identity, or history of IPV victimization.

We aimed to study intentions to seek help for IPV within a diverse sample of LGBTQ individuals. It is important to use a general sample of the LGBTQ community, as opposed to sampling only those who are engaging in help-seeking behavior, so that we can capture the opinions of those who have experienced IPV in the past and never sought help for abuse. These individuals may be experiencing some of the greatest barriers to help seeking, and their opinions are critical to this line of research.

In addition, because not everyone in a community sample of LGBTQ individuals has experienced IPV, we used a measure of LGBTQ individuals' intentions to seek help if they experience IPV in the future. Behavioral intentions are more closely related to behavior than many other constructs, such as attitudes toward help seeking (Armitage & Connor, 2001), particularly when the measure of intentions is specific and the context is closely aligned with that of the context in which a person would carry out the actual behavior (Ajzen, 1991; Ajzen, 2002). Thus, we used a measure of LGBTQ individuals' behavioral intentions to seek help for IPV if they were abused in the future.

Method

Participants

Participants ($n = 317$) were eligible to participate if they identified with a minority gender identity or sexual orientation. Their ages ranged from 18-66 ($M = 31.00$, $SD = 11.16$). Of these participants, 28.1% identified as men, 47.3% identified as women, and 24.6% identified as transgender or non-binary. Thirty-eight percent of the sample identified as gay/lesbian, while 27% identified as bisexual, 25% identified as queer, 6% identified as other, and 4% identified as heterosexual and transgender. Additionally, 38% of the sample identified as White, 22% identified as Black, 19% identified as Asian, 12% identified as multi-racial, and 9% identified as Latino. Finally, most participants were well educated, as 36% completed some college or technical school, 33% attained a 4-year college degree, and 23% completed a masters or doctorate program.

Procedure

This study is part of a larger investigation of sexual minorities' health and health-related behaviors. The Virginia Commonwealth University Institutional Review Board reviewed and approved the following procedures. A description of the study and the contact information for the study coordinator was posted on several social networking websites, including Facebook and Craigslist, and at several community sites, including LGBTQ resource centers, health centers, and grocery stores. Interested participants emailed the study coordinator who screened participants across the following eligibility criteria: participants needed to identify as lesbian, gay, bisexual, transgender, or queer and they needed to be 18 years of age or older to participate. Eligible individuals were

emailed a link to the survey and a unique access code. Participants read the informed consent and completed a series of online questionnaires. Given the sensitive nature of some of the health-related measures, at the end of the survey participants were given the phone numbers of a 24-hour National Treatment Referral Hotline and a Drug Counseling Hotline. Finally, after completing the survey, participants entered their email address and they were paid \$15 via electronic Amazon gift card for completing the measures.

An automatic deletion process was used to safeguard against the high likelihood of obtaining false responses when conducting online research involving participant incentives. Responses were automatically deleted from the survey if they met the following criteria: a) there was any indication of false responding, such as completion time of less than 20 minutes or more than 24 hours, b) for implausible response patterns, such as selecting the first response for every single item on a scale, or c) if participants did not accurately respond to at least 4 of 6 randomly inserted accuracy checks (e.g., “Please select *strongly disagree* for this item”).

Measures

Demographics. Participants reported their age, race/ethnicity, socioeconomic status, level of education, gender identity, and sexual orientation.

Intimate Partner Violence. In order to assess whether participants had been perpetrators or victims of IPV in their lifetimes, participants completed the Revised Conflict Tactics Scales (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). Participants responded to this measure on a Likert Scale from 1 (*once in the past year*) to 6 (*over 20 times in the past year*), with additional response options of 7 (*not in the past*

year, but it did happen before) and 8 (*this has never happened*). Items were scored by using responses to the CTS-2 to create dichotomous variables that reflected whether participants had experienced any physical and/or sexual abuse or any psychological abuse from an intimate partner in their lifetimes, as well as two dichotomous variables that reflected whether they had experienced any IPV overall in their lives and in the past year. The scale demonstrated adequate internal consistency ($\alpha = .87$) in this sample.

