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Perceptions of and Experience With System Responses to Female Same-Sex Intimate Partner Violence

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Abstract

Female same-sex intimate partner violence (FSSIPV) is a significant problem that affects the physical and mental health and the safety of sexual minority women. A mixed-methods study was conducted to (a) identify risk and protective factors for victimization and perpetration of repeat violence in abusive same-sex relationships and (b) examine participant experiences with system responses (by domestic violence services, criminal justice systems, and health care services) to FSSIPV. The purpose of the article is to report the findings from the qualitative component (e.g., focus groups and individual interviews) of the parent study that are specific to survivors' perceptions of and experiences with domestic violence services, criminal justice systems, and health care services. The findings indicate a significant need across all systems for increased awareness, enhanced understanding, and provision of services specific to survivors of FSSIPV.

Keywords

same-sex intimate partner violence; sexual minority women; system response to intimate partner violence; qualitative methods

Female same-sex intimate partner violence (FSSIPV) is a significant problem that affects the physical and mental health as well as the safety of lesbian, bisexual, and transgender women (Poorman, 2002; Ristock, 2003). Prevalence estimates of FSSIPV have varied widely (8%–60%) because they are often based on small or convenience samples and have used varying definitions of violence, time frames, and sampling procedures (Glass et al., 2008). The National Violence Against Women Survey is the only population-based study that has included FSSIPV. Tjaden, Thoennes, and Allison (1999) found that of 79 women who reported cohabitation, 11.4% reported a lifetime prevalence of physical or sexual violence by a female partner. Rose's (2003) community-based study used a convenience sample of 229 lesbians and reported that 12.2% of women had experienced at least one incident of intimate partner violence (IPV) in the past year. This prevalence estimate is consistent with estimates of past-year IPV in heterosexual relationships (Tjaden & Thoennes, 2000).

Although such violence is frequently undocumented in the legal system, the problem is substantial and growing. Among the 12 regions reporting data to the National Coalition of Anti-Violence Programs (NCAVP), there were substantial increases in the documented reports of SSIPV between 2006 and 2007 in Chicago (+68%), Tucson (+37%), Kansas City (+27%), and San Francisco (+23%) (NCAVP, 2008). This increase may reflect improved reporting procedures as well as an increased acknowledgment of FSSIPV and more

willingness of same-sex survivors to report their abuse. In 2007, 48% of the total reports of SSIPV in the United States were from women, with the Seattle region reporting that 70% of their hotline calls were from women (NCAVP, 2008).

While research on IPV among heterosexuals has progressively expanded over the past 30 years, a similar increase has not occurred with regard to addressing FSSIPV. However, the body of literature on FSSIPV is growing, and efforts to highlight this issue and considerations unique to this kind of violence have received increased attention over the past 15 years.

In FSSIPV, survivors and batterers share some similar risk factors for experiencing or perpetrating violence in an intimate relationship. These include witnessing parental violence, previous experience of child abuse, experiencing physical and/or sexual violence in a previous relationship with a male or female, substance abuse, depression, and ending the previous relationship (for extensive review and meta-analysis, see Riggs, Caulfield, & Street, 2000; Stith, Smith, Penn, Ward, & Tritt, 2004). First researched in heterosexual couples, these risk factors have been found to be similar in same-sex couples who experience violence in their relationships (Glass et al., 2008; Renzetti, 1992; West, 2002).

It is important to note that despite the recognition of these risk factors in FSSIPV, the majority of existing risk models, risk assessment instruments, and prevention and intervention strategies have been based primarily on the characteristics of heterosexual samples and later applied to FSSIPV (Hassounah & Glass, 2008). Scholars have expanded the feminist analysis of gender-based violence to include the intersection of gender with race/ethnicity, class, and homophobia and how these factors affect survivors and perpetrators of violence differently based on previous experiences and current realities (Crenshaw, 1995). For example, Balsam and Szymanski (2005) reported on the impact of minority stress (e.g., internalized homophobia and external discrimination) as a risk factor for IPV that is unique to same-sex relationships. However, research examining the intersection of IPV and homophobia is limited, and this knowledge deficit hampers community agencies, health care professionals, and criminal justice and legal systems in assessing, treating, and implementing interventions specific to survivors and perpetrators of FSSIPV.

This article seeks to build on previous research by addressing the gap in knowledge related to FSSIPV survivors' perceptions of and experience with domestic violence services, criminal justice systems, and health care services. The findings from this research provide useful insights for the development of systems that reflect an increased awareness and enhanced understanding of FSSIPV and that offer tailored services to support its survivors and sanction its perpetrators.

