Women’s Experience of Obtaining Health and Social Services following Intimate Partner Violence: Lesbian, Gay, Bisexual, Transgender, and Queer Relationships in Rural Communities

Emily E. Soares, The University of Western Ontario

Supervisor: Jackson, Kimberley T., The University of Western Ontario
Mantler, Tara, The University of Western Ontario

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Abstract

The aim of this secondary analysis was to explore the intersection of gender, sexuality, and rurality on a person’s experience of seeking health and social services following intimate partner violence (IPV). Data from the primary study, *SPEAK: Sharing Personal Experiences of Accessibility and Knowledge of Violence*, were used for this secondary analysis. This study reviewed the experience of women who identified as being lesbian, gay, bisexual, transgender, and/or queer (LGBTQ), and lived in a rural community. Using a case-study design utilizing Heaton’s (2004) guidelines, the experiences of LGBTQ women who had experienced IPV seeking health and social services in rural communities were explored. Data collected from demographic questionnaires and interviews indicated that sexuality and rurality hinder a woman’s ability to engage in help seeking behaviours. These findings may be useful to inform future practice and policy of resources and services available to facilitate LGBTQ women in rural communities when seeking care.
Keywords

Intimate partner violence, rural, LGBTQ, health services, social services
Summary for Lay Audience

The goal of this study was to explore the relationship between gender, sexuality, and rurality on woman’s experiences of seeking health and social services. This study explored the experience of women who had encountered intimate partner violence and identified as being lesbian, gay, bisexual, transgender, and/or queer (LGBTQ), and lived in a rural community. Interviews were conducted with four women and analysis showed sexuality and rurality hinder a woman’s ability to engage in help-seeking behaviours. These findings may be useful in shaping future practice and policy of resources and services.
Co-Authorship Statement

Any publications resulting from this thesis will be co-authored by Dr. Kimberley Jackson, Dr. Tara Mantler, and Dr. Abe Oudshoorn.
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Chapter 1

Introduction

In 2017, the World Health Organization (WHO) identified violence against women to be a major public health issue and a violation of human rights. Intimate partner violence (IPV) is defined as a pattern of physical, sexual, psychological, economic, and/or spiritual abuse by an intimate partner in the context of coercive control (Tjaden & Thoennes, 2000). The most recent Statistics Canada data indicated that IPV is the leading form of violence experienced by women; moreover, women are four times more likely to experience IPV than men (Burcycka, 2018). The data presented by Statistics Canada is representative of IPV that has been reported. It is important to note that data on IPV is considered to be under-representative of the true occurrence, as most cases of IPV go unreported to law enforcement (Burcycka, 2018; West, 2002).

While violence may have tangible manifestations such as physical acts of power directed at a partner, this violence is still often unnoticed by outsiders (Wendt & Hornosty, 2010). If a violent relationship is not noticeable to those outside of the relationship, the person experiencing abuse may be reluctant to share their experience in fear of outsider disbelief. Moreover, those outside of the relationship may be unlikely to reach out to support where violence is unnoticed, or the individual is fearful of disclosing violence (Wendt & Hornosty, 2010).

As a major public health concern, the impacts of IPV exert direct and often long-standing negative effects on women’s health. Ford-Gilboe et al., (2009) identified that women who leave an abusive partner experience health repercussions for an average of 20 months after ending the relationship. Furthermore, IPV can be impactful for generations, through the potential development of cycles of intergenerational violence (Butchart & Mikton, 2014). This violence has potential negative impacts on women’s physical, mental, sexual, and reproductive health throughout their lifespan. Such consequences include psychological disorders, unintentional pregnancies, induced abortions, miscarriage, gynaecological problems, sexually transmitted infections, psychological injury, homicide, and suicide (García-Moreno et al., 2013). In addition
to the impact on the family, IPV poses a threat to the social harmony of communities through the distress that it causes (Butchart & Mikton, 2014). Such impact may be due to psychological outcomes, including depression, anxiety, bipolar disorder, and post-traumatic stress disorder, that may be secondary to, or exacerbated by IPV (García-Moreno et al., 2013). As such, the emotional and economic impact of IPV has far-reaching implications beyond just those who directly experience it (Butchart & Mikton, 2014).

Historically, the focus of IPV research and awareness has been on the experiences of heterosexual, cis-gendered women without particular attention to the various expressions of a person’s identity and/or sexuality (Subirana-Malaret et al., 2019). Therefore, available research specific to those who do not identify as such may be difficult to seek and obtain. The literature search for this paper posed difficult in accessing reliable, and current data that was representative of the population of interest. As such, there is a paucity in the IPV literature reflecting the experiences of those who identify as lesbian, gay, bisexual, transgender, and/or queer (LGBTQ).

The scarcity in research of IPV within this community is situated within the broader issue of the discrimination entrenched within society towards the LGBTQ community as a whole (Davis & Glass 2011; Duffy, 2011). Research suggests that supports and resources for women who have experienced IPV have predominantly been directed towards and accessed by heterosexual and cisgender women. Identifying as LGBTQ introduces the potential for neglect and discrimination based on sexual orientation and/or gender identity by those providing community resources (Patton & Baum, 2003). Unfamiliarity with diverse expressions of gender and sexuality outside traditional cisgender identities can pose limitations for those providing care (Snyder et al., 2017). Apart from explicit discrimination, implicitly a health or social services provider may assume heterosexuality in all cases, consequently creating barriers to LGBTQ-identifying individuals (Snyder et al., 2017; Turell & Herrmann, 2008). This potential gap in provider knowledge then poses a barrier for LGBTQ women seeking services secondary to experiences of IPV (Turell & Herrmann, 2008). The inability to offer appropriate resources for women who do not fit traditional norms risks further traumatization following an incident or the presence of IPV (Turell & Herrmann, 2008). Such resources include adequate patient-provider communication,
respect, and openness about topics surrounding sexual, physical and emotional health (Snyder et al., 2017). The intersection of various identities, such as gender and sexual orientation, becomes a space of multiple forms of marginalization of LGBTQ women.

A final social location of consideration in this study is rurality. Being a woman, identifying as LGBTQ, living in rural communities, and experiencing IPV are all factors that contribute to marginalization, which can create significant gaps in the potential network of support services (Rollè et al., 2018). The unique challenges experienced by those who identify as LGTBQ may have added layers of complexity when a person lives in a rural context. For example, isolation can be further expressed in rural communities, where resources and facilities are more limited (Ristock & Timbang, 2005). Limited resources are a concern for all members of rural communities, as smaller populations often see the allocation of fewer resources than their urban counterparts (Mantler & Wolfe, 2017). However, the addition of an LGBTQ-identity amplifies the risk for potential barriers, therefore creating additional difficulties when seeking to access resources (Rollè et al., 2018). Rural communities have been shown to have higher rates of familiarity and closeness, which often brings with it a lack of privacy, anonymity and confidentiality (Wendt & Hornosty, 2010). Such community characteristics may become challenges for woman seeking support, as health or social providers may be socially acquainted with the abuser (Wendt & Hornosty, 2010). These factors illustrate a distinct barrier for those who wish to access care for IPV (Carastathis, 2014). Independently, gender, sexuality, and rurality all pose as an obstacle for women accessing care (Crenshaw, 1989). Therefore, the intersection of these factors may have a compounding negative effect on the ability to obtain adequate treatment and care (Felix et al., 2016; Furman et al., 2017; Ibrahim, 2019).

Definitions

Provided in this section are key terms addressed throughout the study. The population, concepts, and context described herein will help frame the phenomena explored through this study.

Intimate Partner Violence
IPV is a phenomenon of much controversy and confusion based on variability among definitions and reporting (Tjaden & Thoennes, 2000). IPV includes aggressive strategies that are a type of manipulation enacted in an attempt to maintain control and power over a partner and a relationship (Furman et al., 2017). The most easily recognisable form of IPV is physical abuse, which is the act of force that has the potential to cause bodily harm. This includes hitting, kicking, choking, biting and any other form of violence that causes physical stress (Gillespie et al., 2013). The forms of violence that are more difficult to recognise are sexual, psychological, economic and spiritual abuse. Sexual abuse can include but is not limited to sexual assault, rape, and sexual harassment (Government of Canada, 2018). Psychological abuse is the systemic destruction of a person’s self-esteem or a sense of safety (Doherty & Berglund, 2008). Economic abuse is the control over another’s access to financial recourses, limiting the woman’s ability to support themselves (Postmus et al., 2012). Finally, spiritual abuse is the misuse of religion for manipulation towards another (Bent-Goodley & Fowler, 2006).

**Gender**

Gender refers to the societal roles, behaviours, and characteristics that are considered appropriate to be categorized as masculine or feminine (American Psychological Association, 2015). This social construction helps in understanding cultural norms, but the common binary nature of the construct also supports environments of stereotyping and expectations specific to each category (Government of Canada, 2018). Internationally, women experience higher rates of gender-based barriers and gender-based discrimination. (Stamarski & Hing, 2015). This is a human rights violation and therefore the United Nations Sustainable Development Goals have included a focus on gender equity. In spite of decades of efforts towards gender equality, inequities persist across the determinants of health.