Experiences with Harassment, Rejection, and Discrimination. Participants completed the Heterosexist Harassment, Rejection, and Discrimination Scale (HHRD; Szymanski, 2006), a 14-item measure that assesses the extent to which individuals have experienced harassment, rejection, or discrimination as a result of their sexual orientation in the past year. The scale measures harassment, rejection, and discrimination across multiple contexts, including at school/work, at home, with friends, and with strangers. The measure was adapted slightly to include negative attitudes toward transgender and genderqueer identity, as well. For example, the item “How many times have you been verbally insulted because you are an LGB individual?” became “How many times have you been verbally insulted because you are an LGBTQ individual?” Participants responded on a Likert Scale from 1 (*the event has NEVER happened to you*) to 6 (*the event happened ALMOST ALL OF THE TIME [more than 70% of the time]*). Higher scores indicate greater histories of harassment, rejection, or discrimination based on LGBTQ identity. The scale demonstrated strong internal consistency ($\alpha = .91$) in this sample.

Internalized Homophobia and Transphobia. Participants completed the Internalized Homonegativity Scale (IHS; Currie, Cunningham, & Findlay, 2004), a 13-item measure that assesses the degree to which an individual has internalized the homonegativity that is reflected in contemporary attitudes toward homosexuality. The measure was adapted slightly to include negative attitudes toward transgender and genderqueer identity, as well. For example, the item “Social situations with LGB individuals make me feel uncomfortable” was adapted to be “Social situations with LGBTQ individuals make me feel uncomfortable” Participants responded on a Likert Scale from 1 (*strongly disagree*) to 6 (*strongly agree*). Higher scores indicate higher levels of internalized homophobia and transphobia. One item (*It is important to control who knows about my sexual orientation/gender identity*) was removed from the scale, because a) it was negatively correlated with the other items, and b) a high score on this item may be more reflective of an individual’s need to protect themselves from actual discrimination, as opposed to internalized homo/transphobia. After removing this item, the scale demonstrated adequate internal consistency ($\alpha = .78$) in this sample.

Outness. Participants completed the Outness Inventory, an 11-item measure that assesses the degree to which an individual with a minority sexual orientation has disclosed his/her sexual orientation to others in his/her life, including friends, family members, coworkers, and strangers (Mohr & Fassinger, 2000). The scale was adapted slightly to include transgender and queer identities. Participants responded on a scale from 1 (*person definitely does NOT know about my LGBTQ-identity status*) to 7 (*person definitely knows about my LGBTQ-identity status, and it is OPENLY talked about*) for

each type of person in his/her life. The scale can be broken down into three subscales: Out to World (which includes being out to new straight friends, peers, supervisors, strangers, and old straight friends), Out to Family (which includes being out to parents, siblings, and relatives), and Out to Religion (which includes being out with both members and leaders of a religious community). Higher scores indicate greater levels of outness across these contexts. The scale demonstrated strong internal consistency ($\alpha = .82$) in the sample.

Intention to Seek Help for IPV. Calton, Cattaneo, and Perrin (2016) recently adapted the GHSQ to measure of LGBTQ individuals' intentions to seek help for LGBTQ IPV, using the same sample as the current study. The measure is based on The General Help Seeking Questionnaire (GHSQ; Wilson, Deane, & Ciarrocchi, 2005), which was originally developed to measure intentions to seek help for mental health issues but was designed to be easily tailored to various problem-types and help sources in future research. Per recommendations by Wilson, Deane, and Ciarrocchi (2005), the authors adapted the measure to be specific to help seeking for LGBTQ IPV and include a variety of potential help sources. Calton, Cattaneo, and Perrin (2016) used the stem "If you were the recipient (victim) of intimate partner violence in the future, how likely is it that you will seek help from the following people?" Participants responded on a scale from 1 (*extremely unlikely*) to 7 (*extremely likely*) for each of the following list of 15 potential help sources: friends, parent or formal legal guardian, sibling or other non-parental family member, coworker, the police, the court system, a medical doctor, a mental health professional, a domestic violence network, a domestic violence hotline, a domestic

violence shelter professionals, domestic violence resource center, a general health clinic, a LGBTQ resource centers, a LGBTQ health clinic, or no one. Responses to the item that assessed whether they would not seek help from anyone were reverse scored. Higher scores on each individual item reflect greater intent to seek support from each help source.