BACKGROUND

Research is limited regarding the extent and nature of FSSIPV survivors' perceptions with traditional service systems and their experience with these systems; including domestic violence service agencies and criminal justice and health care services. Recently, Bornstein, Fawcett, Sullivan, Senturia, and Shiu-Thornton (2006) reported qualitative findings from a study that examined the sexual minority women (SMW) community's perspective on IPV. Isolation was described as central to experiences of IPV, and participants discussed a variety of isolation tactics specifically experienced by SMW communities. Isolation also contributed to the difficulties they experienced in seeking help. These women often did not access mainstream community domestic violence services because of concerns about homophobia and transphobia. Instead, the participants noted the importance of friendship

and community networks, sharing information about FSSIPV, and holding batterers accountable for their behavior (Bornstein et al., 2006).

Other studies have examined the barriers encountered by FSSIPV survivors seeking assistance from the perspective of either the survivors themselves or the resource providers. Invisibility of FSSIPV within society, as well as the heterocentric responses they received from friends, families, and resource providers, constituted a key barrier for SMW interviewed in Australia (Irwin, 2008). Simpson and Helfrich (2007) interviewed providers and found their perceptions of barriers to include systemic barriers on the societal level, institutional barriers on the organization level, and additional barriers on the individual level.

A great deal of discussion has been dedicated to the role of law enforcement and health care in addressing IPV. Much of the research on the responses of the law enforcement, legal, and health care systems to IPV has concentrated on IPV in heterosexual relationships (Pattavina, Hirschel, Buzawa, Faggiani, & Bentley, 2007). However, a number of studies have begun to highlight the existence of racial and ethnic disparities in the help-seeking behaviors of abused women (Bauer, Rodriguez, Quiroga, & Flores-Ortiz, 2000; El-Khoury et al., 2004; Henning & Klesges, 2002; Krishnan, Hilbert, & VanLeeuwen, 2001), but few have examined the role of homophobia and discrimination against sexual minorities in the disparities in help seeking across diverse systems. While some barriers to accessing criminal justice, health care, and domestic violence resources by survivors of heterosexual IPV have been identified, such as a lack of culturally and linguistically competent services, these barriers have rarely been examined in the context of FSSIPV. Even though these barriers may prove to be the same for survivors of heterosexual IPV and FSSIPV, they may pose a greater obstacle for SMW, given their marginalized status in society.

STUDY OBJECTIVE AND AIMS

The data reported in this article represent an analysis of the qualitative data gathered in a mixed-methods study that was conducted to (a) identify risk and protective factors for victimization and perpetration of repeat violence in abusive same-sex intimate relationships and (b) examine reports on system responses to FSSIPV (by domestic violence services, criminal justice systems, and health care services). The article focuses on survivors' perceptions of and experience with the system response (specifically, domestic violence services, health care services, and criminal justice systems) to FSSIPV. The findings expand our understanding of SMW's experiences and identify areas in which response systems can be improved to reflect a greater appreciation of the needs of this often-underserved population and to address the FSSIPV they have experienced.

METHODS

Participants

SMW living in Oregon and self-reporting current or past-year SSIPV (i.e., physical, emotional and/or sexual violence perpetrated by their current or former same-sex partner) were eligible for participation in this study. A total of 47 survivors participated in this qualitative component of the parent study: 41 participated in group interviews and 6 in individual interviews. Participants ranged in age from 15 to 64 years. Four participants were 15 to 17 years of age, and 10 women defined themselves as belonging to racial or ethnic minorities. Only one participant was self-identified as a transgender woman; therefore, the extent that our findings can be applied to this population is unknown (Hassounah & Glass, 2008). We included adolescents (those 15–17 years of age) in our study as recommended by our community partner, the Sexual Minority Youth Resource Center (SMYRC). SMYRC

provides services to sexual minority youth (15–24 years of age) who are often rejected by their families because of their sexual orientation and may experience homelessness, be living independently, or be living with an abusive intimate partner. The two-phase mixed-methods study was approved by institutional review boards (IRBs) at Oregon Health and Science University and Johns Hopkins University.

Data Collection

The study was advertised through sexual minority organizations, their newsletters, e-mail listservs, and regularly scheduled activities, including weekly support groups. It was also advertised through avenues such as statewide sexual minority newspapers, bar/social locations, university campuses, Craigslist, and domestic violence agencies. There were also several word-of-mouth referrals that occurred once the study was under way.

Women interested in participating used the toll-free 800 telephone number included on all study materials to contact members of the research team for information about the study. Those calling were informed that the study was exploring domestic violence in lesbian, bisexual, and transgender female same-sex relationships. A woman was eligible if she identified herself as a FSSIPV survivor. IPV was denned as physical (e.g., being pushed, hit, slapped, choked, kicked, or punched) and/or sexual violence (e.g., being forced to have sexual intercourse) or a threat of physical and or sexual violence during the past year.