**Intersectionality**

Intersectionality is the interconnected nature of social locations as they apply to individuals or groups (Crenshaw, 1989). These social locations have the potential to be sites of overlapping and interdependent systems of discrimination or disadvantage (Carastathis, 2014). Intersectionality
theory helps us avoid the error of presuming cultural experiences based off of any one single social characteristic (Crenshaw, 1989). Intersectionality helps us understand that women are not solely victims of IPV based on gender, but also due to other social locations such as sexual orientation, rurality, and race or ethnicity.

**Sexual Orientation**

**Lesbian**

A lesbian is a woman who experiences romantic, physical, and/or emotional attraction to other women. Often referred to as gay women, a lesbian is a woman who is attracted to someone of the same gender identity (GLAAD, 2016).

**Bisexual**

Someone who identifies as bisexual is a person who experiences emotional, romantic, or sexual attractions to, and engages in a romantic or sexual relationship with women and men. Bisexual people comprise of the largest single group within the LGBTQ community for both men and women (American Psychological Association, 2015). According to the National Intimate Partner and Sexual Violence Survey (NISVS), bisexual women are 1.8 times more likely to experience IPV than women engaged in heterosexual relationships. Furthermore, of the women, 89.5% indicated the attacker was male. Bisexual women have addressed concern with seeking resources as they do not identify as heterosexual or lesbian, which are often the populations explicitly addressed by services (Turell et al., 2012). This is an identified barrier within the bisexual community, as individuals feel isolated from resources directed towards lesbian or heterosexual communities (Ibrahim, 2019).

**Transgender**

Someone who identifies as transgender is a person whose gender identity differs from the sex they were assigned at birth. The term transgender includes people who identify with the binary genders of man and woman, and those who do not fit within the gender binary, including non-
binary, gender non-conforming, genderqueer, and agender (Government of Canada, 2018). Individuals who have “transitioned”, by adopting the physical characteristics of the gender they identify with rather than were born to, may experience stigma, discrimination, and assault, including towards the body parts that hold meaning to the person’s expression of identity (Goodmark, 2013). The intersection of these discriminatory attitudes influences the nature of IPV a person may face.

*Queer*

The adoption of a queer identity indicates that a person does not limit or define their sexuality according to traditional societal standards. This unique identity may be a point of implicit or explicit stigma that hinders a person’s ability to access appropriate services and care based on the lack of understanding from those outside of the LGBTQ community. Of the limited research focusing on the experience of IPV among LGBTQ people, reports indicate the incidence of IPV may be greater or equal to those in heterosexual relationships (Edwards et al., 2015).

*Rural Context*

*Rurality*

Rural communities in Ontario, are those with a population less than 30,000 and are greater than 30 minutes away from a community with a population of greater than 30,000 (MoHLTC, 2010). The challenges of access to quality care in rural communities stems from factors such as geographic remoteness, low population densities, and infrequency of provider availability (Douthit et al., 2015). The experience of unmet needs and fewer services hinders access of women living in rural communities to supports and services related to IPV (de Marco & de Marco, 2010).

*Background*

Attitudes towards IPV have evolved from being a private matter exclusive to the relationship to being recognized as a public concern with the potential for criminalization based on the type and
severity (Meyer, 2012). The Canadian 2010 police report on IPV indicates that approximately three in ten victims of police-reported crimes among those aged 15 and older were victims of IPV (Ibrahim, D. (2019). The rates are considerably high, and particularly so given the knowledge that the majority of IPV occurrences go unreported, and even more so in the LGBTQ community (Ibrahim, 2019; Poon & Saewyc, 2009; Turell & Herrmann, 2008). Furthermore, data are difficult to collect for rural communities based on even greater levels of under-reporting and the lack of available social services that would take part in data collection (Rollè et al., 2018).

The National Intimate Partner and Sexual Violence Survey (NISVS) is the ongoing survey used to collect data on IPV, sexual violence, and stalking victimisation in the United States (NISVS, 2019). The NISVS data indicated that there is a higher prevalence of IPV experienced in a lifetime among LGBTQ women than heterosexual women (Brown & Herman, 2015). The intersection of sexuality, and rurality have the potential to create barriers to those seeking help and resources following IPV. The addition of belonging to a further marginalized social location creates risk for greater discrimination which further hinders one’s ability to access care and supports (Ibrahim, 2019).

**Aim**

The underrepresentation of rural, LGBTQ people in IPV literature limits the knowledge base for the creation of effective and welcoming services for marginalized women. Furthermore, the ongoing intolerance for LGBTQ people seen in many communities is problematic for the movement towards equity in care. As such, the aim of this research is to gain a better understanding of the help-seeking behaviors of rurally residing LGBTQ women who have experienced, or who are experiencing IPV, as they access health and social service-related resources. This study is a secondary analysis of the primary study, *Sharing Personal Experiences of Accessibility and Knowledge of Violence: A Qualitative Study* (Mantler et. al, 2020). The focus of the primary study, using interpretive case methodology, was to explore the intersection of rural and social services and how women who experience IPV navigate these services (Mantler et al., 2020). The study consisted of eight participants who identified as women, lived in rural communities, and experienced IPV. Four of the primary study’s
participants identified as LGBTQ. Following the completion of a scoping review, the researchers noted a gap in studies looking particularly at LGBTQ women’s experiences in rural communities. Therefore, this secondary study focuses on the navigation of health and social services for LGBTQ women in rural communities who have experienced IPV.

**Significance**

The purpose of this study is to work towards filling a current gap in the IPV literature by exploring the experiences of under-represented populations. Identifying as LGBTQ and living in rural communities can negatively influence a woman’s help-seeking behaviours (Turell & Herrmann, 2008). By exploring the ability of women to access health and social services while experiencing confounding oppressive factors, the objective of this study is to create knowledge that can be used to support this population. To do this, further research is required to motivate political action towards government involvement to facilitate public resources for all expressions of identity.

As an identified public health concern, IPV is a significant factor affecting the health and wellbeing of individuals, families, and communities. IPV has noted intergenerational effects, referring to the impact on several generations, which may contribute to future outcomes of violence (Butchart & Mikton, 2014). IPV has been noted to create physical, emotional, economic, and/or spiritual strain on individuals and communities. Eliminating the stigmatization and barriers associated with help-seeking actions following IPV have been prioritized to reduce the increasing costs associated with the abuse, such as impaired health, lost productivity, and criminal justice expenditure (Peterson et al., 2018). These costs include personal, interpersonal, and societal factors associated with increased anxiety, depressive symptoms, dissociation, substance use disorders, cognitive disorders, and somatization (Santos et al., 2017). Eliminating barriers to health and social resources is beneficial to both the person seeking help as well as the community as a whole. For example, the cost savings associated with fewer outreaches to first responder and emergency department visits due to increased access to community resources. An upstream approach, referring to early intervention to prevent a problem rather than an approach after the fact, are beneficial to the person and community (Andermann, 2016). Through the
creation of inclusive resources in all communities, the healthcare system can take an upstream approach to preventing reoccurrence of abuse and the sequelae that often follow.
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Chapter 2

Problem

Intimate partner violence (IPV) is a serious human rights issue with negative health and social outcomes for women and their families (Butchart & Mikton, 2014). IPV is described as abuse that occurs within an intimate relationship by a current or former partner (Felix et al., 2016), which can be enacted in physical, sexual, psychological, economic, and spiritual ways (Wendt & Hornosty, 2010). Described as a means of coercive control, IPV frequently involves the exacerbation of aggressive tendencies or the imposition on normative perceptions of power, control, or free agency in interpersonal relations (Carney & Barner, 2012). Women who experience IPV have high needs for health and social services (Dichter & Rhodes, 2011); however, in addition to help-seeking barriers faced by all women, the multiple forms of marginalization that exists for LGBTQ women living in rural communities may further problematize access and exacerbate the need for accessible health and social services. Furthermore, the existence of co-factors of identity that contribute to marginalization is impactful to the person’s perception and emotion towards the situation and those involved. This can include attitudes towards the service providers at health and social service organizations, other women that that accessing such resources, and the community members that are involved in the township. From an intersectional lens, the marginalization that affects women who experience IPV, women who identify as LGBTQ, and women living in rural communities, is magnified when these variables exist in concurrence (Rollè et al., 2018). Therefore, women who identify as such may be further disadvantaged when seeking health and social services following IPV.

