Exploring 2S/LGBTQIA+ people's experiences with intimate partner violence during the COVID-19 pandemic in Ontario: A multi-methods qualitative study

by Kyle Drouillard
Supervisor: Dr. Angel M. Foster, DPhil, MD, AM

Interdisciplinary School of Health Sciences
Faculty of Health Sciences
University of Ottawa
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Abstract

Intimate partner violence (IPV) involves aggressive or abusive behaviour that harms or intimidates a current or former romantic partner. Although sexual and gender diverse (2S/LGBTQIA+) people may disproportionately experience IPV, their experiences are not well documented in the Canadian context. This multi-methods qualitative study documents 2S/LGBTQIA+ survivors' experiences with IPV and access to related services throughout the COVID-19 pandemic via in-depth interviews with survivors and service providers.

Survivors experienced multiple, concurrent forms of abuse that contributed to poor mental health outcomes, both of which were intensified by the COVID-19 pandemic. Survivors had difficulty recognizing themselves as victims and were unaware of services. Services are insufficiently funded and unable to meet the needs of their communities. Gender-based violence organizations want to serve transgender women and transfeminine people but second-wave feminist frameworks in policy and funding mechanisms are a barrier to expanding services. Service providers need predictable, annualized funding, must improve outreach, and shift to an intersectional feminist framework that includes 2S/LGBTQIA+ people. Comprehensive sexual health education and regular IPV screenings by mental health professionals are crucial for IPV prevention.

Résumé

La violence entre partenaires intimes (VPI) implique les comportements agressifs ou abusifs qui blessent ou intimident un(e) partenaire actuel(le) ou ancien(ne). Bien que les personnes de la diversité sexuelle ou de genre (2S/LGBTQIA+) pourraient être touchées d'une façon disproportionnée par la VPI, ses expériences ne sont pas bien documentées dans le contexte canadien. Cette étude multi-méthodes rend compte les expériences des survivant(e)s de VPI pendant la pandémie COVID-19 et leurs expériences avec les services via des entrevues en profondeur avec des survivant(e)s de VPI et des fournisseurs de services.

Les survivant(e)s avaient subi multiples formes de violence concomitantes qui ont provoqué des problèmes de santé mentale aggravés par la pandémie COVID-19. Les survivant(e)s ont eu de difficulté en se reconnaissent comme des victimes de violence et ignoraient des services. Les services sont insuffisamment financés et ne peuvent pas répondre bien aux besoins de leurs communautés. Même que les organisations de lutte contre la violence fondée sur le genre veulent offrir les services aux femmes transgenres et les personnes transféminins, les politiques et les mécanismes de financement fondés sur la deuxième vague féministe sont une barrière de l'élargissement des services pour ces communautés. Les fournisseurs de services ont besoin de financement prévisible et annualisé; ils doivent implémenter des programmes de sensibilisation et changent vers un cadre de féminisme intérsectionnel qui inclue les communautés 2S/LGBTQIA+. L'éducation complète de la santé sexuelle et le dépistage régulier par les professionnels de la santé mentale sont cruciaux pour la prévention de la VPI.

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List of acronyms and abbreviations

2S/LGBTQIA+	Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other sexual and gender diverse identities
GBV	Gender-based violence
IDI	In-depth interview
IPV	Intimate partner violence
KI	Key informant
KII	Key informant interview
NAP	National Action Plan
PAR	Partner assault response
PI	Principal investigator
PTSD	Post-traumatic stress disorder
REB	Research ethics board
SMM	Sexual minority men
SMW	Sexual minority women
SSPPS	Survey of Safety in Public and Private Spaces
TFV	Technology-facilitated violence
TGD	Trans and gender diverse
UCR	Uniform Crime Reporting (Survey)
VAW	Violence against women
WAGE	Women and Gender Equality Canada
WHO	World Health Organization

Chapter 1: Introduction

1.1 Background

1.1.1 Intimate partner violence

Intimate partner violence (IPV) is a significant public health problem characterized by actions committed by a current or former intimate partner with the intent of harming or intimidating their current or former intimate partner(s) (Krug et al., 2002). These behaviours include physical violence or aggression, sexual violence or coercion, psychological abuse, controlling or coercive behaviours, criminal harassment (i.e. stalking), financial abuse, spiritual abuse, reproductive coercion, and technology-facilitated violence (Women and Gender Equality Canada [WAGE], 2022; World Health Organization [WHO], 2021b). Intimate partner violence experiences are associated with myriad physical, sexual, and psychological health problems that can manifest during, and persist beyond, the violence experience. These include physical injury, chronic pain, sexually transmitted and blood borne infection transmission, unintended pregnancy, genitopelvic pain, gastrointestinal issues, depression, post-traumatic stress disorder (PTSD), substance abuse, and death (Campbell, 2002; WHO, 2021b).

Risk factors associated with experiencing or perpetrating IPV include individual and relationship stress, previous exposure to violence (including family violence), acceptance of violence, differences in social power between partners, social isolation, substance abuse, and lower education and lower socioeconomic status (Capaldi et al., 2012; World Health Organization & Pan American Health Organization, 2012). Though IPV can occur in any type of intimate relationship, regardless of the sexual orientation or gender identity of the victim or perpetrator (WAGE, 2022), women bear the brunt of IPV worldwide, with 1 in 3 women experiencing IPV during their lifetime (WHO, 2021a). Indeed, IPV often gets conflated with violence against women (VAW) and gender-based violence (GBV), with feminist movements and discourses laying the theoretical groundwork for what constitutes IPV, who is considered a victim of violence, and who is a perpetrator of that violence.

1.1.2 Intimate partner violence in feminist and queer discourses

Second-wave feminism

Second-wave feminism emerged in the 1960s to raise consciousness of sex discrimination in public and private spaces. The movement centred patriarchy as the primary form of oppression that subjugates people "principally, though not exclusively, through *ideological* control" that is deeply ingrained in institutions, the State, and culture (Thornham, 2001, p. 31, emphasis in original). Second-wave feminists identified domesticity, family, and motherhood as key sociocultural tools by which men subjugate women. Therefore, patriarchal oppression is inextricably linked to sexual and reproductive health and rights, and reproductive technologies are the arbiter of bodily autonomy and consequently, women's liberation. However, the movement was primarily centred on the liberation of middle-class white women despite Black women being instrumental in the development of early radical second-wave feminist groups (Thornham, 2001).

Second-wave feminism advanced discourses that IPV (often referred to as "domestic violence"), GBV, and VAW are the result of patriarchal control and hegemonic masculinity perpetuated by a male-dominated culture in which men seek to retain their status by subjugating women through physical, sexual, and psychological control (Price, 2005). This early framework – while laudable for raising GBV in the public consciousness – reinforces dichotomies: male-female, oppressor-oppressed, perpetrator-victim, gay-straight (Cannon, 2020). This lens places the gender binary at the forefront of violence experiences and ignores other identities or sociocultural factors that may affect IPV perpetration or victimization. Effectively, this discourse precludes people of colour, heterosexual men, and Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex, or asexual people, and other sexual and gender diverse people (2S/LGBTQIA+; Cannon & Buttell, 2016) from being considered "legitimate victim[s]" (Little, 2020, p. 69). In theory, if the IPV experiences of these populations are "illegitimate", then IPV-

related services like shelters, crisis lines, counselling services, and partner assault response (PAR) programs need not apply to any person other than middle-class, cisgender, heterosexual, white women.