Women were informed that the parent study's goals were to reduce the risk of repeat violence in abusive female intimate same-sex relationships and to improve domestic violence, criminal justice, and health care organizations' resources and programs. If an eligible woman self-identified as a survivor of IPV, she was asked to provide her abusive partner's name to the study team; this was an IRB-approved process intended to prevent the woman's perpetrator from entering a focus group with the survivor. Those who were eligible were informed of the safe and convenient location and times for the focus groups. Most groups were conducted at our partner agencies, at locations known by the participants. Eligible women who indicated that they were more comfortable in a one-on-one environment and wanted to complete an individual interview chose a safe location and time for the interview. Verbal informed consent was obtained from each participant, and participants were provided a \$20 reimbursement for their time and expertise.

We used a semistructured interview format for both individual interviews and focus group discussions. As is standard for such qualitative techniques, we began the interviews and discussions with general questions (e.g., "What do you think domestic violence is? How would you define it?"), and, using those definitions, we progressed to more specific (and in this study, more sensitive) questions, such as asking participants to share examples of violence they had experienced. While the moderators used a semistructured interview format, they did allow flexibility for clarification and probing. Natural conversation, including new thoughts and ideas, was also encouraged. All focus group discussions and interviews were audiotaped.

Several strategies were implemented to protect the study participants while maintaining confidentiality: participants were informed that they could end their participation in the focus groups or interviews at any point, and appropriate domestic violence service referrals would be provided. All discussions and interviews were conducted in private; that is, persons were not present or within hearing distance of the focus groups or individual interviews if they were not associated with the study. Research team members were trained in the assessment of immediate danger as well as procedures for ensuring participant safety during study participation. As an additional safeguard, all participants were asked for permission to audiotape the focus groups or interviews, and personal identifiers were not

collected from participants. In addition, women were reminded prior to initiating the discussion that information shared among the group was to be kept confidential. The women were encouraged to share only what they felt comfortable discussing in front of others, as challenges in ensuring absolute confidentiality are a limitation of focus group methodology.

Analytic Process

The recordings from the focus groups and the individual interviews with women who self-identified as survivors were transcribed verbatim and saved electronically. The transcripts were reviewed for accuracy by the investigators who facilitated the groups and conducted the individual interviews.

Thematic analysis was performed on all the narratives. We reviewed the transcripts four times, with each read providing a deeper level of contextualization and analysis. In order to gain a global understanding of the content and context of each narrative and to identify possible themes to explore, we first read all the transcripts in their entirety. The second read allowed us to identify data that addressed the question “What is the perceived system environment and response to same-sex intimate partner violence, and how does this impact an abused woman’s experience?” During this read, we found that many of the narratives referred to the perceived community response as a key factor in influencing the woman’s likelihood of accessing and utilizing available resources.

The narratives were then uploaded into NVivo 7 (QSR International Pty Ltd, 2006). During the third read, we used initial, inductive coding, thereby allowing the participants’ perceptions and experiences to lead the categorization and avoid forcing molding the data into preformed categories (Miles & Huberman, 1994). Our open coding of the narratives used the terminology of the participants and indicated the system (police, legal, health care, or domestic violence services) that was involved. We then examined these individual preliminary codes for initial impressions of commonalities and differences across the focus groups and individual interviews. Sixty-seven codes (e.g., pieces of data) were generated on the basis of our preliminary analysis.

The fourth, systematic reading was done across transcripts and codes, making comparisons and identifying patterns that occurred within and across focus groups and individual interviews. We also explored possible relationships and associations between codes. These pieces of data were then combined into “meaningful units according to relatedness into larger units, known as themes” (Leininger, 1985, p. 61). Identified themes brought “together components or fragments of ideas or experiences, which often are meaningless when viewed alone” (Leininger, 1985, p. 60).

We then examined the code files for exemplars to illustrate each theme and/or subtheme. The following criteria were used when selecting exemplars: (a) logical fit with themes, (b) clarity and strength in message, (c) diversity in speakers, (d) ability to mirror subtle nuances in themes, and (e) singular usage (to avoid using exemplars more than once) (Hassouneh & Glass, 2008). When selecting the exemplars, we referred back to the narratives from which they were extracted to ground ourselves in their context, thereby ensuring optimal accuracy of intent. To ensure representativeness, we also compared the chosen examples with the other data that had been coded similarly.