Consistent with other scales that measure coping strategies for IPV (e.g., IPVSI; Goodman, Dutton, Weinfurt, & Cook, 2003), the endorsement of one variable on the LGBTQ-ISH measure does not necessitate endorsement of another variable on the scale. Given that a survivor may only intend to seek help from one type of source (e.g., a friend) out of a variety of sources that differ greatly, endorsement of one item on this help seeking scale may not be highly correlated with other items on the scale. Thus, instead of creating one sum score for the measure, it is possible to examine responses to each source individually or to collapse the items into categories. Calton, Cattaneo, and Perrin (2016) identified the following categories of formal support, which were used as outcomes in this study: the justice system (sum of the police and the court system), domestic violence services (sum of domestic violence shelter, domestic violence phone hotline, and domestic violence network), LGBTQ supports (sum of LGBTQ resource center and LGBTQ health clinic), medical professionals (sum of general health clinic and a medical doctor), and a mental health professional (response to the single item).

Data Analysis Plan

Preliminary Analyses. Participants were not given the option of skipping items, and data from participants who did not complete the study in its entirety (within a 24 hour

period) were automatically deleted. Thus, full data were obtained for all analyses. We first generated descriptive statistics to describe the sample and assess for univariate and multivariate normality.

Main Analyses. To test Hypothesis 1, we examined correlations among intentions to seek help from formal sources and discrimination, internalized heterosexism, and outness. To test Hypotheses 2 and 3, we created a path analysis in Amos 19.0 (Arbuckle, 2010). Score on the HHRD scale was entered as the independent (exogenous) variable, with intentions to seek help for IPV from 5 different sources (mental health professional, domestic violence services, LGBTQ supports, medical professionals, and the justice system) entered as primary outcome (endogenous) variables. Scores on the internalized homophobia/transphobia and outness scales were modeled as mediating variables, with paths from HHRD score to each of these variables, and paths from each of these variables to all five outcome variables (see Figure 1). Covariances were specified between the error terms of the two mediating variables and among the error terms of the five outcome variables, resulting in a fully saturated model. To obtain significance estimates for the indirect paths from HHRD to help-seeking intentions, we used bootstrapping with 5,000 resamples.

To prepare the data, we centered the predictors by subtracting the mean score from each data point (Frazier, Baron, & Tix, 2004). To evaluate how well the hypothesized model fit the data, we used a variety of indices including the Root Mean Square Error of Approximation (RMSEA), Comparative Fit Index (CFI) and Chi-square. A Monte Carlo Simulation (Muthén & Muthén, 2009) with a sample size of 317 and α

of .05 indicated that we had enough power at .80 to detect medium-large effects for Hypotheses 2 and 3.

Multi-group Tests. We conducted multi-group tests to determine whether there were differences in Hypotheses 2 and 3 based on participants' sexual orientation, gender identity, and history of IPV victimization. For the test that examined differences by sexual orientation, the groups were lesbian/gay, bisexual, and queer. We dropped heterosexual participants from this analysis due to the small sample size of this cell ($n = 12$). For the test that examined gender differences, the groups were men, women, and transgender/non-binary individuals. For the test that examined differences by IPV history, the groups were those with a history of physical or sexual victimization, those with a history of psychological victimization, and those without a history of victimization. For each multi-group test, we first explored a model where each of the paths was freely estimated across all groups, which produced a fully saturated model with perfect fit indices. We then examined a constrained model in which the directional paths of interest (i.e., from HHRD, internalized homo/transphobia, and outness to each help-seeking outcome) were constrained to be equal across groups. If the constrained model displayed good model fit, it suggested that there were no significant differences in the paths across groups.

Results

Sample Description and Bivariate Relationships

Descriptive statistics and correlations for study variables are displayed in Table 1. Results indicated that, on average, participants reported a history of experiencing

discrimination, rejection, and/or harassment once in a while (~10% of the time or less) and they espoused mid-range levels of internalized homo/transphobia. Participants also reported fairly high levels of outness. We also found participants reported intentions to seek help from medical professionals, the justice system, and domestic violence services that, on average, fell in the somewhat unlikely – neutral range. However, their average intentions to seek help from mental health professionals and LGBTQ services were higher, falling in the neutral-somewhat likely range.