Black feminist thought and intersectional feminism

In her seminal work, *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*, Collins (1990) set the stage that challenges second-wave feminist discourses as being representative of all women. Collins suggested that apparently individual features and social classifications like race, class, and gender form a "matrix of domination" (p.23) that variably oppresses individuals based on combinations of interconnected identities. Fundamentally, Collins "argu[es that] Black women cannot choose between their identity as a woman and as a Black person" (Cannon, 2020, p. 40), and that violence against Black women – including IPV – is tied to both gender and race.

Intersectional feminism (or, intersectionality) is a theory advanced by Crenshaw (1991) that expands on Black feminist thought. Intersectionality conceptualizes individual identity as being more than the sum of its parts. Identity is a multi-dimensional, interconnected array of social and political categories that overlap and reveal the privilege and oppression that individuals experience due to the combination of those categories. Regarding Black women's experiences of VAW – especially of battering, rape, and domestic violence – Crenshaw's intersectional lens criticizes siloed applications of second-wave feminism and anti-racism to VAW because "the narratives of gender are based on the experiences of white, middle-class women, and the narratives of race are based on the experiences of Black men" (1991, p. 1298). As such, the risk, incidence, and impact of IPV cannot be understood merely as the product of a male-female dichotomy, with men as perpetrators and women as victims. Rather, intersectional forms of oppression based on age, sex, gender, race, class, Indigeneity, sexual orientation, socioeconomic status, (dis)ability, and immigration status, among others, contribute to the use of IPV as an expression of social power and subjugation (Cannon et al., 2015).

Queer theory

Queer theory argues that sexual identity is not static, but performative, and that "the context in which [sexuality] is performed and negotiated *matters*" (Cannon, 2020, p. 45, emphasis in the original). Non-heterosexual behaviour and the context in which it is performed is a statement of queer identity, and is thus transgressive against embedded norms of heteronormativity and homophobia in society and culture, as Warner (1993, p. xiii) elucidates:

> Every person who comes to a queer self-understanding knows in one way or another that her stigmatization is connected with gender, the family, notions of individual freedom, the state, public speech, consumption and desire, nature and culture, maturation, reproductive politics, racial and national fantasy, class identity, truth and trust, censorship, intimate life and social display, terror and violence, health care, and deep cultural norms about the bearing of the body.

Thus, queer theory shifts focus from a biological essentialist model to one of performative roles as a source of oppression, and further challenges discourses that reinforce the binary of male dominance over female victims as the purpose of IPV (Cannon et al., 2015). Collectively, these theoretical frameworks identify the oppressive systems that perpetuate the conditions for IPV across populations. Intimate partner violence as a tool of oppression is not merely based upon gender and misogyny, but upon its intersections with race, sexual orientation, (trans)gender identity, immigration status, HIV serostatus, ableism, religion, ethnicity, socioeconomic status, education, heterosexism, and heteronormativity, and contributes to a culture that condones and encourages IPV across identities.

1.1.3 IPV in 2S/LGBTQIA+ communities

Minority stress

Heteronormativity and cisnormativity prevent 2S/LGBTQIA+ people from being considered "legitimate" victims of IPV and therefore act as barriers to help-seeking among these communities (Cannon et al., 2015). Moreover, these sociocultural conditions may contribute to unique stressors that increase risk of IPV perpetuation and victimization, as elucidated in minority stress theory.

Minority stress theory is an extension of social stress theory that characterizes discrimination and prejudice as unique stressors related to minority status. Minority stressors are classified on a continuum from the distal (objective) to the proximal (subjective) and are additive and chronic (Meyer, 2003, 2015). Distal stressors involve interpersonal experiences of discrimination based on minority status, whereas proximal stressors involve the internalization of previous experiences of discrimination and prejudicial attitudes related to minority status (Meyer, 2003). For sexual and gender diverse people, proximal stressors may include internalized homophobia or transphobia, stigma consciousness – that is, the degree to which discrimination is expected, whether real or perceived – and identity concealment (Carvalho et al., 2011; Meyer, 2003).

Minority stress may be related to disparities in negative physiological and psychological health outcomes among sexual and gender diverse people, including cardiovascular disease, heightened immune responses, respiratory infections, depression, anxiety, PTSD, eating disorders, substance use and suicide (Bockting et al., 2013; Flentje et al., 2020; Meyer, 2003; Plöderl & Tremblay, 2015; Testa et al., 2015; Ward et al., 2014). Despite advances in legal rights and social acceptability for sexual and gender diversity in Canada and the United States, experiences of minority stress have not decreased; rather, minority stress has *increased* among younger sexual minority cohorts compared to older cohorts (Meyer et al., 2021). Therefore, minority stress remains relevant to health disparities among sexual and gender diverse people, and may further explain how "cultural aspects of homophobia and cissexism can be internalized by sexual and gender minorities, increasing their risk for IPV" (Brubaker, 2020, p. 56).

High levels of internalized homophobia have been associated with higher rates of both IPV perpetration and victimization (Kelley et al., 2014), particularly physical and sexual IPV (Balsam & Szymanski, 2005). Identity concealment may also be an indicator of increased IPV perpetration overall, and physical IPV in particular among sexual minorities (Edwards & Sylaska, 2013). Importantly, same-sex relationships may demonstrate bidirectional IPV, where perpetrators report being victims of IPV, and

vice versa (Carvalho et al., 2011), further suggesting that minority stress may play a role in IPV in sexual minority communities. Due to a dearth of research, linkages between IPV and minority stress among trans and gender diverse people (TGD) remain unclear.

Prevalence of IPV among LGBQ people

The 2010 National Intimate Partner and Sexual Violence Survey in the United States found that men who experience physical IPV are more likely to self-identify as bisexual (53%) than heterosexual (28.7%) or gay (25.2%). However, self-identified gay men are more likely to experience psychological IPV (59.6%) than bisexual men (53%) or heterosexual men (49.3%; Breiding et al., 2014). Dickerson-Amaya and Coston (2019) similarly found that gay men are more likely to be victims of emotional abuse and stalking than bisexual men or heterosexual men.

Women, regardless of their sexual orientation, are more likely to experience physical IPV than men, and queer women experience more psychological IPV than men (Coston, 2017). In addition, sexual minority women (SMW) experience more sexual IPV than sexual minority men (SMM; Campo & Tayton, 2015). Moreover, sexual minority women are generally more likely to be a victim (Bermea et al., 2018; Breiding et al., 2014) or perpetrator (Bucik, 2016) of IPV than heterosexual women. Furthermore, bisexual women are more likely to be victims of all forms of IPV than lesbian or heterosexual women (Breiding et al., 2014), and self-identified bisexual women are twice as likely to experience IPV than women who have sex with women who do not identify as bisexual (Coston, 2017). This suggests that a bisexual label itself may be a risk factor for IPV, rather than mere engagement in “bisexual behaviour” (Corey et al., 2022).