Authenticity and Trustworthiness of Qualitative Data and Analysis

Qualitative interpretation requires the implementation of safeguards to ensure credibility, confirmability, and authenticity (Tobin & Begley, 2004). Credible interpretation must be a good “fit” between the respondents’ views and experiences and the researcher’s interpretation of them (Tobin & Begley, 2004). The interpretation process must be sound

and relatively free of biases during the research process. Although member checking was not an available tool for use in this analysis, one of the authors (N.G.) was the principal investigator who facilitated many of the group and individual interviews and was well engaged with the material. After each read, the three authors discussed their findings, checking for accuracy of interpretation.

We employed peer review and debriefing during the analytic process as a qualitative mechanism analogous to assessing interrater reliability in quantitative research (Creswell, 2003). During the first three phases of the iterative coding process, we each read the narratives independently and drew our own conclusions. We then came together and discussed our findings and interpretations as necessary during the analytic process to ensure consistency in interpretation.

RESULTS

This article provides an overview of findings from the analytic category “The Influence of Systemic Incapacity to See and Address Same-Sex IPV on Women’s Experience of Violence.” Themes belonging to this category included (a) reinforced marginalization: “We are beyond second class”; (b) system incompetence: “Laughing it off”; and (c) compounding abuse: “If you can’t protect us, at least don’t abuse us.” The themes were derived from the common perception and experiences of the participants. Table 1 provides an overview of the themes and related subthemes.

Reinforced Marginalization: “We Are Beyond Second Class”

Survivors often voice feelings of shame and marginalization when they come into contact with the social service and criminal justice systems, as though they are somehow to blame for the abuse. At the same time, sexual minorities in the United States exist within a larger societal context that operates under the assumption that lesbian, gay, bisexual, and transgender individuals are flawed, deviant, or immoral. Those experiencing FSSIPV may undergo feelings of *peripheralization* from being in an abusive relationship compounded by the societal prejudice against their identities as sexual minorities. Participants in this study who utilized services such as law enforcement, health care, and domestic violence services to address their abuse found this homophobia to be pervasive within the systems they accessed. These women’s interactions were tainted by this underlying prejudice. A survivor said,

I called the police, uh, you know the second squad car comes, and the officer walks down, and he goes, “It’s just a couple of dykes, whatever,” and they walk off. I get to the police station and they call me Charlize Theron, because I had straggly blond hair at the time, and I’d had the crap beat out of me, and I pretty much looked like her from the movie “Monster.” And then, the way they treated us during the interviews and stuff, it was just so different from anything I’d ever seen or experienced. And it was like, we were beyond second class.

This marginalization can prove to be a substantial barrier to seeking help, as evidenced by one woman who said, “How many times does it take for a lesbian that’s being battered in any situation to call the cops?... It took two years for [me].” Several survivors voiced similar hesitancy to engage with law enforcement because of the prejudice they felt they would receive. This perception was based on some women’s direct experiences as well as friends’ stories from survivors who had not engaged with law enforcement.

Another participant witnessed marginalization in the health care systems. One survivor who worked as a nurse saw the reaction of other nurses when a lesbian came in for care after being abused. She said,

The other nurses were... judgmental. Because it was domestic violence and it was same-sex, somehow it was worse and maybe she deserved it. Or, you know, in other words, [instead of] the kind of help or support that you'd normally give to someone, even in the face of an abuser, you'd say, "Oh, you're so far gone, you deserve it."

There is a perception from the women participating in the study that, in these interactions, the system responders would rather not deal with women who have experienced abuse in a same-sex relationship. In discussing the underlying causes for this, one participant said,

Fear. Ignorance, and lack of knowledge, and education. And not wanting to be educated. Not really interested in same-sex relationships. You know, the heterosexual population would just as soon have the gay populations just disappear. They wouldn't have to deal with it in any shape or form.

Recognition—Although IPV has received more attention in the past few decades as a societal issue that needs to be addressed through the health care, criminal justice, and social service systems, the most widely accepted norm of perpetrator-survivor is that of male-to-female violence (Poorman, Seelau, & Seelau, 2003). Even within sexual minority communities, FSSIPV is not widely recognized or discussed. Women in same-sex abusive relationships often have difficulty identifying the violence they are experiencing as IPV (Girshick, 2002a). One survivor said, "I didn't know it was domestic violence. And so, you know, there was no way for me to try to reach out, if I didn't know what it was." Another focus group participant voiced similar feelings when she said, "I wouldn't have known. Because domestic violence was something that happened between men and women, you know? It didn't even dawn on me."

SMW experiencing violence must also combat the stereotypes that women are not violent in relationships (Hassouneh & Glass, 2008). "[Being a] lesbian turns [the violence in relationships] twice-fold, and also turns it into a silent—what's the word—a silent um, violence. It's not talked about, it's not recognized, there's no statistics on it," said one participant when discussing stereotypes. Because female perpetration is at the core of FSSIPV, survivors were often not believed when they tried to tell others. One participant said,

And it seems to me that it doesn't have the same acknowledgement in the broad sense... It's not as supported, and people don't know about it, and every time I say "I was almost killed by a woman," people just say, "By a woman? You've got to be kidding me."