Determining the prevalence of IPV within the LGBTQ community is difficult. Many women do not report incidents of IPV because they either do not recognize their experience as abuse or because of fear of judgment towards them or the LGBTQ community (West, 2002; Ristock & Timbang, 2005). Furthermore, individuals may feel reluctant to seek resources due to fear of rejection from the LGBTQ community and those outside of the community (Ristock & Timbang, 2005). This sense of rejection may stem from the fear of disappointing the community by
bringing attention to the problem of IPV. From the limited literature, recent Canadian research estimates that from 18 to 43 percent of lesbian women and 38.9 percent of bisexual women have experienced IPV within the past five years (Badenes-Ribera et al., 2015). Although there is very little information regarding IPV among women who are transgender, IPV within the transgender community is estimated to range from 31.1% to 50% (Brown & Herman, 2015). As such, it is possible that these data are an underrepresentation of the actual prevalence of IPV among women who identify as LGBTQ.

Based on the diversity of gender and/or sexual expression associated with an LGBTQ identity, individuals in these relationships are noted to seek greater privacy. This privacy may be secondary to the fear of negative community opinion. Privacy and avoiding formal services due to stigma can create higher risk within the context of IPV where isolation, manipulation, and control are core elements of abuse (Walters, 2011). Manipulation can also exist through the threat of exposing a partner’s sexual orientation. A person who identifies as LGBTQ may not be comfortable sharing this with those outside of the relationship from fear of societal harassment (Higa et al., 2014). These threats have the potential to further isolate a person experiencing IPV (Ristock & Timbang, 2005).

Compounding the potential isolation associated with identifying as LGBTQ, the sociocultural context of rurality may pose further barriers to accessing appropriate resources. Such barriers include geographic isolation, limited resources, lack of confidentiality and anonymity, and financial dependency (Wendt & Hornosty, 2010). These factors will be further addressed in chapter two. Statistics Canada data on (2016) police reported IPV by province and territories, indicates that IPV is more prevalent in less populated regions. Based on this information, further investigation is required to determine the existing factors that are creating this differential.

Through conducting research specific to this demographic group, a greater understanding will create knowledge aimed at reducing the frequency of IPV – and the deleterious outcomes that result – in these regions.

**Literature Review**
From January to April 2019, an extensive literature search was conducted for this study using the following electronic databases: CINAHL, PubMed, Scopus, ProQuest, and PsychINFO. A further search using the institutional library database, search engines containing scholarly metadata such as Google Scholar, and a hand search of the reference list of the literature that qualified for inclusion in this paper was completed. Statistics Canada and the NISVS databases were also utilized in this search. The literature review included studies that explored the relationships between the help-seeking behaviours of a person who identifies as a woman, experiences IPV, identifies as LGBTQ, and lives in a rural community. Studies were included if: 1) help-seeking behaviours were established; 2) there was identified exposure to IPV; 3) participants identified as LGBTQ women; and 4) study participants lived in a rural community. The section to follow will summarize key findings from this review, in addition to noted inconsistencies and gaps in the literature. The review of literature will explore the experience of accessing health and social services for LGBTQ women in rural communities that have experienced IPV.

The literature review will begin by introducing and providing context to each domain of interest. The domains will then be merged to illustrate the nature of two domains when existing together. Finally, all of the domains will be presented together to provide a more accurate representation of the experience of help seeking following for LGBTQ women in rural communities following IPV.

**Experiencing IPV**

Frequently defined as a pattern of behaviour, IPV involves the coercion, domination, or isolation of a person by their intimate partner (Furman et al., 2017). These particular behaviors are recognizably used as a means of control, commonly referred to as “coercive control”, including isolating their intimate partner and seeking to confine them within the intimate relationship. Introduced by Schechter (1978), coercive control is the strategic form of ongoing oppression used to instill fear. Coercive control is not the act of violence itself, however, is generated by continuous and potentially diverse forms violence over time (Cattaneo, 2008). IPV includes
strategies that are a type of manipulation enacted in an attempt to maintain control and power over a partner and a relationship (Furman et al., 2017).

**Consequences of Rurality**

Rural communities in Ontario are those with a population less than 30,000 and are greater than 30 minutes away from a community with a population of greater than 30,000 (MoHLTC, 2010). Unique circumstances of rural inhabitants which may lead to increased vulnerability are geographic isolation, limited resources, lack of confidentiality and anonymity, and increased financial dependency (Wendt & Hornosty, 2010). As such, rural communities encompass unique circumstances that facilitates greater vulnerability compared to their urban counterparts. Such vulnerability can be attributed to smaller population density, fewer health and service providers, and distance from neighbouring urban centers (Douthit et al., 2015; Hart et al., 2005).

**Stigmatization of Sexuality**

Ristock and Timbang (2005) stated that modern society often harbours discrimination and prejudice that is at times directed towards those who are not members of a dominant cultural group. For LGBTQ people, the experience of inequality concealed through societal phobia can be of concern. Phobias and/or discrimination can include homophobia, biphobia, lesbophobia, transphobia, and heterosexism (Ristock & Timbang, 2005; Turell & Herrmann, 2012). Transphobia, the prejudice against transsexual and transgender people, is a phenomenon that creates additional risks of IPV within relationships. Transmisogyny, is specific to transgender women, where the transphobia, negative attitudes, and discrimination are directed towards one’s feminine identity (Greenberg, 2012). Turell and Herrmann (2012) stated that LGBTQ people who were interviewed indicated that two key concerns are anonymity within the LGBTQ community and the avoidance of gender and sexual-based phobia when seeking assistance outside of the community. Such concerns may hinder a person’s ability to identify as their true self based on fear of judgment.

**Help-Seeking Behaviours**
Help-seeking behaviour is the interpersonal interaction that involves a person pursuing assistance for an identified area of concern (McCleary-Sills et al., 2016). Such behaviours are often directed towards agencies that provide safe access to health and social services. These services provide the organized efforts to advance human welfare through government or charitable organization funding (McCleary-Sills et al., 2016). The anticipated welcoming nature and safety one would associate with agencies that facilitate health and social services is not the reality for all women (Patton & Baum, 2003). Often, these resources are generalized and lack focus for those who may require specialized care. Such generalization may impose hesitancy when seeking health and social services based on the fear that a person’s needs may not be met, or that they will feel judged (Patton & Baum, 2003; Turell & Herrmann, 2008). Those that identity outside of the traditional assumption of heterosexual identity may be reluctant to seek help based on concerns of proper support (Patton & Baum, 2003).

**IPV in Rural Communities**

In urban areas, roughly 70% of all women experiencing IPV pressed charges, compared to the 51% of rural victims that did so. Burczycka (2018) collected data from the Statistics Canada report on “Victims of police-reported intimate partner and non-intimate partner violence, by victim sex and province or territory, 2016 to 2017”. Rates of IPV to women were calculated on the basis of 100,000 people aged 15 and over. The results indicated the highest rate in Nunavut (6,695), the Northwest Territories (4,782), Yukon (1,775), and Saskatchewan (1,099). In 2017, the average rate of IPV to Canadian women was 487 per 100,000 people, which illustrates these province and territories to be more than double the National average (Burczycka, 2018).

In the following paragraphs, salient consequences of rurality will be discussed, specifically those which intersect with the experience of IPV. These consequences include geographic isolation, limited resources, lack of confidentiality and anonymity, and financial dependency (Wendt & Hornosty, 2010).

*Geographic isolation*
Distance to health and social services is an important barrier to accessing care. For those that choose to travel outside of their community to assess care, they are often burdened with heavy travel costs, having to take time off of work (Hart et al., 2005), being removed from community supports (Dichter & Rhodes, 2011), and bearing the risk of being unable to do so secretly without partner discovering (Patton & Paum, 2002). Whether it be a financial or social cost, the additional effort to access care when the distance is a significant factor can hinder many from the ability to do so (Hart et al., 2005).

**Limited resources**

The existence of health and social resources facilitate the independence of help-seeking behaviours for women experiencing IPV. Scarcity of resources, noted in rural communities due to population size and provider availability, may hinder such help-seeking behaviours (Dichter & Rhodes, 2011). Furthermore, such resources may not have staff that are familiar with working with LGBTQ people (Turell & Herrmann, 2008). Proper understanding of those a community serves, including those representing all forms of identity, is necessary to providing appropriate responses (Patton & Paum, 2002).

**Lack of confidentiality and anonymity**

Close connections to social networks are an identified limitation that poses a conflict to rural women seeking assistance (Wendt & Hornosty, 2010). Frequent in rural communities, relationships between the doctor and patient often involve family or in some cases mutual friends (Townsend, 2009). Such relationships may hinder a woman’s ability to openly speak about IPV from a partner that the doctor may know or even care for. In addition to women’s hesitation to seek assistance out of fear of judgment, many women do not want to jeopardize their connection to their community. In Canadian rural settings, it is common for women not to seek help due to fear of judgment from members of the community.