Experiences with discrimination were significantly positively correlated with internalized homo/transphobia, but not significantly correlated with outness. Internalized homo/transphobia was significantly negatively correlated with outness. Experiences with discrimination and internalized homo/transphobia were both significantly negatively correlated with intentions to seek help from mental health professionals, but not significantly associated with intentions to seek help from any other sources (see Table 1). In addition, outness was not significantly associated with intentions to seek help from any of the sources. Taken together, these results suggest Hypothesis 1 was only partially supported for intentions to seek help from mental health professionals, and it was not supported for any of the other sources of support.

Impact of Barriers on Intentions to Seek Help for IPV

Figure 1 displays the full results of the path analysis that tested Hypotheses 2 and 3. Results were consistent with correlations, in that the only significant paths to help-seeking intention outcomes were those from experiences with discrimination and internalized homophobia/transphobia to intentions to seek help from mental health

professionals. In addition, internalized homo/transphobia and outness did not mediate the relation between experiences with discrimination and intentions to seek help from domestic violence services ($b = -.02, p = .203$), the justice system ($b = -.00, p = .886$), LGBTQ sources ($b = -.01, p = .482$), or medical professionals ($b = -.01, p = .702$). In contrast, the indirect effect of experiences with discrimination on intentions to seek help from mental health professionals through internalized homo/transphobia and outness was significant ($B = -.02, p = .049$). These results suggest that Hypotheses 2 and 3 were only partially supported for intentions to seek help from mental health professionals.

Results of multi-group tests that explored differences in Hypotheses 2 and 3 based on gender, sexual orientation, and IPV history indicated that there were no significant differences in the models between groups. For each test, models produced an excellent fit for the data when paths were constrained to be equal across genders ($\chi^2[30] = 30.65, p = .43, CFI = 1.00, RMSEA = 0.01$), sexual orientations ($\chi^2[30] = 38.49, p = .14, CFI = .99, RMSEA = 0.03$), and IPV history ($\chi^2[30] = 45.99, p = .03, CFI = .98, RMSEA = 0.04$).

Discussion

This study is the first to examine the impact of minority stress processes on LGBTQ individuals' intentions to seek help in the event they experience IPV in the future. Several qualitative studies (e.g., Walters et al., 2011; Bornstein, Fawcett, Sullivan, Senturia, & Shiu-Thornton, 2006) and literature reviews (e.g., Calton, Cattaneo, & Gebhard, 2015) have called attention to barriers to help seeking for LGBTQ survivors in recent years, but quantitative research that explores the extent to which these barriers prevent them from seeking help for abuse from particular sources is lacking. Our results

add to this literature, as we examined the relation between LGBTQ peoples' intentions to seek help for IPV and three minority stress processes: discrimination, internalized homophobia/ transphobia, and outness.

Sample Characteristics

The sample statistics frame our interpretation of the results. First, the sample reported they had seldom experienced discrimination in the past year. Thus, the opinions of those who have experienced a great deal of discrimination are not well represented in this sample. These experiences with discrimination are consistent with participants' fairly low levels of internalized homo/transphobia, as well as their fairly high levels of outness. Given that participants were not experiencing high levels of distress, were accepting of themselves, and were fairly open about their identity, they may have an easier time seeking help for IPV than a more distressed sample. This restricted range also limited our ability to detect statistical effects.

On average, participants' intentions to seek help from domestic violence services, medical professionals, and the justice system fell in the somewhat unlikely-neutral range, suggesting they did not have very high intentions to seek help from these sources. However, participants' average intentions to seek help from mental health professionals and LGBTQ resources fell in the neutral-somewhat likely range, indicating that LGBTQ individuals had higher intentions to seek help from these formal sources than the other sources.

Minority Stress and Intentions to Seek Help

Overall, results indicate that minority stress processes are related to each other in a way that is consistent with Meyer's (2003) Minority Stress Model. Nearly all of the minority stress processes were significantly correlated. For example, consistent with prior theory and research (Kashubeck-West, Szymanski, & Meyer, 2008; Meyer & Dean, 2008; Meyer, 1995), discrimination was significantly associated with internalized homo/transphobia and suggested those who experience more discrimination experience greater self-devaluation. Similarly, those with higher levels of internalized homo/transphobia reported significantly lower levels of outness, which is also consistent with research that has shown that those who engage in greater self-devaluation are less open about their identity (Herek et al., 1997; Frost & Meyer, 2009).