Prevalence of IPV among trans and gender diverse people

A large-scale study of TGD adults in the United States found that 54% of participants reported experiencing IPV at some point throughout their lives, with 24% of those respondents classifying that

violence as “severe” (James et al., 2016, p. 198). Multiply marginalized TGD participants, including people of colour, people with disabilities, people experiencing homelessness, undocumented people, and people involved in remunerative sex work reported even higher IPV rates (James et al., 2016). While existing research suggests that TGD people experience IPV at higher rates than cisgender people (Bucik, 2016; Garthe et al., 2018; Langenderfer-Magruder L. et al., 2016; Valentine et al., 2017), research about IPV among TGD people is scarce compared to research about sexual minorities.

1.1.4 IPV in the Canadian context

The Statistics Canada Survey of Safety in Public and Private Spaces (SSPPS) collects data from people aged 15 and over from across Canada about their experiences of safety in the home, at work, in public, and online, with IPV being one of the topics (Statistics Canada, 2019). The 2018 SSPPS found that 44% of women and 35% of men in Canada experienced some form of IPV throughout their lifetime (Statistics Canada, 2021c). Respondents most commonly experienced psychological abuse, followed by physical, then sexual abuse, with 58% of women and 47% of men who experienced psychological abuse also experiencing some other form of abuse (i.e., physical or sexual). The most reported forms of psychological abuse were related to social isolation, beratement, and attempts by perpetrators to track victims’ whereabouts. Broadly speaking, women are more likely to experience all forms of abuse than men, and are more likely to experience multiple, more severe forms of abuse than men.

Prevalence of IPV among LGBQ people in Canada

According to the SSPPS, more than half of SMM in Canada reported experiencing some form of IPV compared to 36% of heterosexual men (Statistics Canada, 2021a). Sexual minority men are more likely to experience all forms (i.e., physical, psychological, sexual) of IPV compared to heterosexual men, and are more likely to experience severe forms of physical and sexual abuse, including being beaten,

choked, forced into sex, or being locked in a room. Two-thirds of SMW have experienced IPV at some point throughout their lives, compared to approximately two-fifths of heterosexual women (Statistics Canada, 2021b). Though SMW most frequently reported psychological abuse, nearly half also reported being physically or sexually assaulted, almost double the rate reported by heterosexual women. Bisexual women reported the highest rates of physical and sexual assault among SMW. Like SMM, SMW were also most likely to experience the most severe forms of physical and sexual abuse compared to heterosexual women.

Whitehead and colleagues' (2020) analysis of the Statistics Canada Uniform Crime Reporting (UCR) Surveys (2008-2011) suggests that same-sex survivors of IPV reported their experiences to police at a rate proportionate to their numbers in society (3%) and that police reporting of IPV occurred most frequently in smaller urban areas and small towns. Their analysis also suggests that the most reported incidences of same-sex IPV to police involve threats, perhaps related to "outing" a victim or divulging HIV serostatus.

While the SSPPS and UCR surveys are rigorous national data collection programs, it is unlikely that these sources capture the full picture of IPV among LGBQ individuals. The SSPPS is primarily conducted by mail, and subsequently by telephone, requiring respondents to have a permanent address or a reachable phone number, and the time, resources, and inclination to participate. Sexual and gender diverse communities experience higher rates of unemployment, financial insecurity, and poverty across the lifespan compared to heterosexual, cisgender people, and may lack some or all these assets (Kia et al., 2020). Additionally, in the case of someone experiencing IPV, participants would also need to feel safe enough to divulge their experiences if they are living with their perpetrator. Regarding the UCR surveys, IPV experiences are underreported to police (Carvalho et al., 2011; Statistics Canada, 2021c), especially among 2S/LGBTQIA+ communities that have historically been targeted and oppressed by

police. Therefore, these communities may be reticent to engage law enforcement related to their IPV experiences due to lived or perceived stigma (Calton J.M. et al., 2016; Shields, 2021).

Prevalence of IPV among TGD people in Canada

Canadian TGD people may be twice as likely as cisgender people to experience IPV (Bucik, 2016). Indeed, results from the TransPULSE Canada survey in 2019 suggest that 64% of transgender women have experienced IPV since age 16, including verbal abuse (56%), physical assault (29%) and threats of physical violence (24%), and sexual coercion (33%; TransPULSE Canada, 2021). In a study of migration patterns of Two-Spirit and Indigenous LGBTQ Canadians, Ristock and colleagues (2019) found that nearly half of their participants experienced IPV in addition to domestic family violence. That said, research on 2S/LGBTQIA+ IPV in Canada is heavily focused on sexual minority groups, and research on the IPV experiences of gender minority groups and Two-Spirit people in Canada is limited.

Accessing 2S/LGBTQIA+-friendly IPV services in Canada

Furman and colleagues (2017) interviewed VAW shelter staff, community organizations, and counselling services in Ontario to determine IPV-related services' effectiveness in supporting 2S/LGBTQIA+ survivors of IPV. Participants acknowledged that their organizations operate on a feminist framework, in part because "funders and agencies privilege cisgender heterosexual women survivors" (p. 374). This funding structure acts as a barrier to 2S/LGBTQIA+ people accessing IPV, GBV, and VAW services, including through outright refusal to serve 2S/LGBTQIA+ people, a lack of inclusive language in policies and resources, judgement by service providers, and harassment of 2S/LGBTQIA+ survivors by staff or other clients (Baker et al., 2015). Interviewees suggested that a client-centred approach to services – where existing VAW services are tailored to individual clients – and training from 2S/LGBTQIA+ community organizations could improve existing services for sexual and gender minorities

and would be more effective than developing *de novo* IPV services specifically for these populations (Furman et al., 2017). They further recommend a shift from second-wave feminist frameworks to intersectional feminist frameworks for funding mechanisms to make VAW services more readily available for 2S/LGBTQIA+ survivors.

1.1.5 COVID-19

As governments and public health agencies mandated quarantines and stay-at-home orders to prevent the spread of COVID-19, such directives may have trapped victims of violence with their perpetrators, increasing the frequency and severity of IPV (Peitzmeier et al., 2022). At the same time, IPV-related services and other community organizations experienced disruptions in the transition to virtual models of care for their clients (Carrington et al., 2021) resulting in the conditions for a "perfect storm" (Usher et al., 2021, p. 1022) that contributed to a concurrent "shadow pandemic" of IPV (Haag et al., 2022).

In response, the Government of Canada provided $100 million for VAW and GBV services for women experiencing violence in the first year of the COVID-19 pandemic (WAGE, 2021). Sexual and gender minority populations were markedly absent from this initial emergency funding, despite previous acknowledgements that TGD people disproportionately experience GBV and IPV compared to cisgender, heterosexual people (Public Health Agency of Canada, 2018). Indeed, 2S/LGBTQIA+ people are more likely to experience precarious housing and financial situations, even before the onset of the pandemic (Kia et al., 2020; Statistics Canada, 2020); therefore, these communities may be more vulnerable to financial and employment stressors that could contribute to more frequent or severe IPV, or otherwise affect 2S/LGBTQIA+ persons' ability to be financially independent enough to leave their perpetrators.