**Financial dependency**
Financial abuse is a form of IPV whereby the abusive partner strategically controls financial resources as a means of exerting power and control (Meyer, 2012). This may involve the threat or action of taking or destroying a partner’s property as a form of IPV, or a result of the partner seeking help (Wendt & Hornosty, 2010). For some rural women, leaving an abusive relationship means leaving the family farm which is a source of identity and livelihood. As such, a woman is not only without a home but also a source of income without their farm (Wendt & Hornosty, 2010). Furthermore, higher costs are associated with accessing resources as a rural woman compared to their urban counterparts (Minore, 2008). These additional costs are associated with travel (Hart et al., 2005), including cost for the city bus and taxi within town limits. Furthermore, to travel outside of the city the purchase of a bus or train ticket is often necessary (Minore, 2008).

**IPV Among LGBTQ Couples**

IPV may involve the undermining of an individual’s sexual orientation and/or identity. The abusive partner may dismiss their partner’s representation of identity or shame them for their embodiment of that gender identity (Furman et al., 2017). Further psychological manipulation has been identified through the threat of exposing an individual’s sexual orientation. Some individuals may not publicly disclose their sexual orientation for reasons such as personal preference, fear of other’s opinions, and potential societal harassment (Higa et al., 2014). Therefore, threats to share this information are emotional and psychologically abusive to the woman (Ristock & Timbang, 2005). Canadian researchers, Israel et al. (2014) addressed potential barriers to reporting IPV to include fear of discrimination from police (Berrill & Herek, 1992), failure for police to take the reported crime seriously, and reluctance of police in noting anti-LGBTQ aspects of reported crimes (Wolff & Cokely, 2007).

Patton and Baum (2003) describe an incident where a police officer had stated that they did not understand the LGBTQ relationship and therefore did not enforce any punishment for the abusive partner. In the case of lesbian relationships, the judicial system is often stated to not enforce justice due to the perception of a mutual altercation based on traditional gender standards (Turell & Herrmann, 2008). The descriptive study, conducted by Whitehead et al., (2020),
sought to understand the prevalence and characteristics of IPV in same sex to heterosexual relationships within Canada. The researchers identified the occurrence that police officers may be unaware IPV has occurred, unless they inquire about the relationship of the persons involved and may therefore improperly report the incident (Whitehead et al., 2020).

Research presented by Blosnich and Bossarte (2009) addresses the shame felt by a significant number of female victims that experience IPV from their female partners. An example provided by Patton and Baum (2003), following the interview with an LGBTQ woman living in rural Ohio, was in the case of the more physically dominant partner experiencing IPV from their physically inferior partner. The woman described this experience as being very difficult to report due to the fear of being judged by law enforcement and not taken seriously.

Based on the literature, women in LGBTQ relationships are more likely to experience violence on the psychological or emotional level, as opposed to physical (Felix et al., 2016). Using data from the National Violence Against Women Survey (NVAWS), Messinger (2011) illustrated the victimization frequencies among sex and sexual orientation subsamples. This data suggested that gay women are two times as likely to experience verbal or controlling IPV victimization than physical. Additionally, couples identifying as bisexual are at a greater risk of experiencing IPV compared to those who identify as gay or lesbian. Biphobia may be responsible for these findings, as well as the lack of accessible resources and support for individuals identifying as bisexual (Guadalupe-Dias & Yglesias, 2013).

Marginalization of LGBTQ People in Rural Communities

In Canada, research pertaining to sexual orientation, gender identity, and expression has traditionally focused on large urban cities due to the higher numbers of LGBTQ people (Lee & Quam, 2013). Rural communities tend to rely more heavily on social networks and, therefore, the fear of exposing one’s sexuality elicits concerns of being judged by the community (Wendt & Hornosty, 2010). Some individuals have even expressed that they have experienced fear of losing their careers in response to employers discovering their true sexual identity (Bornstein et
al., 2006). A violation of the Canadian Human Rights Act created in 2017, that demands equal opportunity without discrimination against gender identity or expression.

The literature notes that LGBTQ-identifying individuals often experience ridicule and harassment, resulting in feelings of isolation. Such data were collected from Statistics Canada, Police-reported violence among same-sex intimate partners in Canada, 2009 to 2017 (Ibrahim, 2019) and a Canadian based study that interviewed LGBTQ women experiencing IPV (Ristock & Timbang, 2005). It has been identified that feelings of isolation are exacerbated within the context of rural communities due to limited access to services and resources as well as the traditional attitudes of the community, which inform negative perceptions towards the LGBTQ community (Bornstein et al., 2006 Ibrahim, 2019; Guadalupe-Diaz & Yglesias, 2013; Poon & Saewyc, 2009). Anonymity in this context refers to the ability to act freely without the fear of judgment from others. Fear of phobia and discrimination were also concerns expressed by the participants, secondary to the projection of ridicule based on identity (Turell & Herrmann, 2008).

**Help Seeking Behaviours of LGBTQ Women Following IPV**

Help-seeking behaviours are defined as the complex decision-making process motivated by a problem that challenges personal abilities (Cornally & McCarthy, 2011). Turell and Herrmann (2008), who conducted research with LGBTQ women living in rural communities, concluded that volunteers of social programs often lack training on same-sex IPV. Guides such as “providing inclusive services and care for LGBT people”, presented by the National LGBT Heath Education Center, are examples of ways in which organizations can train staff. Despite the shared interest in serving those of the LGBTQ community, many women who have experienced IPV have shared their concerns about the effectiveness of the service given the limitations on the training provided (Guadalupe-Diaz & Ygelias, 2013; Helfrich & Simpson, 2006; Ristock & Timbang, 2005; Rollè et al., 2018; Simpson & Helfrich, 2014; Turell & Herrmann, 2008).

Stigma towards sexuality is experienced both internally, between individuals within the LGBTQ community, and externally—from individuals who identify as heterosexual and cisgender to those who identify as LGBTQ (Felix et al., 2016; Furman et al., 2017; Ibrahim, 2019).
Individuals may be reluctant to seek resources due to fear of rejection from the LGBTQ community or of judgment from external sources for being associated with this community (Patton & Baum, 2002; Ibrahim, 2019). Many incidents involving IPV go unreported due to women either not recognizing their experience as abuse or because they fear the backlash they may receive from the LGBTQ community (Turell & Herrmann, 2008). Those who experience IPV may also be reluctant to seek health and social resources based on manipulation from their partner. The abusive partner may manipulate the women to remain in the relationship by threatening to expose their sexual identity and relationship to others (Furman et al., 2017). For example, the abusive partner threatening to expose the relationship to one’s family and community members if that partner has not yet “come out” (Furman et al., 2017).

Patton and Baum (2003) address an incident where a police officer had stated that they did not understand the LGBTQ relationship and therefore did not enforce any punishment for the abusive partner. The example had been provided by an LGBTQ woman in rural Vermont who has called the police following IPV. The participant shared that the police told her that they “don’t understand lesbian relationships” and told the abusive partner to take a walk and cool down rather than enforce punishment (Patton & Baum, 2003). In the case of lesbian relationships, the judicial system is often stated to not enforce justice due to the perception of a mutual altercation based on traditional gender standards (Turell & Herrmann, 2008). An example provided by Patton and Baum (2003) was in the case of the more physically dominant partner experiencing IPV from their physically inferior partner. A woman participant described this experience as being very difficult to report due to the fear of being judged by law enforcement and not taken seriously.

Evidence illustrates that rates of IPV within LGBTQ relationships is equal to or greater than IPV within heterosexual relationships (Blosnich & Bossarte, 2009). As discussed in Chapter Two, incidents of IPV are not only high but greater than the national average for police reported IPV (Ibrahim, 2019). Alarmingly, it is likely that these rates are even higher, since most IPV occurrences in the LGBTQ community go unreported (Ibrahim, 2019; Poon & Saewyc, 2009; Turell & Herrmann, 2008). One explanation for how prevalent the underreporting of IPV is
among LGBTQ people may be the ambiguity in defining what constitutes ‘assault’ (Peterson & Muehlenhard, 2004) or abuse that does not involve bodily harm (West, 2002). Women experiencing sexual abuse that does not involve penile penetration may be reluctant to share their experience because that is what the term “rape” traditionally implies (Ristock & Timbang, 2005). The unclear classifications for assault, in addition to the fear of not being taken seriously, has resulted in lower reports of IPV (Peterson & Muehlenhard, 2004).

The inability to express a person’s true self, can have lasting impacts on their self-esteem and self-image. The inability to be true to one’s self – through self-expression, identity and sexuality – can cause distress (Meyer, 2013). For groups that are not readily accepted, such as the LGBTQ community, this stress has the potential to cause lasting impacts on one’s mental health (Meyer, 2013). Introduced by Furman et al., (2017) minority stress is related to the experience of high levels of frustration faced by members of stigmatized minority groups, such as the LGBTQ community. This form of stress is said to accurately predict the behaviour of both partners in the relationship. Furman et al. (2017) also state that this stress can accumulate and, without release, can defer the woman’s attempts to seek support. The reason for this deferral is the fear of being further “victimized” and judged for seeking health and social services (Turell & Herrmann, 2008). Although the LGBTQ community represents many sub-categorizations of sexual preferences and gender identities, it is common for these sub-categories to be over-simplified and viewed as one (Turell & Herrmann, 2008). As a result, the communities have been misrepresented and therefore misunderstood within the research.