Generally, these minority stress processes did not act as barriers to seeking help for IPV from LGBTQ resource centers, medical professionals, domestic violence services, or the justice system in this sample. However, the sample characteristics outlined above indicate this sample is not experiencing great distress related to their LGBTQ identities, so it is possible that minority stress processes have a greater impact on intentions to seek help in more distressed groups of LGBTQ people. It is also possible that LGBTQ individuals have fears about experiencing discrimination from help sources and being outed as a result of help seeking, but that these fears do not overshadow the need to seek help. This result is consistent with research with general samples of IPV survivors that indicates survivors seek support for IPV despite barriers to seeking help, especially as violence increases in severity or frequency (Gelles & Strauss, 1988;

Goodman, Dutton, Weinfurt, & Cook, 2003; Zanville & Cattaneo, 2012). Similarly, although internalized homo/transphobia can contribute to turmoil within relationships (Balsam & Szymanski, 2005; Carvalho, 2011; Igartua et al., 2003), it may not prevent many LGBTQ individuals from accessing these formal sources from if they need it. Survivors who have experienced more discrimination and, subsequently, have greater internalized homo/transphobia may be more hesitant to seek help from formal sources as a result of this oppression; however, the nature of our sample precluded such a comparison.

However, even within this sample that was not exhibiting high levels of distress, there was one exception to this general pattern. Some of these processes had a significant impact on intentions to seek help from mental health professionals. Those who experienced greater discrimination had lower intentions to seek help from mental health professionals than those who had experienced less discrimination. Moreover, part of this association was explained by internalized homo/transphobia. This finding is consistent with one study that demonstrated that minority stress processes can impact seeking help for physical health problems (McGregor et al., 2001), and it suggests that those who have higher levels of minority stress may decide not to come forward for counseling for IPV. Mental health professionals are trained to provide sensitive and empathetic care; however, if LGBTQ individuals have experienced much discrimination in the past, they may be particularly distrustful of discussing their stigmatized identity and relationships in great detail with anyone, which is typical of a counseling session. Furthermore, given that internalized homo/transphobia explains part of the relation between discrimination and

intentions to seek help from mental health professionals, it is also possible that LGBTQ individuals have low self-esteem around their identity and/or the IPV and, as a result, they would feel even more uncomfortable discussing their relationship in therapy.

Implications for Practice

In this sample, experiences with discrimination and internalized homophobia/transphobia acted as barriers to seeking help from mental health professionals but not from other formal sources of support. Although identifying within the LGBTQ spectrum is no longer diagnosed as a mental illness and many psychologists and counselors specialize in providing sensitive LGBTQ care, some LGBTQ individuals may not be aware of these changes, and/or they may not feel comfortable seeking services. Mental health professionals who have training in providing care to the LGBTQ community should advertise their services and ensure that they also have training in LGBTQ IPV.

Furthermore, some LGBTQ individuals may be hesitant to seek mental health services because they have had negative experiences with therapy in the past. Research suggests that survivors find counseling helpful if the counselor is non-judgmental, non-homo/transphobic, demonstrates knowledge about LGBTQ IPV, explicitly acknowledges the abuse, helps survivors to view abuse as unhealthy, and guides them toward solutions to abuse (Irwin, 2008; Oswald, Fonseca, & Hardesty, 2010; St. Pierre & Senn, 2010). Mental health providers can elicit feedback from LGBTQ clients and consult with IPV and LGBTQ agencies to ensure that services are sensitive to LGBTQ IPV survivors' needs.

Limitations & Implications for Future Research

Several limitations frame these findings. First, the scale that measured participants' intentions to seek help for IPV was developed using the same sample. Although our sample is diverse in terms of sexual orientation, race, and gender, this scale has not been tested in other samples and requires further testing in order to establish predictive validity. In addition, this sample is cross-sectional. Future studies should investigate the relationship between past behavior, behavioral intentions, and help-seeking behavior over time. It is possible that people intend to seek help more generally, but that these intentions decrease when people actually experience IPV. Minority stress processes may become barriers to seeking help once LGBTQ individuals are in the process of finding support, so future research should investigate whether minority stress processes are more prominent barriers in the aftermath of abuse. Research on past help seeking and intentions to seek help for IPV would further researchers' knowledge of how past experiences impact future decisions to seek help, particularly if data on the quality of survivors' past experiences is included in analyses. For example, feeling highly supported by formal supports in the past or perceiving services to be highly effective at addressing IPV may increase intentions to seek help again. Similarly, positive experiences seeking help for other problems may generalize to intentions to seek help for IPV.