In addition, services that address FSSIPV are limited in many communities and often difficult to locate. Many domestic violence shelters and advocacy resources do not have the capacity to incorporate sexual minorities in an inclusive manner. In the United States as of 2001, fewer than 30 agencies specifically addressed the issue of violence within sexual minority relationships, and five were located in the state of California (L.A. Gay and Lesbian Center, 2001). Mainstream domestic violence agencies may have programs that address violence against SMW, but participants voiced frustration with their struggles in locating these services. One survivor recounted her frustration when she realized that she was experiencing IPV but that she had nowhere to go:

Everything you hear about domestic violence, you know, it's always man on woman. You know. So you—and then you get in this situation and it's like, "Who do I call?" Because most of the places, you know, everything is formatted around men and women. Who do you call if it's a woman [beating you up]?

Masking the Nature of Violence for Self-Protection and Preservation—Many of the participants reported that the lack of acknowledgment of FSSIPV made them afraid: “I’m afraid they’d dismiss it. I’m afraid they’d say it wasn’t real, or it didn’t really happen because it was with another woman.” This fear can influence interactions with authorities and health care providers because a woman experiencing FSSIPV may not challenge the assumptions that the person abusing her is a man. “It would be helpful if health care providers wouldn’t just automatically assume that it’s a man. Because I would play along with it, if they automatically assumed, I’d play along with that, so I could stay safe with them.” Another survivor spoke of how she masked the nature of the violence when her health care providers seemed uncomfortable broaching the subject:

They kind of asked, but not really. It was very, very easy for me to lie about it and say I got knocked down at work, I fell down, I tripped into a brick wall at work, or whatever. I almost wish they had put a little bit more effort into it, because I kind of thought, how often does someone really trip and fall sideways? When I trip normally, I don’t hit my head so hard I can’t hear.

Formal System Use as a Last Resort—A subtheme that arose within this context was that of using a formal service system as a last resort. Survivors voiced an aversion to utilizing this kind of resource until they saw it as their only mechanism to avoid serious injury. Participants reported that they would contact authorities only when the need for self-preservation superseded their distrust of the system: “I didn’t realize, somewhere in the back of my mind, that [being gay in a domestic violence shelter] had been a fear. But the fear of my survival kind of overwhelmed that fear,” said one participant. Still others reported difficulty overcoming the distrust of formal systems and admitted that it required others (e.g., friends, family, or coworkers) outside the relationship to call authorities on their behalf for assistance. For example, one participant stated, “So I was hesitant, but to save myself, I had to do something. But I did not actually call the police, it was somebody else.... I was very hesitant, and I don’t even know if I would call them.”

Protection Through Silence—Another subtheme that arose was using silence as a way to avoid further marginalization. Although they were in abusive relationships, many of the participants had not discussed their situation with others in order to protect themselves and their partners from confirming existing negative stereotypes of sexual minorities. One participant said that she stayed quiet in the abusive relationship because

I was in this fishbowl, and if I was to tell somebody what was going on, then... they’d look at the whole lesbian thing and, “See, it’s not supposed to be that way, because look what happened to you.” And it really added a lot of pressure... because I really felt like I had to represent a good relationship. And prove that I made the right choice.

One participant reported not wanting to contribute to anti-gay images and messages conveyed through the media: “The right wing recently has been really pushing that gay relationships are more violent than straight relationships. And this is one reason we shouldn’t get married. Uh, and I think, and I know people who have kept quiet because of the fear of adding to that.” Others felt that they needed to put up a united front against societal prejudice, even at the expense of their own health and safety within the relationship. As another survivor stated,

My guess is that battering between women is in some ways much more similar to battering between opposite-sex couples who are racial minorities.... When I was working at [the shelter] there was a level of violence that African-American women would tolerate because they were aware of the racism against their partner. It was

very similar to a level of violence that I had tolerated because I knew what my woman partner had been through.

SMW often face additional barriers, such as discrimination, ridicule, issues with disclosure of sexuality, and even the potential dangers of being “outed” or exposed to additional violence, that prevent them from freely and safely accessing domestic violence resources through formal systems (Girshick, 2002a; Renzetti, 1992). SMW who are able to access domestic violence shelter services are not always comfortable speaking about their experiences in front of other women who have experienced heterosexual IPV. The reaction that they get from both the shelter staff and the other survivors is not always understanding or supportive. One participant explained a dynamic that represented several other FSSIPV survivors’ experience when she said,

It’s amazing, women battered by men, some of them really have a lot of attitude [toward] a woman who comes in who wants to talk about being hit by another woman. I don’t talk about it in the light, I know that there are people who don’t want to hear it, I’m not going to burden them with it.