**Intersection of Rurality, Sexuality, and Help-Seeking Behaviours Following IPV**

IPV is a serious social and health issue that affects individuals across their entire life span. Current literature illustrates the stigma surrounding IPV, as well as discrimination that occurs when the intersection of gender, sexuality, and rurality is present, has lasting impact on a person. The discrimination experienced by individuals identifying as LGBTQ can be further expressed in rural contexts. Same-sex IPV victims living in rural communities are more than twice as likely than those in urban communities to request that the police take no further action on the accused abuser (Ibrahim, 2019). This may be due to some LGBTQ-identifying individuals experiencing
feelings of fear and discrimination, preventing them from seeking assistance following IPV in a rural community (Turell et al., 2012). In addition to the hesitancy to initiate help-seeking behaviours following IPV that may prevent a person from accessing health and social services, the reasons for not seeking help are not well researched; therefore, creating difficulty in accurately determining the prevalence of IPV within the LGBTQ community. The group is often researched as a whole, with no consideration for the vast amount of intergroup distinctions.

**Gap in Knowledge**

Consistent among many of the articles included in this literature review, was the issue of inadequate access to health and social services for people experiencing IPV. When including the addition of rurality, it was clear that availability of resources is frequently dependent on population density and perceived need. Rollè and authors (2018) suggested that LGBTQ-welcoming services, such as those that are universal for all people, are scarce in urban communities and even harder to locate in rural settings. Consequently, social isolation among the LGBTQ community is more common in rural communities due to this limited access to informative resources and support services (Bornstein et al., 2006; Ibrahim, 2019; Patton & Paum, 2002; Ristock & Timbang, 2005). Therefore, people who are both LGBTQ and rurally located, and have experienced IPV and are seeking help, face significant, intersectional, compounded barriers to support.

The literature review illustrates some of the barriers that exist for LGBTQ women seeking health and social services in the rural setting. Based on the addressed literature, it is evident that the intersection of gender, sexuality, rurality, and experience of IPV further influences the marginalization of a person. Such marginalization has the potential to hinder the ability to access health and social services secondary to IPV. Across the literature, themes of fear, discrimination, and isolation among LGBTQ people experiencing IPV were found. The literature frequently addressed select social factors, between IPV, sexuality, rurality, and help-seeking behaviours; however, no study addressed the intersection of these factors.

**Purpose**
The impetus for the study originated from Mantler et al.’s (2020) primary study *Sharing Personal Experiences of Accessibility and Knowledge of Violence: A Qualitative Study*. The primary study focused on rural women’s help seeking behaviours following IPV. From this sample, a subsample of four LGBTQ women was identified. The sample presented further barriers to accessing resources through the intersection of sexuality, gender, and their rural identity. The literature review indicates that this sub-group is not represented at all in current literature, and therefore requires further exploration. While the literature reviewed touches upon several of the key factors discussed here, there was no consideration given to all four intersectional variables that are the focus of this study. Therefore, the purpose of this study was to explore the intersection of gender, sexuality, and rurality on help seeking behaviours secondary to IPV among LGBTQ women.

**Research Question**

The research question guiding this study is: “*What is the experience of seeking health and social services for LGBTQ women in rural communities following IPV?*” The objectives of the study were to: i) describe how the women are seeking health and social services; ii) explore the challenges and facilitators of the women in seeking care.

**Methods**

**Theoretical Grounding**

The theoretical framework for this study is Intersectionality. Introduced by Crenshaw (1989), intersectionality challenges the notion of gender as the primary factor contributing to one’s experience. The theory argues that the experience of being a woman cannot be considered independently, but rather in conjunction with compounding factors that emphasize each other. Intersectionality is argued to address “the most central theoretical and normative concern within feminist scholarship: namely, the acknowledgment of differences among women” (Davis, 2008). Furthermore, the theory proceeds beyond the static perception of inequality to recognize the generation of inequality forms from one another that cannot exist independently (Stubbs, 2015).
The development of intersectionality aids in the mitigation of the widespread misconception that experience is entirely the sum of an independent oppressive factor such as sexism (Samuels & Ross-Sheriff, 2008). Broadly, intersectionality would propose that the reason women experience IPV is not solely based on LGBTQ identity, but also the influence of rurality confounding the experience. As previously mentioned, IPV has been historically viewed as the universal experience of violence generated against the female partner (Furman et al., 2017). However, the current understanding is that the experience of IPV within an LGTBQ relationship is just as unique as the relationship itself. The emergence of multiple, marginalized groups has introduced the notion that many facets of identity exist that require further research and understanding.

**Methodology**

This study was a secondary analysis of data from the primary study, *Sharing Personal Experiences of Accessibility and Knowledge of Violence: A Qualitative Study*, conducted by Mantler et al. (2020). For the secondary analysis, a case study design was utilized as per Heaton’s (2004) guidelines. Heaton’s Reworking Qualitative Data (2004) was used based on the facilitation of a reflexive approach to investigating the data of a secondary analysis. The method of secondary analysis used for this paper will be discussed further in “Data Collection”. The aim of this study was to explore the experience of help-seeking behaviours of LGBTQ women, living in rural communities, and who have experienced IPV. I aimed to identify if the intersection of gender, sexuality, and rurality pose any influence on the experience of health and social resource seeking behaviours of women.

**Sample and Setting**

The primary study consisted of eight women living in rural settings of Southwestern Ontario, who experienced IPV, and had used a health of social services within the past six months. The inclusion criteria were: (1) identifying as a woman; (2) being 18 years of age or older; (3) could speak/read English; (4) were using primary health care services within the prior 6 months; (5) using a rural women’s shelter in the prior 6 months, and (6) willing to be audio-recorded during a telephone interview. Of this sample, a distinct sub-group was identified which consisted of four
women from LGBTQ relationships. The sample presented further, and at times, unique barriers to accessing resources through the intersection of sexuality in addition their gender and rural identity.

**Sample Characteristics**

The demographic characteristics of participants are displayed in Table 1. The sample comprised of four women who each self-identified as within an LGBTQ relationship. All of the participants in the study self-identified as female, born in Canada, and were living in a rural community. The average age of participants in this study was 26.75 years and had been with an abusive partner for an average of 3.75 years.

**Demographic Results ($N=4$)**

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Count (n)</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place of birth</td>
<td>Canada</td>
<td>4</td>
</tr>
<tr>
<td>Highest level of education completed</td>
<td>Elementary</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Highschool</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>College/</td>
<td></td>
</tr>
<tr>
<td></td>
<td>University</td>
<td>2</td>
</tr>
<tr>
<td>Employment status</td>
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</tr>
<tr>
<td></td>
<td>Part-Time</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Full-Time</td>
<td>3</td>
</tr>
<tr>
<td>Annual household income (in thousands)</td>
<td>&gt;50</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>50-99</td>
<td>2</td>
</tr>
<tr>
<td>Rural* (In thousands)</td>
<td>&lt;30</td>
<td>4</td>
</tr>
<tr>
<td>-----------------------</td>
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</tr>
</tbody>
</table>

* Based on Ministry of Long-Term Care (2010) definition of an Ontario rural city

<table>
<thead>
<tr>
<th>Demographic</th>
<th>M</th>
<th>Sd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>26.75</td>
<td>5.25</td>
</tr>
<tr>
<td>Years with abusive partner</td>
<td>3.75</td>
<td>1.25</td>
</tr>
</tbody>
</table>

**Data Collection**

The primary study used interpretive description for data abstraction through the use of interviews. Interviews were conducted by the primary researcher and each participant. Data were collected via digital voice recordings, stored electronically and then transcribed verbatim to an electronic word document file.

**Data Collection**

Data collection for this secondary analysis was guided by Heaton’s Reworking Qualitative Data (2004) approach. The selection of this method was driven by the need to conduct a secondary analysis on a subset of the participants. As the data had already existed from the primary study, the appropriate coding of information was essential for the secondary analysis. Through using Heaton’s framework, I was able to maintain a reflexive approach to data collection. For instance, reflexivity provided a more effective and impartial analysis through the examination and conscious acknowledgement of my assumptions that may influence the results (Palaganas et al., 2017). I referred to Heaton’s guide throughout analysis to ensure that I didn’t impose bias to the data. Supplementary analysis was the type of secondary analysis selected for this study in order to conduct a more in-depth investigation of data that was not addressed by the primary research through the emergence of a post-hoc matter of interest (Heaton, 2004). This analysis explored the issues pertaining to the sub-sample of LGB TQ women within the primary population of rural women who have experienced IPV. The interests of the secondary analysis were unique to the
primary study and therefore conduct a more in-depth analysis of data that were of interest for this study. Similar to the primary study, the secondary analysis aimed to address the help seeking behaviours of women following the experience of IPV. The analysis of the data was structured as an adjunct to the primary study rather than as an alternative to it. To accomplish this intention, the structure and presentation of theme of the primary study was used as influence for the current study. An example being the use of participant interviews to support the stated themes. The data collection for the primary study will be described below.