Our sample characteristics also provide some limitations. First, participants in our sample reported fairly low levels of discrimination and high levels of outness. Although rates of discrimination vary, recent reviews of research on LGBTQ hate crimes suggest rejection, harassment, and discrimination are common experiences within the LGBTQ

community (e.g., Katz-Wise & Hyde, 2012; Stotzer, 2009). This prior research suggests some LGBTQ people experience more rejection and discrimination than the participants in this sample reported. Thus, it is possible that a sample with a greater history of discrimination would be less open about their identity, which could contribute to greater reluctance to seek help. Our methods aimed to address methodological shortcomings of prior research on LGBTQ IPV by obtaining a sample that was diverse in terms of gender identity, sexual orientation, and racial identity and that was not limited to participants with IPV histories or past experiences seeking-help. Future research should employ snowball sampling to recruit participants that have had more experiences with minority stress and replicate this study's design. It may also be helpful to recruit from locales with small openly-LGBTQ communities in order to obtain samples that may be less open.

Finally, future research should also investigate other barriers to help seeking for LGBTQ IPV survivors. We did not assess whether expectations of rejection and discrimination from IPV help sources impacted participants intentions to seek help for IPV. Minority stress theory posits that expectations of future rejection is another key minority stress process that impacts LGBTQ individuals' behavior (Meyer, 2003). Fears of future rejection and discrimination may be more predictive of intentions than past experiences with discrimination, because people who expect to be met with unhelpful responses from providers are unlikely to seek help. In addition, silencing IPV within the LGBTQ community is another potential barrier to seeking help for IPV (Edwards, Sylaska & Neal, 2015). Given that LGBTQ people are already marginalized, many may

feel pressured not to draw attention to any issues that might further stigmatize the LGBTQ community, thereby preventing them from disclosing abuse.

Conclusion

This study is the first to quantitatively examine the relationship between minority stress processes and intentions to seek help for IPV among LGBTQ individuals. Results indicated that experiences with discrimination, internalized homo/transphobia, and outness did not act as barriers to intentions to seek support from the justice system, domestic violence services, LGBTQ sources, and medical professionals if participants experienced IPV in the future. However, discrimination and internalized homo/transphobia acted as barriers to seeking help from mental health professionals. These findings suggest that LGBTQ individuals may not feel comfortable seeking help from mental health professionals if they have experienced high levels of marginalization in the past, so it is particularly important for mental health professionals to advertise LGBTQ affirming services and ensure that they provide sensitive care.

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Table 1

Descriptive Statistics and Correlations

	1	2	3	4	5	6	7	8
1. Discrimination	--							
2. IH	.19**	--						
3. Outness	.03	-.34**	--					
4. Medical Prof.	-.11	-.09	.10	--				
5. Justice System	-.11	-.04	.02	.59**	--			
6. DV Services	.00	-.09	.06	.62**	.41**	--		
7. Mental Health Prof.	-.15**	-.14*	.04	.61**	.38**	.58**	--	
8. LGBTQ Services	.05	-.05	.06	.64**	.35**	.68**	.51**	--
Mean	2.37	2.92	4.38	3.59	3.67	3.9	4.51	4.11
Standard Deviation	0.91	0.88	1.40	1.85	2.03	1.93	2.02	1.96
Range	1-6	1-6	1-7	1-7	1-7	1-7	1-7	1-7

Note. Abbreviations: IH = Internalized heterosexism, Prof. = Professional, DV = domestic

violence, LGBTQ = lesbian, gay, bisexual, and transgender.