Unfortunately, these experiences often force women to turn to informal sources of help, such as friends, who are often not in a position to offer the necessary safety and support (Girshick, 2002b; Renzetti, 1992). A 2004 report highlighted the difficulties confronting survivors of FSSIPV and suggested that SMW leaving abusive relationships are at risk of homelessness because of the limited shelter and housing resources (ACON, 2004).

System Incompetence: “Laughing It Off”

System incompetence refers to survivors’ perceptions of and experiences with practitioners in criminal justice, health care, and social service systems, who may not always be aware of how their internalized and/or externalized homophobia affects their interactions with SMW seeking assistance. This incompetence reflects an inability to see the gravity of a given situation. It may result in discrimination, whether intentional or not, and can lead to a compounded level of danger. Several survivors reported not being taken seriously and having their reports of violence laughed off.

Survivor 1: “I never, um, felt that when I dealt with police that they were very understanding. They’d act confused. And needed to have a lot of explanation about who was who and what was what even to be able to deal with me. And they didn’t know what to do.”

Survivor 2: “That’s the same kind of experience [I had]... they pretty much laughed it off.”

Competence of service providers in working with survivors of FSSIPV is imperative yet is often missing in interactions with SMW. Having to be one’s own advocate in an environment in which few people validate the IPV is emotionally exhausting. A participant explained her self-doubt in a time of crisis when she said,

How can I take something so serious as to get help for me, if the people around me are not, by me being a lesbian? It’s like—I called the police just exactly once. And I’ll never do that again. Because usually, it’s a big old macho guy, and they won’t take it serious.

Another participant stated,

They’re not taking it seriously, you see damage done to a body, but the other person gets off with it—and they don’t get prosecuted, they don’t get put in jail, and this person ends up being a threat. You are afraid for your life, and if nobody else is taking it seriously, it means a lot.

Still another participant was told, “Oh, we don’t prosecute same-sex domestic violence.” She added, “[What she did to me] is a straight-up felony if you’re straight. And then [my case] got kicked down to a misdemeanor, and then, the prosecutor 3 weeks ago, he told me he was going to throw the case out.”

The inability of the systems to recognize and acknowledge potentially lethal violence is of grave concern. Although the women can perceive the danger, they feel the systems cannot. A survivor said, “I need help doing this. I am trying to keep myself safe, and not somewhere six feet deep.” Another woman, who reported being substantially larger than her abusive partner, spoke of how first appearances often belie the truth. She said, “They were looking at my size and treating me like I was the guy. And you know, in the dyke relationship, it doesn’t mean the little one can’t knock the shit out of you, or kill you.”

Finally, incompetence also exists in health care systems. Studies have shown that, as compared to heterosexual women, SMW experience significant health disparities in both preventive care access and utilization and in health outcomes. They are less likely to engage in preventive care and screening and more likely to receive suboptimal care as a result of factors operating at the patient level as well as at the provider and health care system levels (Hutchinson, Thompson, & Cederbaum, 2006). It is critical that health care providers appropriately assess for IPV in all patients regardless of sexual orientation. Unfortunately, providers often assume that their patients are heterosexual unless their patients explicitly state otherwise (Robertson, 1992). SMW note that the heterosexual bias exhibited by their health care professionals left them feeling disrespected and discriminated against (Saunders, 1999). As noted for other system components, a lack of awareness and sensitivity by health care providers regarding SMW’s health and wellness may discourage survivors of FSSIPV from establishing trusting relationships with these providers and therefore from seeking and receiving appropriate resources.

Compounding Abuse; “If You Can’t Protect Us, at Least Don’t Abuse Us”

Perhaps the most alarming theme identified by the survivors was the notion of compounding IPV. Numerous participants perceived an inappropriate and/or insufficient system response (by the police, support services, or the legal system) that discouraged them not only from reporting IPV and seeking assistance but also from taking legal action against their abuser. One participant said, “If they can’t protect us, at least don’t hurt us. There should be enough education out there that they should know better.”

Survivors also perceived that the responses they received from police were unsupportive and “abusive.” Indeed, one participant commented that the police response was only slightly better than the abuse she suffered from her partner:

It’s so inappropriate, it’s beyond nonsupportive, it’s abusive. And so that particular aspect of it, just from the authoritarian—you know, the first person you call when you’ve been clobbered and knocked out is the police.... They were the first ones that showed up and treated me not much better than my partner did.