In March 2018, ethical approval was granted for the primary study by the Health Sciences Research Ethics Board at Western University. Data collection was completed during interviews by the researcher. A short demographic questionnaire was completed by participants prior to beginning the session. The sessions ranged from 60 to 90 minutes in duration and were audio recorded in addition to the notes taken by the primary researcher. As I was involved in the primary study, I explored auto-data, a researcher or team’s data (Heaton, 2004), for the secondary analysis. I was able to re-examine the interviews and code only for the selected subgroup.

**Data Analysis**

The interviews from the primary study were obtained and used to shape this secondary analysis. For this secondary analysis, the study was positioned using an intersectional lens using an interpretive description approach (Thorne et al., 1997). The intersectional lens guides the understanding of complexity of oppression and discrimination that the population of interest experience (Thorne et al., 1997). As such, this theoretical framework facilitated the in-depth exploration of gender-based violence in the context of the combination and intersection of sexual identity and social location, therefore assisting in the understanding of the complexity of IPV through the multidimensional factors of sexual identity and social isolation.

Interpretive description was selected to guide data analysis based on the researcher’s presumptions of theoretical knowledge, clinical pattern observation, and scientific basis surrounding the phenomena of IPV within populations experiencing multiple discriminatory
factors and identities (Thorne et al., 2004). This was done while maintaining a reflexive approach to mitigate the potential of agglutinating to assumption and jeopardizing the premature closure of emerging conceptualizations. Thorne et al. (2004) describes this methodology to be the evolution to articulating the qualitative approach to clinical description through an interpretive or explanatory lens. This approach facilitates the grounding for the conceptual linkages identified between gender-based violence, sexual identity, and social location.

Transcriptions of the interviews from the data subset were collected for inductive analysis using Thorne’s (1997) approach of repeated immersion of data. The transcripts were once again reviewed, and hand coded by me to identify commonalities in pattern within each interview to identify patterns. Following initial coding, my master’s supervisor and advisory committee conducted their own review of the transcripts. The separate coded transcripts were merged to identify similarities and differences between the researcher’s analysis. The final stage was completed to assure all codes for theme and sub-categories were identified. A total of three themes emerged, along with the sub-themes that were reflective of the participants’ experiences. It was imperative to maintain a reflexive approach to data analysis to not impose a theme based on pre-existing opinion without reviewing the literature and data.

Reflexivity is the degree of influence that a researcher imposes on the findings that is either intentional or unintentional. Such influence, including values, preconceptions, and behaviours of participants, limits the quality of research by showcasing researcher bias rather than raw data (Jootun et al., 2009; Pagis, 2009). I practiced reflexivity by first acknowledging any pre-existing bias I may have towards the population of interest, including beliefs I may have developed in practice or from polarizing research, and then actively removing such thought to not interfere with the research. I practiced reflexivity while engaging in physical activity (Pagis, 2009), as this is a time, I practice mindfulness towards emotional growth. For instance, while running, I would have the peace and attention required to investigate my own prejudice and create strategies to overcome them. Data analysis was conducted independently by myself, my supervisors, and advisory committee before discussing findings. The use of collaboration facilitated a more in-depth analysis and conscious effort to not impose bias. By practicing reflexivity through physical
activity and group analysis, I was able to conduct an impartial analysis of the data to limit my influence on the results (Palaganas et al., 2017).

**Ethical Considerations**

The principal investigators of the primary study declared no potential conflicts of interest with respect to the authorship and/or the anticipated publication of this research. Ethical approval to conduct this study was granted by the Human Research Ethics Board (HSREB) at Western University. Participation in the study was voluntary, and the participants were informed of their right to withdrawal from the study if needed. As it was not necessary to do so for this study, I did not reobtain participant consent for the data accessed. To mitigate the risk of a privacy breach, all data collected were stored by the primary investigators and myself under Western’s institutional firewall. Additionally, all data were encrypted, and password protected per Western University’s institutional policies on research ethics.

**Limitations**

Limitations of this study pertain largely to qualitative secondary analyses research. As I was not present during the interview process, the risk of misinterpreting participant tone or intent was possible. Heaton (2004) describes this limitation as creating an issue by “fitting” data to the research question. The diversity of LGBTQ people and their identity(ies) were not represented in the study, as the existing sample only containing four participants. Furthermore, the participants were grouped as LGBTQ-identifying women and therefore the experience of lesbian, gay, bisexual, transgender, and queer people were not reviewed in isolation. This perpetrated the current limitation that exists for LGBTQ-specific research, as the identities were studied in collection and therefore the findings were generalized as such. Although the interviews enabled insight into the population of interest, the analysis reflects the lived experience of four women, and therefore cannot be generalized to all LGBTQ women who live in rural communities and have experienced IPV. Considering both the sample size and the diversity of the group, it is important that the results be considered within these contexts and taken as motivation for further research.
Findings

Descriptive Themes

Once the multiple stages of coding were completed, three themes emerged from the data: (1) *shame on us*, (2) *I can do this*, and (3) *expectation for equity in care*. Based on these themes, seven sub-themes emerged, including; *shame on us*, (1) rejection from resources; (2) Stigma around perpetrators of violence, (3) My partner may find me; I can do this, (4) *empathetic support systems*; (5) available support groups; *expectations for equity in care*, (6) desire for community understanding/education; and (7) required access to resources.

Participants

Participant names have been changed to maintain anonymity in the study.

Lisa. Lisa identified as a 25-year-old transgender woman who was living in rural Ontario. Lisa was recently divorced from her woman partner and was fighting for the legal custody of her children.

Mary. Mary identified as a 26-year-old woman who was living in rural Ontario. Lisa and her woman partner recently separated.

Heather. Heather identified as a 32-year-old woman who is separated from her woman partner. Heather lives in rural Ontario.

Stephanie. Stephanie identified as a 24-year-old woman who is separated from her former female partner. Stephanie lives in rural Ontario with her children.

Shame on us

This first theme, *Shame on us*, explores the negative experience of women in LGBTQ relationships accessing health and social services in rural communities. By sharing the lived experience of these women, this theme provides insight on the barriers and challenges that the women have faced when initiating help seeking. This theme includes the sub-themes of rejection
from resources, stigma around women being the perpetrators of violence, and my partner may find me. Each sub-theme presents the unique challenges associated with the steps required of women when seeking care.

**Rejection from resources.** The sub-theme, rejection from resources, captures women’s experience when initiating help seeking behaviours and the challenges that are associated with doing so. Women in the study recognized that access to a shelter was difficult at times based on shelter rules and policies. For most participants these issues were related to the inability to return to a shelter after leaving for a short period, for example, after a holiday weekend. For transgender women, access may be denied based on their biological sex. Lisa shared her experience of seeking a shelter as a transgender woman:

I couldn’t find a single shelter or assistance in order to separate [from my marriage]. I tried the women’s shelters in the Windsor area and they all obviously turned me away. They weren’t aware of anywhere that I could turn to for domestic violence assistance because I am trans… Because there’s no services, it is publicly unacceptable to discuss this, to even attempt to discuss this, or share this.

Additionally, Lisa shared her experience communicating her concerns with a local community member while seeking assistance.

Even the lawyer admitted that there was [*sic*] no services for me that he was aware of or could find. The lawyer is somebody heavily involved in this stuff multiple times a year. That’s somebody who would be or should be at least in contact or know how to get a hold of these services. I know the courthouse is full of services or brochures and helpful people to help you, guide you, through this process of how to get to these locations and do it safely and how to protect your kids and stuff. But for me, there’s just zip. Zip, zilch, nothing.

**Stigma around perpetrators of violence.** The second sub-theme, stigma around perpetrators of violence, captures the challenges that women experience when their perpetrators of violence are same-sex or trans. Historically, violence has been viewed as the power domination created by the
perceived superior partner. The consideration that violence could be enacted by the perceived inferior partner is often secondary. The data indicated that the perpetration of violence is based on who chooses to enact it, rather than based on stereotypical perceptions of violence. Meaning women are just as capable of enacting violence as a man, and vice versa.

Lisa spoke on her experience being the perceived dominant partner, as a transgender woman, experiencing abuse by her female partner:

> We have a massive stigma around women as the perpetrators of violence in this century, in domestic abuse. Shame on us.... I now have no faith in our legal system either. If the lawyers think like this – well the judges were lawyers before, so they think like this too. So, our court system and our legal system is [sic] biased against men within the domestic trade as well… Even the police in this country are biased against me as a victim of domestic assault.