* = $p < .05$, ** = $p < .01$

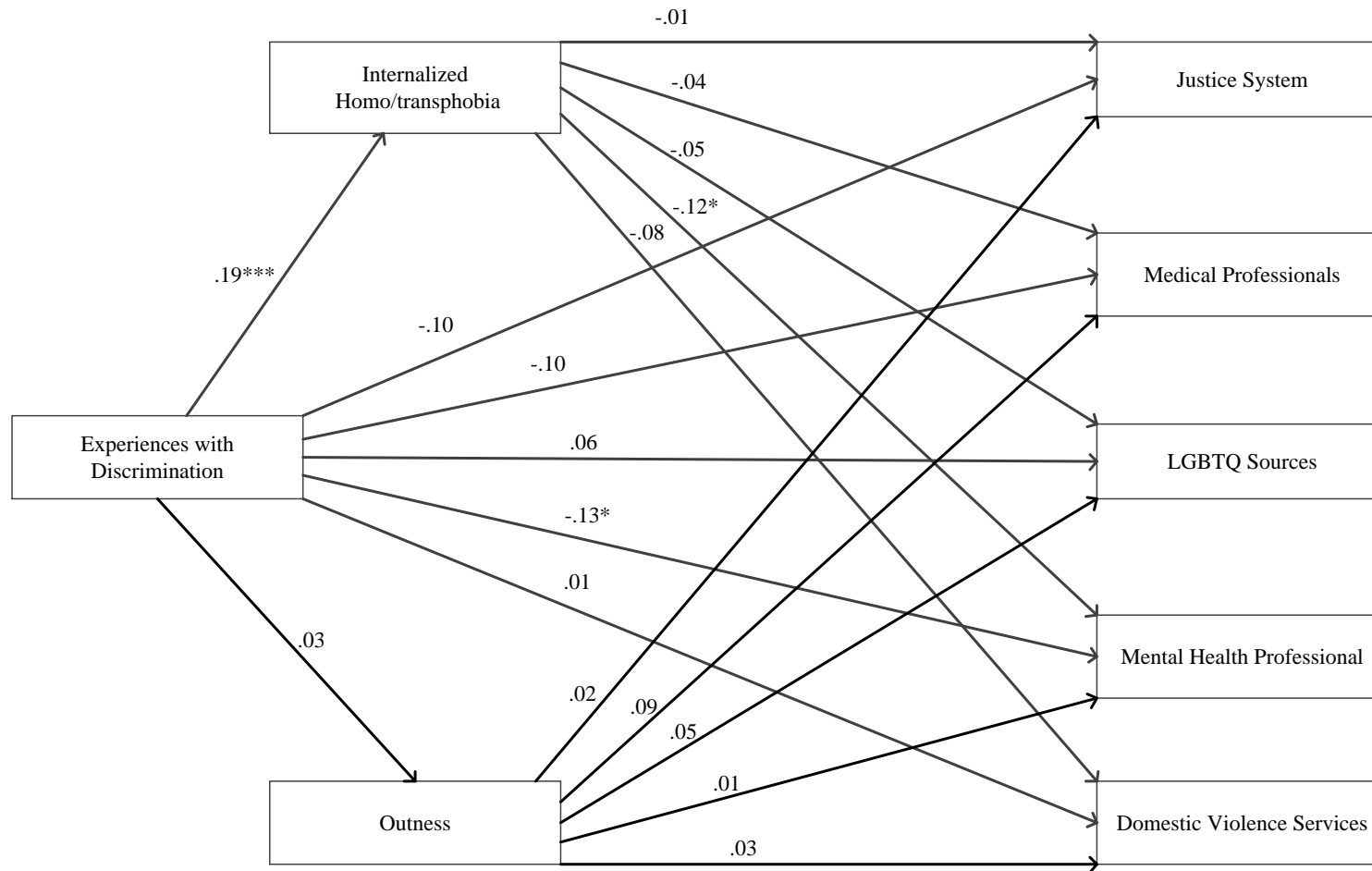


Figure 1. Path analysis examining the relation between minority stress processes and intentions to seek help for IPV from formal sources of support. The model was fully saturated. Standardized coefficients are displayed. * = $p < .05$, ** = $p < .01$, *** $p < .001$.

BIOGRAPHY

Jenna M. Calton graduated from Land O' Lakes High School, Land O' Lakes, Florida, in 2007. She received her Bachelor of Science in Psychology and her Bachelor of Arts in Women's Studies from the University of Florida in 2011. She received her Master of Arts from George Mason University in 2013.