Another participant discussed a policeman’s response to her call for help:

I felt more beaten, more threatened and scared. I mean, here is this big hairy guy holding a gun, and a stick on his side, telling me to shut the f—up, and go sit down. That’s just what I needed, after what I had been through. Did they tell me that there was a shelter or any help? No.

Insufficient resources contributed to heightened levels of frustration and a sense of perpetuation of the women’s experience of IPV. A participant said, “Why not help somebody that needs the help? I couldn’t find anybody that actually would help me when I

needed the help. I call the crisis line, and the crisis line's like, 'Oh, we don't do that anymore.' And it's like, oh my God, you know? What can I do?"

Several participants voiced frustration with police officers' lack of integrity and commitment to the sexual minority community. A participant noted, "And yet, they're trying to, I don't know, are they trying to do their job? They're judging me. I don't know, it sure as hell didn't feel supportive." In many cases, the difference between the study participants' expectations concerning the kind of assistance and support they felt they deserved and the actual police response was substantial and was seen as making the IPV worse. Regrettably, this type of experience negatively affects women's future decisions to involve the criminal justice system in reporting IPV.

While the majority of participants reported negative experiences with the police, legal, and health care systems, it is encouraging that participants were able to recall positive experiences when interacting with shelter services and law enforcement. One participant commented, "The most supportive shelter I've ever been in had a lot of orientation around the queer community, and they accepted me for the whole thing." Another participant discussed a positive experience with police response and noted, "I have the cop's personal cell phone number, and his badge number, and what his first name was even, and he just, he gave me a lot of good stuff. And picked me up to take me to a safe house."

DISCUSSION

Relatively few research studies have examined same-sex IPV, but what research exists in the literature is consistent with the concerns that were voiced by participants in this study. Our findings reinforced the marginalization of FSSIPV that is known to occur within the criminal justice, health care, and domestic violence service systems. The underlying prejudice and homophobia against sexual minorities within society challenges authorities and providers who have not had sensitivity training to provide adequate assessment and interventions for IPV. Survivors of FSSIPV reported not knowing that what they were experiencing was IPV. Previous studies have shown that some SMW minorities have never heard of FSSIPV and that there is little recognition of it in society as a whole (Bornstein et al., 2006; Poorman et al., Seelau, Seelau, & Poorman, 2003). Survivors of FSSIPV may struggle to label their relationship as abusive (Relf & Glass, 2005), and a qualitative study by Wolf, Ly, Hobart, and Kernie (2003) has further highlighted survivors' hesitance to label their experience as abusive because the women felt that "physical evidence" was necessary to involve the police. However, difficulty in labeling one's experiences as abusive is not unique to survivors of FSSIPV; rather, many women struggle with defining their relationship as abusive, or their definition of what constitutes abuse shifts over time (Liang, Goodman, Tummala-Narra, & Weintraub, 2005).

This study also underscored the fact that societal awareness of FSSIPV is incomplete, and SMW who are victims of such violence are often stigmatized. Poorman et al. (2003) found that when given legal scenarios that involved cases of male-to-female and same-sex IPV, study participants considered male-against-female abuse to be more severe than same-sex IPV and same-sex survivors less credible than heterosexual survivors. This perceived difference in credibility affected the study participants' recommendations concerning judgment and sentencing of the hypothetical arrestees.

The marginalization of SMW echoes the struggles of oppressed groups, including women in general and people of color (Hall, 1999). SMW as a group are experiencing discrimination and marginalization in today's society, and individuals in this group may be exposed to a wide range of such experiences. For example, more than 50% of lesbian, gay, bisexual, and

transgender participants in one study reported some kind of sexual orientation-based discrimination (Ossana, 2000). This type of “cultural oppression” affects sexual minorities’ experiences with the systems that are supposed to provide services and support (Balsam & Szymanski, 2005). Homophobia within these systems exacerbates SMW’s sense of isolation; our study’s participants stressed that this homophobia caused them to feel marginalized because they were in a same-sex relationship. In turn, external homophobia can affect a woman’s experience of her own relationships if she internalizes these negative perceptions (Ossana, 2000), and her negative feelings can in turn be exacerbated by the experiences of IPV. The participants in our study spoke of their desire to keep quiet about the IPV for fear of reinforcing negative external stereotypes; this reticence may represent a realistic assessment of external homophobia but also could illustrate Balsam and Szymanski’s (2005) assertion that internalized homophobia is a stressor that significantly correlates with experiences of FSSIPV.