**My partner may find me.** The final sub-theme of shame on us addresses the experience of women who have overcome the preliminary challenges of accessing resources, and the associated stigma, and now have to navigate the shelter experience. Captured by the theme, shame on us, the intention of this sub-theme examines how the system has failed those seeking care based on the existence of fear in an environment intended to provide safety and shelter. Shelters are frequently segregated by gender for the protection of those seeking help (Aspani, 2018). This design was driven by traditional, heterosexual relationship norms and negates those who differ from this. For those in same-sex relationships, this poses the risk that the abusive partner may locate the person. Although shelters are frequently aware of these situations, the fear may still exist for these women (Aspani, 2018). Heather spoke on her experience in a women’s shelter after leaving her female partner:

> Yes. With my partner being a woman it makes it hard for me to use the shelter because of safety…Yeah, like they know my partner is a girl and so they are not going to let her in, but when I’m in the shelter it makes me worried, because I am afraid I see her when we are in here.
Mary shared her fears when accessing care following her experience of IPV:

A barrier for me would have been even just, at that point, just leaving because it was scary. You didn’t even really know what was going to happen. My ex-partner was a little bit crazy, so she had a tendency of just showing up places. So, there is this fear of being able to get out.

**I can do this**

The second theme, I can do this, highlights the facilitators that exist for women in LGBTQ relationships when seeking health and social services in rural communities following IPV. A facilitator is a person or thing that reduces the difficulty of an action or process. The sub-themes include empathetic support systems and available support groups.

**Empathetic support systems.** Despite the hardships experienced following IPV, the LGBTQ women in this study acknowledged that the health and social centers staffed attentive and supportive individuals. Mary shared her experience with the shelter’s doctor.

She’s actually really great. My first appointment with her, there’s obviously – doctors are busy they schedule – but my first appointment with her was almost two hours. She actually asked me questions like, “What kind of traumatic things have happened in your life? How do you think this impacts your life?” I was able to tell her I’m having nightmares and she’s asking, “Is it the same nightmare? Are they recurring? Is it something that actually happened? Are they more like a memory?” She’s been really great, but it took me a long time to get there… She’s the first person to ask.

**Available support groups.** Where, *available support groups*, represents community inclusiveness where members of the LGBTQ community came together to support one another. One participant spoke on her discovery of a support group for transgender women, such as herself, that was greatly advantageous for social connection. Despite such resources being available, Lisa indicated that they are frequently independent of government funding.
Well, I found a trans support group… The group turned out to be self-funded. They had no government assistance. There was a half a dozen or so that would meet every couple [of] weeks. However, if somebody needed to meet more often for a while they would. They looked after each other really well and I ended up – it felt really good in the beginning and I kind of connected with one of the women right off the bat.

Heather expressed the conflict she felt during shelter-run support group meetings. Heather shared the hardship in being surrounded by women after leaving her female partner. This is a reality that women in LGBTQ relationships may face when accessing female-only organizations.

Expectations for Equity in Care

The third theme, Expectations for equity in care, addresses areas that the participants indicated as having importance for their needs moving forward. The sub-themes include desire for community understanding/education and require access to resources.

Desire for community understanding/education. The sub-theme, desire for community understanding/education, captures women’s wish for greater community knowledge. The participants in the study frequently addressed their wish for community understanding. Although she was seeking supports to leave an abusive environment, Stephanie addressed her feelings of disapproval and isolation from the community she lived in. Such understanding may be related to the LGBTQ relationship, experience of IPV, or need to access government resources.

I think just that people should realize that abuse comes from all different backgrounds… allowing the community to understand that the women are there to escape abuse, and we’re not there to cause issues or bring violence into the area. We’re just looking to live a normal life like everyone else… But there’s a lot of us in there that come from educated
backgrounds who have just fallen through the crack due to circumstances, and they’re just trying to get back up.

Heather also expressed her opinion and wish for public acceptance:

Yes, I just wanted to feel safe. Maybe just if people realized abuse is not the same for all people and is different depending on who your partner is.

**Require access to resources.** The final sub-theme captures women’s expressed need for increased access and greater supports. Across all the participants, the need for increased access and greater supports has been stated. Lisa expressed her concerns with current government involvement in support surrounding IPV within LGBTQ families.

So, the system – at every experience I’ve had in order to protect my children, access my children, legally, in the process that has been laid out by our government for our citizens – has been broken in every step of the way. I have told multiple groups, multiple people, media, my MP, my MPP and there is literally no one who will try to do anything let alone bring it into the public eye. So, if you’re trans in this country you will get nowhere in family law… domestic violence or be able to protect your kids.

The interviews indicated the complexities that exist for women in LGBTQ relationships when navigating health and social services for IPV. The passages include the factors that both influence and hinder a women’s ability to access care as well as the requirement for greater public understanding and education. The themes, *Shame on Us, I can do this, and Expectations in Equity of Care*, capture the areas in which the interviews presented importance and commonalities. While frequency in barriers is noted among the participants seeking care, facilitators were noted to exist. Such findings are promising to provide guidance for current and future resource creation.
Discussion

The findings of this secondary analysis capture some of the experiences – both positive and negative – that are present for women in LGBTQ relationships in accessing health and social services in their rural communities following IPV. Among the four women, three were able to access a shelter in their area, while one was turned away based on their sexual identity. This fourth participant was denied access to women-centred care and services because she was a transgender woman. Turell and Herrmann (2008) highlight that, although resources may be available, the homophobic, transphobic, or heterosexist nature of these institutions may present challenges for women in LGBTQ relationships. Aspani (2018) also addresses the phenomenon of shelters denying access to transgender women based on their perceived threat to the other women. Domestic violence shelters are at times presented as “women-only”, which can be interpreted as providing an empowering, safe space for women. However, this poses unique difficulty to transgender women when seeking help secondary to IPV. Federal policies such as the Canadian Human Rights Act, created in 2017, are designed to give equal opportunity and to eliminate discrimination against gender identity and expression. Leaving an abusive partner poses great challenges for the individual, and the inability to access resources secondary to this experience can be further isolating and can lead to hesitancy/avoidance in seeking safety and/or care (Ibrahim, 2019).

One participant indicated that the risks associated with leaving the shelter to access resources led to uncertainty as to whether the woman will get food that day, or in another case, let her back into the shelter. The inability to access resources within the shelter and the distance required to travel for care may hinder a woman’s ability to access care (Mantler & Wolfe, 2017). Along with the sub-theme of lack of availability with resources, one participant stated their perceptions of receiving “substandard care” while in the women’s shelter. Hart et al (2005) indicated in their study that women’s shelters in rural areas are described to be of limited supply and provide fewer health and social services. These findings are similar to those identified within this secondary analysis, where participants expressed frustrations with the resources available to them while in a
women’s shelter. Brems et al., (2006) collected a sample of 1,500 health care providers in the United States to study the influence rural and urban communities have on barriers to healthcare. The results of this study indicated that small rural practitioners have extremely limited access to colleagues for consultations, referrals, and special expertise. Statements of poorer access to health care providers and facilities is also supported by Lutfiyya et al., (2012); however, they contrast the notion of the overall hindrance of health. The researchers of this study suggest that rural communities encompass stronger support systems which may be protective to community health. This study did not indicate sexuality as a variable to its findings. Strong community ties have been noted to pose negative influence on couples in LGBTQ relationships, as pre-existing bias may hinder a woman’s action of help seeking behaviours (Wendt & Hornosty, 2010).

All participants indicated that there were no mental health support services available to them within the shelter. The availability of a social worker was presented to all women; however, a psychiatrist, psychologist, or any other mental health-trained professional was not present. The participants indicated the desire for a specialized professional to access while in the shelter. A qualitative study conducted by Rasool (2012) considered the experience of abused women when accessing social workers in shelters. The study indicated that women generally lack knowledge of the existence of social workers or are unaware of the role they can play in situations of IPV. Agresta (2004) compared and discussed the roles of counselors, social workers, and psychologists in school-based professions. The roles differ in educational requirements as a psychologist is a master or doctoral prepared career, social work is a masters prepared career, and a counselor has an undergraduate degree and have obtained licensure (Johnston, 2000). Of the three roles, a counselor is most present in rural areas followed by a social worker then psychologist (Agresta, 2004). Such data suggests the potential limitation that exists for those seeking care in rural communities if the expertise of a psychologist is required. In contrast, this data is also favorable in indicating that trained professionals are available, and the discrepancy lies within the knowledge to connect with them, a problem that is less complex to solve.

Hesitancy to speak with community members was addressed by one participant as a barrier to them receiving appropriate care from a healthcare provider. Members of LGBTQ relationships
have been noted to experience feelings of isolation (Ibrahim, 2019; Ristock & Timbang, 2005) that can be further exemplified by the inability to speak candidly with a care provider. One participant indicated that they felt that they could not speak to police officers nor lawyers about their experience, because of lack of understanding. The participant shared her feelings of bias based on being a transgender woman experiencing abuse by her female partner. Patton and Baum (2003) speak on this phenomenon, where police officers shared their inadequate understanding of those in LGBTQ relationships, and therefore hesitancy in enforcing punishment towards the abusive partner. Furthermore, the judicial system is perceived to not enforce justice based on the perception of mutual altercation based on biased gender standards (Turell & Herrmann, 2008).