In January 2021, the Government of Canada launched its National Action Plan (NAP) to End Gender Based Violence in a joint declaration with provincial and territorial Ministers for the Status of

Women. The NAP is a 10-year project to address inequities that contribute to GBV by centring survivor supports, prevention efforts, criminal justice reform, social programs, and Indigenous approaches to addressing GBV (WAGE, 2022b). While the declaration includes IPV and 2S/LGBTQIA+ people in its vision, it remains to be seen how the NAP will apply to 2S/LGBTQIA+ experiencing IPV.

1.2 Project rationale

IPV is a significant public health, economic, and sociocultural challenge. Although evidence suggests that 2S/LGBTQIA+ people in Canada may disproportionately experience IPV compared to cisgender, heterosexual people (Bartholomew et al., 2008; Bucik, 2016; Furman et al., 2017; Ristock et al., 2019; Sinha, 2013; Statistics Canada, 2021a, 2021b; Whitehead et al., 2020), research on IPV in LGBQ relationships in the Canadian context is scarce, and research on IPV among TGD people in Canada is virtually non-existent. Moreover, the experiences and dynamics of violence among IPV survivors in these communities in Canada is not well understood. This thesis aims to begin filling this gap. Through a multi-methods qualitative study, we documented the experiences of 2S/LGBTQIA+ survivors of IPV in Ontario and explored how IPV-related services and 2S/LGBTQIA+ community organizations could be improved to better meet the needs of these communities.

1.3 Objectives

The objectives of this thesis are threefold:

i. Document the experiences of 2S/LGBTQIA+ people with IPV in Ontario;
ii. Explore how the COVID-19 pandemic affected participants' IPV experiences and access to related services; and
iii. Identify ways that IPV and 2SLGBTQIA+ community services could be improved.

1.4 Research questions

This qualitative study aimed to answer the following research questions:

1) What are 2S/LGBTQIA+ people's experiences with intimate partner violence in Ontario?
2) How did the COVID-19 pandemic impact 2S/LGBTQIA+ persons' experiences with IPV and access to services?
3) How could services for 2S/LGBTQIA+ persons be improved?

1.5 Outline

This thesis follows the format of a "thesis by articles" and is divided into six chapters. Chapter 1 includes background information on IPV in 2S/LGBTQIA+ communities, IPV in Canada, and IPV throughout the COVID-19 pandemic to give context to this work. This chapter also includes the rationale and objectives for this study, the research questions, and an outline of the thesis.

Chapter 2 explains the multiple methods implemented to complete the thesis, including descriptions of the eligibility criteria, recruitment strategies, in-depth interview (IDI) and key informant interview (KII) protocols, analytic techniques, and ethical considerations applied to complete the work.

Chapter 3 contains a scoping review protocol under the working title, *Intimate partner violence among 2S/LGBTQIA+ people in Canada: A scoping review protocol*. We have designed this review to capture the breadth of peer-reviewed and scholarly literature about what is currently known about IPV among 2S/LGBTQIA+ people in Canada. This is an ongoing project. As such, we do not present any results and include only the protocol in this thesis.

Chapter 4 includes the article*, "It definitely changed me": Exploring sexual and gender minorities' experiences with intimate partner violence in Ontario*, *Canada* which describes 2S/LGBTQIA+ people's experiences with IPV in Ontario. We have submitted this article to *Perspectives on Sexual and Reproductive Health* and followed the formatting requirements of this peer-reviewed journal.

Chapter 5 includes the article, *"Falling through the cracks": Exploring the barriers to serving 2S/LGBTQIA+ survivors of intimate partner violence in Ontario, Canada* which elucidates the current situation of IPV service provision among 2S/LGBTQIA+ people in Ontario. This article draws on the experiences and recommendations from 2S/LGBTQIA+ survivors of IPV and the professional views of key informants from VAW, GBV, and 2S/LGBTQIA+ community organizations to identify barriers to serving 2S/LGBTQIA+ people who experience IPV. We submitted this article to the *Canadian Journal of Human Sexuality* and followed the formatting requirements of this peer-reviewed journal.

Chapter 6 integrates the results described in Chapter 4 and Chapter 5 in a comparative discussion of the main themes from both articles. Drawing on the concordance and/or discordance in themes, we make recommendations to improve services so that they can better serve 2S/LGBTQIA+ people who experience IPV. The chapter continues with a statement of the overall significance of the work, and potential avenues of future research. The chapter concludes with a description of the limitations of the project, reflections on positionality in qualitative research, a statement of contribution of the overall work, and a conclusion. Bibliography and appendices follow.

Chapter 2: Methods

2.1 Scoping review

To provide context to the primary data collection component of this thesis project, we have elected to conduct a scoping review. The objectives of this component are threefold: 1) Determine the breadth of literature about 2S/LGBTQIA+ people and IPV in Canada; 2) Explore the mental health outcomes of 2S/LGBTQIA+ people who experience IPV in Canada; and, 3) Explore the help-seeking behaviours of 2S/LGBTQIA+ survivors of IPV. We established a protocol following the methodological framework initially described by Arksey and O'Malley (2005) and subsequently refined by Levac and colleagues (2010). This framework stipulates five key stages for the review 1) Formulating the research question; 2) Identifying studies; 3) Selecting studies; 4) Data charting; and, 5) Data analysis, reporting, and discussion. Arksey and O'Malley (2005) also propose an optional sixth consultative phase with stakeholders, which Levac and colleagues (2010) recommend to improve methodological rigour, verify results, and disseminate findings. As we conducted key informant interviews as a separate part of this project, we did not incorporate a consultation phase into the scoping review. Our complete protocol is discussed at length in Chapter 3. This is an ongoing project, and the complete results are to-be-determined; as such, we do not present any findings from the scoping review in this thesis.

2.2 Participants

Between November 2021 and September 2022, we conducted 20 semi-structured in-depth interviews with self-identified 2S/LGBTQIA+ survivors of IPV and 10 key informant interviews with representatives from IPV-related services and 2S/LGBTQIA+ community organizations. Due to the ongoing pandemic situation, we conducted all interviews over the telephone or audio-only Zoom, as per participant preferences.

Eligible IDI participants (i) self-identified as 2S/LGBTQIA+, including but not limited to Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex, asexual, pansexual, genderqueer, non-binary, agender, genderfluid, or any combination thereof; (ii) self-identified as having experienced IPV since March 15, 2020; (iii) were 18 years of age or older at the time of their IPV experience; (iv) had access to a telephone or an Internet connection; (v) had a safe space to have a discussion; and, (vi) were sufficiently fluent in English to complete an interview. Key informants were current or former representatives of 2S/LGBTQIA+ community organizations or IPV-related services, including VAW shelters, sexual assault centres, PAR programs, and advocacy organizations.