In our analysis, the extent to which police and legal systems did or did not acknowledge, address, and prosecute FSSIPV further underscored the participants’ perceptions of system incompetence. When FSSIPV is not taken seriously, two messages are sent: perpetrators obtain reinforcement that they will not be punished for IPV, and survivors experience a sense of futility regarding their efforts to access support services (Worcester, 2002). Our findings are consistent with a study by Rose (2003) that reviewed case examples from hotline calls over a period of 4 years. In that study, researchers analyzed the cases suggestive of FSSIPV and lesbian hate crimes and found that the majority of cases demonstrated inadequate and/or dismissive responses by the criminal justice system and domestic violence services. Other studies have found that in cases involving FSSIPV, police are less likely to arrest perpetrators or to enforce protective orders (Connolly, Huzurbazar, & Routh-McGee, 2000; Renzetti, 1989).

The conviction that law enforcement’s responses amplified SMW’s experience of abuse was not distinctive to this study. Generally, police officers are more likely to deem violence between SMW as mutual or consensual IPV (Vickers, 1996). This error in judgment is compounded by the fact that many police officers lack the necessary training to distinguish the perpetrator from the victim, a mistake that can result in wrongful arrest of the victim (National Coalition of Anti-Violence Programs, 2008). The participants’ reports of inappropriate responses by the police are consistent with the findings of a U.S. survey that identified the police as perpetrators of 20% of the anti-gay acts experienced by this population in the form of either outright abuse of the person involved or illicit mishandling of an IPV case. This response to survivors of same-sex IPV indisputably contributes to survivors’ hesitation in reporting IPV for fear of incurring added abuse (Herek, 1990). Not surprisingly, police responses that trivialize a survivor’s experience(s) contribute to a woman’s reluctance to involve law enforcement officers in subsequent disputes (Wolf et al., 2003).

A resounding theme from the majority of participants was the desire to have their experiences acknowledged and appropriately handled by the various formal systems. This goal could be achieved by enhancing and expanding already established services and resources for heterosexual IPV survivors as well as by establishing additional resources and funding mechanisms specific for SSIPV. Organizations should ensure that their employees are offered ongoing training that addresses same-sex relationships and sexual and gender diversity and how these apply to their work. This training should not be limited to domestic violence organizations but should also include law enforcement, health care, and criminal justice institutions. Nonheterosexist language can be added to domestic violence resource and service advertising material so that SMW who are experiencing or have survived FSSIPV feel welcomed to receive supportive services (ACON, 2004; Simpson & Helfrich,

2007). Counseling and other programs for perpetrators of FSSIPV need to be made available to SMW who are ready for or are mandated to batterers' interventions. Efforts by programs and services should be coordinated so that appropriate referrals are made in a timely manner and safety procedures are established. Developing a coordinated response with effective service provision in all sectors will ultimately result in an enhanced recognition of FSSIPV and more effective interventions to address this growing problem.

It is important to note that our findings are not necessarily generalizable to all survivors of FSSIPV because this study represents the views of 47 participants residing in the Pacific Northwest. In addition, while multiple measures were employed to ensure the credibility, trustworthiness, and authenticity of the data, these measures were implemented post hoc to the data collection process (Morse, Barrett, Mayan, Olsen, & Spiers, 2002).

CONCLUSION

While it is estimated that the rates of IPV are similar for heterosexual and homosexual relationships, the legal and health care systems often fail to appreciate the prevalence, severity, and long-term consequences of IPV in diverse populations, such as SMW (Seelau et al., 2003). This reluctance to recognize FSSIPV has led to a perceived and experienced limitation in SMW's access to critical social, community, and health care services (Hassouneh & Glass, 2008). The societal denial of IPV in same-sex relationships, externalized and internalized homophobia, and a lack of sexual minority-appropriate IPV resources are all barriers to reporting incidents and accessing IPV services (Relf & Glass, 2005).

Very few studies have examined the systems' responses to FSSIPV from the perspective of SMW. By highlighting the shortcomings in these responses to FSSIPV as perceived and experienced by the survivors, this study has underscored the need for an increased awareness and acknowledgment of FSSIPV. This awareness can inform the development and implementation of comprehensive assessment, intervention, and prevention strategies that are best suited to the needs of those in same-sex intimate relationships. A concerted effort must be made by professionals in health care settings, criminal justice systems, and domestic violence services to partner with sexual minority community leaders in an effort to gain an improved understanding and appreciation for how best to address the health and safety needs of this community. The systems are charged with ensuring that all survivors receive fair and equal treatment, and a well-informed, coordinated community response will undoubtedly strengthen existing resources to deal with FSSIPV.

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TABLE 1

Results of Qualitative Analysis

Themes and Subthemes			
Theme	Reinforced marginalization	System incompetence	Compounding abuse
Explanatory quote	"We are beyond second class."	"Laughing it off"	"If you can't protect us, at least don't abuse us."
Subthemes	Lack of recognition Masking the violence Formal system is last resort Self-protecting through silence		