The final barrier to access that emerged was the fear of the abusive partner finding the woman at a shelter. As women’s shelters exist to create a safe space for women, there is potential risk that the same-sex partner may enter the shelter in search of their partner. Shared experiences of cis-gendered, heterosexual women indicated that fear of abusive partner finding them was of concern when entering a shelter (McLeod et al., 2010). The participant stated that the shelter would not allow such a thing to happen, however, literature does not clearly identify if this phenomenon exists for others. Based on the limited literature on the sub-theme, it is unclear if all shelters have rules in place to prevent an abusive, same-sex partner from finding their partner.

Although many barriers were found which hindered the participant’s ability to access all the needed resources, there were facilitators that exist to support women. One facilitator was the empathetic and helpful staff that were connected to the women’s shelters. Based on the compounding factors of IPV experience, rurality, and sexuality on a woman’s identity, feelings of isolation have been identified to influence the person in seeking care (Hart et al., 2005). Based on the participant interviews, the ability to speak to someone that is perceived as trustworthy and helpful can motivate a woman to seeking care. Furthermore, the availability of support systems within the agency can provide additional support to someone. Although the transgender support group was self-funded, the space was stated to bring connection amongst the women. Government support would provide great relief to people in LGBTQ relationships, through the
facilitation of creating safe spaces and social connections as well as removing the financial burden from those participating.

The availability of support groups was an indicated facilitative factor that exists for those who wish to participate. For one participant, the ability to speak candidly with a group of transgender individuals, like themselves, was a positive experience. Such support groups exist to encourage positive environment. Mallory et al., (2014) addressed the use of peer mentorship programs for LGBTQ youth in the United States. The paper indicated that LGBTQ youth benefit from mentorship programs through the reporting of fewer depressive symptoms, feeling greater acceptance by their peers, more positive beliefs, and other variables of interest related to the age group. Government attention and funding towards the enhancement of such resources would pose great benefit to rural community health.

The final theme, of expectations of equity in care was presented to represent the common goals stated by the participants moving forward. The two overarching sub-themes identified are the desire for community understanding/education and the requirement of access to resources. An influential factor to contribute to women not seeking care is the fear of community judgement and the potential to jeopardize relationships (Wendt & Hornosty, 2010). Therefore, the need for increased public education on the topic would be beneficial to those gaining the insight and those seeking care. Such education may motivate others to seek care, based on the understanding that their experience can be empathized by others. With more people seeking care, the need for more resources and greater access is needed. People who are seeking care require shelter and assistance, therefore, further policy is required to support this.

Implications for Future Research, Practice, and Policy

Despite limitations of the study, the findings of the secondary analysis provide promising implications for future practice, policy, and research. Research has presented the complexities of service provision for rural women in LGBTQ relationships for IPV. Future research should seek to expand the participation of people who identify as LGBTQ or are in LGBTQ relationships. Doing so will further diversify the results and capture data that are more representative for each
LGBTQ identity. By increasing participant recruitment based on LGBTQ identity or relationship, future research may further explore the experience of accessing health and social services in rural communities for IPV. Future research is encouraged to explore the potential variations in data abstracted from all representation within the LGBTQ identity in rural context. Where the experience of initiating help seeking behaviours may be unique from one sexual identity to another’s. Some expressions of identity may pose benefit when seeking care where others can introduce challenges that are exclusive for such couple. Therefore, a more diverse sample is encouraged to identity such potential discrepancies.

Considering the evidence, gathered by this secondary analysis and the review of existing literature, the existence of difficulty in accessing health and social services is clear. The following foci are required and compatible with other recommendations in the literature (Bornstein et al., 2006; Edwards, 2015; Felix et al., Guadalupe-Diaz & Yglesias, 2013): (1) accessibility to those in need, (2) exploring alternative methods of IPV reporting to maintain confidentiality and autonomy, (3) improved knowledge to first responders and service providers on IPV, (4) funding for supportive services for minority groups, and (5) public education and efforts to enhance awareness.

Addressing IPV among women in LGBTQ relationships in rural communities is a complex and multifaceted process that demands coordinated community response. The collaboration between government, law enforcement, community leaders, community members, and other stakeholders, is critical for equitable access to care. From these unions the creation of programs, policies, and efforts become possible. The Universal Human Rights can be applied to the fundamental requirement of access to health and social services as a requirement for all people. One example is the entitled to all the rights and freedoms included in the declaration, without distinction. Congruent with the aims of the secondary analysis, such distinctions include gender, sex, sexuality, or location of residence. Another right is that everyone has access to standard living that is adequate for the health and well-being, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
(United Nations, 1948). Such rights illustrate the requirement for all people be granted equitable access to care, and that such care be independent of demographic variables.

Within rural communities, the experience of seeking health and social services for IPV is unique. The data collected for this paper identify barriers related to seeking care and disclosing experiences of IPV with community members (Wendt & Hornosty, 2010). Noted in rural communities, relationships between the doctor and patient often involve family or in some cases mutual friends (Townsend, 2009). This experience may pose barrier to a woman disclosing her experience of IPV. Future practice would benefit from the exploration of alternate methods to IPV disclosure to protect autonomy and encourage greater frequency in reporting.

As previously stated, incidence of IPV is under-representative as most cases of IPV go unreported to law enforcement (Burcycka, 2018; West, 2002). The literature search as well as participant interviews addressed the perception that law enforcement does not provide equitable support for rural women in LGBTQ relationships and experience IPV (Turell & Herrmann, 2008). Police shared their perception of a limited understanding in providing support for LGBTQ people and therefore being hesitant to enforce punishment towards the abusive partner (Patton & Baum, 2003). The Universal Human Rights state that all are equal before the law and are entitled without any discrimination to equal protection of the law. Additionally, everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him (United Nations, 1948). Although literature and interviews spoke on law enforcement, employees of health and social services are encouraged to develop sincere collaborative communication to facilitate in the delivery of equitable care. In doing so, those who experience IPV may experience greater facilitators to accessing appropriate care. The findings of this paper should encourage reflection for those in applied fields, including social service employees, healthcare employees, police enforcement, and those involved in the criminal justice system. Discrimination and phobia exist for LGBTQ people when seeking health and social services for IPV in rural communities.
The benefits of social connection are numerous, where the relationships one creates with others satisfies a critical human need required for fulfillment. The dehumanization associated with violence, aggression, and discrimination are influential factors towards a person’s perception of self (Waytz & Epley, 2012). The discussion provided a study from the authors Mallory et al., (2014) as an example of the positive outcomes of mentorship programs. The study addressed the use of peer mentorship programs for LGBTQ youth, indicating the benefit from mentorship programs. Such conclusions were drawn from the reporting of fewer depressive symptoms, feelings of greater peer acceptance, and increased positive beliefs among other variables of interest. These examples provide support of the benefits of safe space creation for those experiencing marginalization of gender, sexuality, rurality, and experience of IPV would pose great benefits. Public funding towards such practices would create an equitable way for those who experience IPV to access support. Community readiness is crucial for a change to occur, which literature has illustrated to be difficult in rural township when addressing IPV (Pruitt, 2008).

**Conclusion**

The study aimed to gain a better understanding of the help-seeking behaviors of rurally residing LGBTQ women who have experienced, or who are experiencing IPV, as they access health and social service-related resources. The three overarching themes of this secondary analysis were: **shame on us, I can do this, and expectations in equity of care** which reflect the barriers, facilitators and expectations that exist for those seeking care secondary to IPV. The barriers that exist for the women are related to healthcare or social worker availability, lack of community support, and stigmatization surrounding traditional perpetrators of violence. Such barriers have been exemplified to hinder a woman’s ability to access the support that is necessary. The interviews address that although resources may exist, the availability is dependent on person and timing. For those who have transitioned and no longer identify as their biological sex, the experience of accessing women specific resources is problematic and at times impossible. Furthermore, for those who have been granted access to the shelter, the ability to seek further resources is difficult based on the limited availability. While there are factors that may hinder a
woman’s ability to seek care, there are supports and resources that exist to do so. Access to appropriate and safe resources that are government funded have demonstrated the greatest positive impact on women accessing care. The influence that government has on practice and policy is significant, when and where it exists. Continued research on the population of interest would provide valued information to aid in the destigmatizing surrounding IPV and therefore fostering of government aids.
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Curriculum Vitae

Name: Emily Soares

Education: 2014 – 2018 Bachelor of Science in Nursing Western University London, Ontario

2018 – 2020 Master of Science in Nursing Western University London, Ontario

Honours and Awards: 2019 Ontario Graduate Scholarship

2018 Ontario Graduate Scholarships Academic All-Canadian

Related Work Experience: 2018 – Present Research Assistant Western University London, Ontario

2018 – Present Registered Nurse Parkwood Hospital London, Ontario