2.3 Data collection

2.3.1 In-depth interviews with 2S/LGBTQIA+ survivors of IPV

We employed a multi-modal strategy to recruit IDI participants. We developed two types of flyers – an online version and a printer-friendly version – designed to recruit participants in virtual and physical spaces. We regularly posted virtual flyers to social media and online marketplaces, including Facebook, Instagram, Twitter, LinkedIn, and Kijiji, and circulated the online and printer-friendly flyers to our personal and professional networks to raise awareness of the project. Given that recruitment occurred during the height of the COVID-19 pandemic, we recruited most participants online.

Potential participants expressed interest via email, whereupon the Principal Investigator (PI) followed up to determine eligibility, explain the study in greater detail, and provide the consent form. We subsequently invited eligible participants to an interview scheduled at a mutually convenient time. We sought oral consent from participants and requested permission to audio-record interviews, reminding participants that they could rescind their consent at any time or refuse to answer any questions without reprisal. We recorded participants' responses on a physical copy of the consent form.

Interviews lasted between 45 and 180 minutes in duration and covered demographic information, including sexual orientation, gender identity, and "outness", relationship history, and IPV experiences before and since the onset of the COVID-19 pandemic. We explored participants' awareness of IPV-related and 2S/LGBTQIA+ services in their communities, probed whether participants accessed such services, and finished interviews by exploring participants' perspectives on how services could be improved. Throughout these domains of inquiry, we explored how the COVID-19 pandemic affected participants' overall health, their relationships, their IPV experiences, and participants' awareness of, or access to, services. We iteratively developed the interview guide, where emerging content affected lines of inquiry in subsequent interviews. At the conclusion of each interview, we emailed participants a CAD40 electronic gift code to Amazon.ca as compensation.

2.3.2 Key informant interviews

We identified potential key informants through publicly available information on organization websites or social media, and the personal and professional networks of the PI and their Supervisor. We established initial contact with key informants via email or direct message on social media with a letter of information detailing the study objectives and the interview process and a copy of the consent form. If a potential key informant indicated interest in participating, we arranged a mutually convenient time for an interview. If we received no response from a potential key informant, we followed up via email or by telephone weekly until we received a response either accepting or rejecting our invitation.

At the outset of each interview, we sought oral consent from key informants to audio-record interviews and requested permission to use quotations from the interviews in publications or presentations. We offered key informants the option to be identified by name, or as representatives of their organizations, should quotations be used. We reminded key informants that they could rescind their consent at any time, or refuse to answer any questions, without fear of reprisal.

Key informant interviews lasted 60-120 minutes in duration, and included information about the key informants' professional background, their current or former involvement with an IPV-related or 2S/LGBTQIA+ community organization, the services their organizations provide, how IPV-related services or 2S/LGBTQIA+ communities are included in their organizations, and how services could better meet the needs of 2S/LGBTQIA+ communities. We did not offer key informants monetary compensation for participating; rather, we offered to share a brief report of the study findings at the conclusion of the project.

2.4 Data analysis

Data collection marked the beginning of data analysis for this project. We kept extensive interview notes, wrote memos immediately following each interview, and audio-recorded and transcribed all interviews verbatim. Collectively, interview notes, memos, and transcripts comprise the data of this project. Memoing is a reflexive and analytic process through which the interviewer considers how her/his/their positionalities affect interview dynamics, how these dynamics influence emerging content (Elo & Kyngäs, 2008), and help determine when thematic saturation – the end point of data collection – is reached (Birks et al., 2008). Though we suspected that we reached thematic saturation after 17 IDIs and 7 KIIs, we opted to complete three more of each type of interview to confirm, for a total of 20 IDIs and 10 KIIs.

We managed our data using ATLAS.ti (Version 22) qualitative data management software. We coded all transcripts and memos for content, then individually explored each code to identify emergent themes using inductive and deductive techniques. We analyzed the IDIs and the KIIs separately for content and themes before integrating the results to identify concordant and discordant themes.

2.5 Theoretical foundations

This project is founded in interpretative and social constructionist approaches. Collectively, these approaches posit that reality is not objectively defined, but socially constructed, and that individuals interpret their own reality (Green & Thorogood, 2004). While we applied the WHO and WAGE definitions of IPV as a practical matter to engage with the literature, formulate research questions, and develop our methodology and data collection tools, we did not prescribe a definition of IPV for our participants. Rather, participants self-defined their IPV experiences through their decision to participate in an interview. Therefore, IPV experiences among IDI participants varied in frequency, severity, and type. Similarly, we did not define participants' sexual orientations or gender identities based on a set of criteria based in biological determinism, gender expression, or sexual or romantic behaviour. Self-identification as being 2S/LGBTQIA+ was sufficient for inclusion in the study.

2.6 Ethical considerations

We received ethics approval for this project from the Social Sciences and Humanities Research Ethics Board (REB; S-05-21-6906; Appendix A). We recognize that we conducted these interviews during the COVID-19 pandemic and stay-at-home orders, and that some participants may have been in an abusive situation at the time of their interview. The safety of our participants was of utmost importance. As such, we ensured that participants were in a safe space and mutually agreed on a protocol with participants at the outset of an interview about how to safely resume an interview if we became disconnected. We supplied participants in distress or in ongoing abusive situations with contact information for queer-centred mental health supports, where possible.

Chapter 3: Scoping review protocol

"Intimate partner violence among 2S/LGBTQIA+ people in Canada: A scoping review protocol"

1.0 TITLE

Intimate partner violence among 2S/LGBTQIA+ people in Canada: A scoping review

2.0 OBJECTIVES

We aim to determine what information is available about intimate partner violence (IPV) among sexual and gender diverse people (2S/LGBTQIA+) in the Canadian context. We have outlined the research questions below and within Table 1.

2.1 Primary research question

- What do we know about IPV among 2S/LGBTQIA+ people living in Canada?

2.2 Secondary research questions

- What are the mental health outcomes of 2S/LGBTQIA+ people who experience IPV in Canada?
- What help-seeking behaviours do 2S/LGBTQIA+ people engage in to escape or improve their IPV experiences?

Table 1. Scoping review details

Scoping review title	Intimate partner violence among 2S/LGBTQIA+ people in Canada: A scoping review
Review objectives	To determine what is currently known about 2S/LGBTQIA+ people and IPV in the Canadian context. To gain insight into the mental health outcomes for 2S/LGBTQIA+ people because of their IPV experiences To learn about the behaviours 2S/LGBTQIA+ people engage in to improve or escape their IPV experiences.
Review questions	What do we know about IPV among 2S/LGBTQIA+ people living in Canada?

	What are the mental health outcomes of 2S/LGBTQIA+ people who experience IPV in Canada? What help-seeking behaviours do 2S/LGBTQIA+ people in Canada engage in to escape or improve their IPV experiences?

3.0 INTRODUCTION

Intimate partner violence is a pervasive, international public health problem (Krug et al., 2002). IPV is often conflated with gender-based violence (GBV) and violence against women (VAW), as 1 in 3 women globally will experience IPV within her lifetime (World Health Organization [WHO], 2021b). While women have historically been the focus of IPV discourses and research, conflating IPV with VAW implicitly excludes any non-heterosexual, non-cisgender female person from being considered a "legitimate" victim of IPV (Little, 2020). Indeed, IPV can occur in any type of intimate relationship, regardless of the sexual orientations and gender identities of the partners (Women and Gender Equality Canada [WAGE], 2022a). In fact, sexual and gender diverse (2S/LGBTQIA+) people may disproportionately experience IPV compared to cisgender, heterosexual people (Garthe et al., 2018; Langenderfer-Magruder L. et al., 2016; Ristock et al., 2019; Statistics Canada, 2021a, 2021b). To understand better the existing literature available and research gaps on the topic of IPV among 2S/LGBTQIA+ communities in Canada, we completed initial searches for existing scoping reviews, systematic reviews, primary papers, and research syntheses. Our preliminary review included searches of Ovid MEDLINE, Embase, APA PsycInfo, CINAHL, Cochrane Database of Systematic Reviews, and BMC Systematic Reviews. We also included a grey literature search on Google Scholar. We included 2S/LGBTQIA+, sexual/gender variant, sexual/gender minorities, LGBT, intimate partner violence, intimate partner abuse, and domestic violence as keywords for our search. While our review revealed some literature regarding IPV among 2S/LGBTQIA+ communities, sources focused on specific sub-groups of populations, most often cisgender, same-sex relationships, with little representation of gender diverse or Two-Spirit people. Few sources explore IPV among 2S/LGBTQIA+ people in the Canadian

context, and none of these studies or reviews summarized available information on IPV and 2S/LGBTQIA+ people in Canada or examined the research in detail. We believe we have identified a need for a rigorous review of the state of knowledge regarding IPV in 2S/LGBTQIA+ communities in Canada; as such, we have designed this scoping review to address the gap.

3.1 Key definitions

Intimate partner violence is a broad term referring "to behavio[u]r by an intimate partner or ex-partner that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours" (WHO, 2021). While the WHO definition is broad and appropriate for an international context, Women and Gender Equality Canada (2022) precisely indicates that IPV can occur regardless of sexual orientation or gender identity, whether partners live together and/or are sexually involved, may occur within or after the conclusion of a marriage, common-law, or dating relationship, and may occur in public, private, or online. They continue by including physical, sexual, psychological, financial, spiritual, and technology-facilitated violence, stalking, reproductive coercion, and coercive control. We will apply the WAGE definition because it is both precise and broad, and specific to the Canadian context.

We will define 2S/LGBTQIA+ to include any non-cisgender and/or non-heterosexual person. This includes but is not limited to anyone identifying as Two-Spirit, lesbian, gay, bisexual, pansexual, transgender, queer, intersex, asexual, aromantic, non-binary, gender non-conforming, genderqueer, or genderfluid. Help-seeking behaviour is the act of "searching for or requesting help from others via formal or informal mechanisms" (American Psychological Association, 2022). Since help-seeking behaviour is often applied and defined in the context of medical or other health interventions, we are applying this broad definition to include any act that an IPV survivor may take to resolve, improve, or escape their situation.

4.0 PROTOCOL DESIGN

Our scoping review is guided by the framework initially proposed by Arksey and O'Malley (2005) and amended by Levac, Colquhoun, and O'Brien (2010).

4.1 Identifying the research question

We formulated our research questions through a preliminary review of the literature and discussions with the study team. These questions guide the scope of the project. We define the questions in Table 1.

4.2 Identifying relevant studies

4.2.1 Inclusion criteria

Table 2 includes details about our inclusion/exclusion criteria. Given that IPV is a significant public health problem with social and political relevance, we expect that a variety of media will be eligible for inclusion in this review. We expect to include primary research studies, systematic reviews, meta-analyses, guidelines, reports, books, abstracts, and reports from conference proceedings. The latter of which may provide insight into emerging ideas.

We will only include literature dedicated to IPV committed by a romantic partner in this review. We will exclude items if they focus on IPV within familial or platonic relationships, or if the violence occurred in the context of an intimate relationship exempt from consent (i.e. child abuse, child grooming). These topics are outside of the scope of this review. Though the focus of this review is 2S/LGBTQIA+ people in Canada, we will include any material discussing 2S/LGBTQIA+-identified people in a "heterosexual-facing" relationship (e.g. a bisexual woman in a relationship with a man).

We are not imposing exclusion criteria based on source, publication date, or language to capture as many sources as possible to understand the current context of IPV among 2S/LGBTQIA+ communities in Canada.

Table 2. Inclusion and exclusion criteria

Population	2S/LGBTQIA+ people
Included concept	Intimate partner violence
Included context	Canada
Types of evidence source	All source types included
Inclusion date and languages	All dates, all languages included

4.2.2 Search strategy

We will "hand search" the reference lists of all sources we acquire from databases to identify additional sources. We also intend to include grey literature following the Canadian Agency for Drugs and Technologies in Health (CADTH) guidelines and by exploring the websites and/or publications of organizations relevant to our research question. The study team will contact an organization or the authors of a publication if any information is unclear or confusing.

Table 3. Search strategy summary

Databases	Medline, Embase, PsycInfo, CINAHL
Key terms	Intimate partner violence, intimate partner abuse, domestic violence/abuse, 2S/LGBTQIA+, sexual/gender minorities, LGBTQ+, sexual/gender variant people, Canada
Types of studies	No exclusion based on study type
Grey literature search information	CADTH guidelines and examination of reports from relevant organizations

4.3 Study selection

We will employ a two-phase screening process. In Phase 1, we will assess the publication title and abstract for inclusion based on our predetermined criteria. Any source without an abstract will immediately advance to Phase 2 to ensure we thoroughly screen all materials. The study team is able to read materials written in English, French, Arabic, Hindi, and Spanish. If we discover materials in languages outside the competence of the study team, we will use Google Translate to get a loose translation of the title and abstract and continue our assessment. In Phase 2, we will conduct a full text review of the materials to determine eligibility. Subsequently, we will "hand search" the reference lists of included materials to identify publications not captured in our search strategy. For included materials in languages other than Arabic, English, French, Hindi, or Spanish, we will attempt to identify an individual competent in the source language to advise the team on eligibility. We will organize and manage our materials with Microsoft Excel.

4.4 Data collection

We will employ a data charting process to record relevant and important information from included sources. We provide detailed descriptions of such relevant information in Table 4. Data charting is an iterative process; as such, the information we consider relevant and important may evolve to be different from that shown in Table 4.

Table 4. Data charting

Heading	Description
Author	Names of authors
Date	Date of article sourced
Title of study	Title of article
Year of publication	Year that the article was published
Publication type	Medium (ex. journal, conference, report, etc.)
Study design	Type of study
Methodology	Methods used in study
Study purpose	Goal of the study

Country of origin	Country the study was conducted in
Study population	Any relevant information about study population
Study sample size	Sample size of the study
Reported benefits	Benefits reported in study
Reported challenges	Challenges reported in study
Overall conclusions	Important aspects of the conclusion
Key findings	Noteworthy or relevant findings

4.5 Collating, summarizing, and reporting the results

Following the framework described by Levac and colleagues (2010), we will conduct this stage of the review in three steps: data analysis, reporting the results, and drawing meaning from the data. We will conduct a quantitative analysis of numerical, descriptive information to describe the characteristics of a study, and thematic analysis to draw meaning from narrative data. We will manage narrative data with qualitative data management software (ATLAS.ti) and collate descriptive information with Microsoft Excel. We will apply the PRISMA-ScR checklist to adhere to reporting standards and ensure consistency in our methods. Finally, we will describe the implications of our findings and methodological considerations for future researchers assessing IPV among 2S/LGBTQIA+ people in Canada, and identifying future directions for research.

4.6 Consultation

Currently, we do not intend to consult with professionals and stakeholders about the findings from this review. Should we decide to include a consultation phase during the review, we will conduct semi-structured interviews with representatives from the IPV sector and 2S/LGBTQIA+ advocates in Canada. These interviews are intended to validate our findings and assess the implications and recommendations that result from the work. This phase would also act as a dissemination strategy and be an exercise in knowledge mobilization to stakeholders who would benefit from the results.

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Chapter 4: Article 1
"It definitely changed me": Exploring sexual and gender diverse people's experiences with intimate partner violence in Ontario, Canada

We submitted this article to *Perspectives on Sexual and Reproductive Health* in July 2023. We have formatted the article to meet the guidelines for this peer-reviewed journal.

"It definitely changed me": Exploring sexual and gender diverse people's experiences with intimate partner violence in Ontario, Canada

Kyle J. Drouillard, MSc(c)[1]
Angel M. Foster, DPhil, MD, AM[1*]

[1]Faculty of Health Sciences, University of Ottawa, Ottawa, ON, Canada
*Corresponding Author
Email address: angel.foster@uottawa.ca

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Conflicts of interest: In 2023, KD received a small honorarium from the Sex Information & Education Council of Canada (SIECCAN) to serve as a student reviewer for their Guidelines for Integrating Gender-Based Violence Prevention within School-Based Comprehensive Sexual Health Education.

Word counts: Abstract: 248 words; manuscript (excluding References): 5,856 words

Key words: Abuse, bisexual, Canada, gay, lesbian, transgender, violence

Bios:
Kyle J. Drouillard, MSc(c) (**they/them/iel)** is a Master's candidate in Interdisciplinary Health Sciences at the University of Ottawa. They previously completed their Honours' Bachelor of Science with Specialization in Psychology and a Minor in Social Sciences of Health, also at the University of Ottawa. Their research interests include sexual and gender minority health and well-being, gender-based violence, and comprehensive sexual health education.

Angel M. Foster, DPhil, MD, AM (she/her/hers/anything respectful) is a Professor in the Faculty of Health Sciences at the University of Ottawa where she leads the Collaborative on Interdisciplinary Global Abortion Research. She received her DPhil from the University of Oxford, her MD from Harvard Medical School, and her master's and bachelor's degrees from Stanford University. Her research focuses on emergency contraception, abortion, and health professions education.

"It definitely changed me": Exploring sexual and gender diverse people's experiences with intimate partner violence in Ontario, Canada

ABSTRACT

Introduction: Intimate partner violence (IPV) involves an individual committing acts intended to harm or intimidate a current or former romantic partner. The COVID-19 pandemic and subsequent stay-at-home orders often trapped victims with perpetrators and intensified IPV. Although sexual and gender diverse people disproportionately experience IPV compared to cisgender, heterosexual people, their experiences are not well documented in the Canadian context. This study aimed to explore the experiences of Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other sexual and gender diverse (2S/LGBTQIA+) people with IPV in Ontario and how the COVID-19 pandemic affected their IPV experiences.

Methods: We conducted in-depth, semi-structured interviews with self-identified 2S/LGBTQIA+ people who experienced IPV on/after March 15, 2020. We audio-recorded and transcribed all interviews and coded the transcripts for content and themes using inductive and deductive techniques.

Results: Our 20 participants experienced physical, psychological, sexual, and financial abuse. Technology-facilitated violence extended abuse geographically and temporally. Intimate partner violence experiences were associated with negative mental health outcomes that were intensified by the COVID-19 pandemic. Participants struggled to see themselves as legitimate victims of IPV. Although participants regretted being victims of violence, many saw their abusive relationship(s) as a learning experience to inform future relationships.

Discussion: Our findings suggest that 2S/LGBTQIA+ people may experience unique forms of violence related to their identities and may have difficulty recognizing their IPV experiences as abuse. Ensuring that comprehensive sexual health education is trauma-informed, anti-oppressive, and includes information about healthy relationship dynamics, 2S/LGBTQIA+ relationships, and IPV is critical.

INTRODUCTION

Intimate partner violence (IPV) is a public health problem in which an individual commits acts intended to harm or intimidate a current or former romantic partner.[1] Intimate partner violence includes physical aggression and psychological abuse, sexual violence and coercion, coercive or controlling behaviours, stalking, financial abuse, spiritual abuse, reproductive coercion, and technology-facilitated violence (TFV) that is, the use of digital technologies to perpetuate harm in-person or virtually.[2,3] Intimate partner violence is associated with acute and chronic health problems including physical injury and chronic pain, sexually transmitted infection acquisition, unintended pregnancy, genitopelvic pain, gastrointestinal problems, and mental health conditions like depression, post-traumatic stress disorder (PTSD), and substance use.[4]

Intimate partner violence is often conflated with violence against women (VAW) and gender-based violence (GBV); indeed, there is overlap between these phenomena, as 1 in 3 women worldwide will experience IPV at some point in their lifetimes.[3] However, Women and Gender Equality Canada acknowledges that IPV can occur in any type of intimate relationship and independent of the gender identity and sexual orientations of the partners involved.[2] In fact, Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other sexual and gender diverse people (2S/LGBTQIA+) may be more likely to experience IPV compared to cisgender, heterosexual people.[5,6] Global research indicates that sexual minority men are more likely to experience physical, psychological, and sexual abuse and stalking compared to heterosexual men[5,7] and sexual minority women experience all forms of IPV more than sexual minority men,[5,8–10] with bisexual women being the most at risk for all forms of IPV.[5,8] These trends appear to be true in the Canadian context, as well.[11,12] In general, transgender and gender non-conforming people experience higher rates of IPV than cisgender people.[13–16] In Canada, analyses from the 2019 TransPULSE survey suggest that more than 3 in 5 transgender women have experienced IPV since age 16, including verbal abuse, threats of physical violence, physical assault, and

sexual coercion.[17] Although prevalence data are scarce, Two-Spirit and LGBTQ+ Indigenous people living in Canada may be at an even greater risk of IPV.[18]

The COVID-19 pandemic and consequent stay-at-home orders often trapped victims with their perpetrators, spurring a "shadow pandemic" of IPV that intensified in frequency and severity.[19–21] In response, the Government of Canada injected CAD100 million (USD75 million) in the first year of the pandemic into VAW and GBV services to ease the suffering of women experiencing IPV.[22] Despite previously acknowledging that 2S/LGBTQIA+ Canadians disproportionately experience IPV compared to cisgender, heterosexual people,[23] these populations were not explicitly included in this emergency funding. Although the prevalence of IPV among 2S/LGBTQIA+ people – especially sexual minorities – is recorded, there is a dearth of literature that documents the experiences of 2S/LGBTQIA+ people with IPV in the Canadian context, whether before or during the COVID-19 pandemic. This study aimed to begin filling that gap.

METHODS

Between November 2021 and July 2022, we conducted semi-structured, in-depth interviews with 2S/LGBTQIA+ people who experienced IPV during the COVID-19 pandemic in Ontario, Canada's most populous province. We aimed to document 2S/LGBTQIA+ people's experiences with IPV, explore how the COVID-19 pandemic affected 2S/LGBTQIA+ survivors' experiences and access to services, and gain perspectives on how IPV-related services for the 2S/LGBTQIA+ community could be improved. Eligible participants: 1) Self-identified as being 2S/LGBTQIA+; 2) Self-identified as having experienced IPV since March 15, 2020; 3) Were 18 years of age or older at the time of the interview; 4) Had access to a telephone or an Internet connection; 5) Had a safe space to have a discussion; and 6) Were sufficiently fluent in English to complete an interview.

We employed a multi-modal recruitment strategy of physical flyers and e-flyers circulated on social media and online marketplace websites including Facebook, Instagram, Twitter, LinkedIn, and Kijiji. The study team circulated the physical and digital flyers through their personal and professional networks to raise awareness of the study. Potential participants contacted the study team via email, where we confirmed participants' eligibility, provided a digital copy of the consent form, and scheduled a mutually convenient time for an interview. KD, the Principal Investigator and Master's candidate in Interdisciplinary Health Sciences at the University of Ottawa, conducted all interviews after intensive qualitative methods and interviewing training from AMF, a medical anthropologist and global sexual and reproductive health researcher.

Due to the pandemic situation at the time of data collection, we conducted all interviews via telephone or audio-only Zoom, per participant preference. We obtained oral consent from participants at the outset of the interview and recorded their responses on a physical copy of the form. We reminded participants that they could refuse to answer questions or rescind their consent at any time without consequence. Interviews lasted between 45 and 180 minutes and included demographic information, relationship history, IPV experiences in current and former relationships, and participants' reflections on their IPV experiences generally and in the context of the COVID-19 pandemic. We concluded interviews with questions about participants' knowledge of and/or experiences with VAW/GBV/IPV services and/or 2S/LGBTQIA+ community organizations. At the conclusion of each interview, we emailed participants a CAD40 (USD30) gift card as compensation.

We took written notes throughout interviews and audio-recorded all interviews with participants' consent, which we subsequently transcribed verbatim. KD formally memoed immediately following each interview to reflect on their positionality, interview dynamics, and emergent content and themes and to establish when we achieved thematic saturation – the endpoint of data collection.[24] We suspected we had reached thematic saturation after 17 interviews and conducted three additional

interviews as confirmation. Collectively, interview notes, audio-recordings, transcripts, and memos comprise the data for this study. We managed our data with ATLAS.ti (Version 22) software, with which we coded our data for content and themes using inductive and deductive techniques.[25]

The Social Sciences and Humanities Research Ethics Board of the University of Ottawa approved this study. We have arranged our results by theme and elucidate our findings with direct quotations and narrative vignettes. We have used pseudonyms to refer to our participants and removed or masked any identifying information to maintain participant confidentiality.

RESULTS

Participant characteristics

We interviewed 20 people for this study. Participants were between 18 and 49 years of age at the time of interview, with the vast majority being under 35. More than half of the participants self-identified as a person of colour, though the largest racial demographic self-identified as being white, Caucasian, or Jewish (n=9). Nearly all participants completed at least some postsecondary education (n=19) with the greatest proportion having completed an undergraduate degree or higher (n=9). Participants self-identified their sexual orientations as being bisexual or pansexual (n=11), lesbian or gay (n=5), asexual (n=3), and/or demisexual (n=2) and identified their gender identities as cisgender female (n=11), cisgender male (n=5), non-binary or genderfluid (n=3), and transgender male (n=1). No participants self-identified as transgender female, transfeminine, Two-Spirit, or intersex.

Although experiences varied, every participant reported experiencing some form of psychological violence, including verbal abuse and coercive and controlling behaviours. Psychological abuse often occurred in conjunction with physical assault or threats of physical violence (n=13), sexual violence or coercion (n=8), and financial abuse (n=4). Five participants experienced at least part of their IPV via technology and almost half of all participants reported experiencing three or more forms of IPV

from the same perpetrator. Participants' IPV experiences lasted anywhere from two months to nine years with most (n=17) lasting three years or less at the time of interview. While most participants had already left their abusive relationships, four remained in ongoing violence situations and one was experiencing a lapse in IPV. Nearly all participants lived in large urban population centres (>100,000 people) at the time of their IPV experience, as per the Population Centre and Rural Area Classification 2016.[26] For detailed information about our participants, see Table.

IPV experiences negatively impacted survivors' mental health

Most participants (n=15) reported mental health problems due to their IPV experiences. Some participants who accessed mental health supports during or after their IPV received new mental health diagnoses from service providers, including diagnoses of depression, anxiety, and PTSD. As Maryam, a 19-year-old bisexual cisgender woman explained, "I was diagnosed with complex PTSD…I used to be a social person that would very easily make friends. Now, I'm just terrified of making new friends because the last new friend I made was [the perpetrator] and that turned out like this." Iba, a 26-year-old bisexual non-binary person was already living with an anxiety disorder and felt that the combined physical aggression, psychological manipulation, and financial abuse they experienced from their perpetrator exacerbated their condition, "I think it negatively impacted my mental health because it heightened my anxiety which I already had".

Participants who did not have a formal mental health diagnosis still recognized that that their abusive situations affected their mental health. Gerald, a 20-year-old cisgender gay man, explained the lasting effects of being repeatedly physically assaulted and berated by his perpetrator:

> It definitely changed me, mentally. I'm not the same person I was…I [am] not as vibrant as before…I just haven't been the same. I used to talk a lot, I used to go out a lot, I used to jump and laugh and scream…now I've just eaten that part of me.

Similarly, Tamara, a 26-year-old pansexual cisgender woman realized in retrospect that her perpetrator's persistent criticism and controlling behaviours contributed to her declining mental health and that she was using alcohol to cope with her abuse and avoid her partner.

> [My mental health had] never been worse, honestly, now that I think about it … I started to drink a lot and really just use any excuse I could possibly find or come up with to be out of the house, which meant a lot of the time, you know, like, going to a bar at one o'clock in the morning by myself and … downing a bunch of beer to put me to sleep and then doing the same thing again the next day, just so I could spend less conscious time awake and around this person.

Three participants revealed that their declining mental health manifested in physical ailments, including physical pain, sudden weight loss, and difficulty managing chronic health conditions, as Hector, a 25-year-old gay cisgender man, described: "I'm not managing my diabetes well. I feel like, kind of, if I weren't dealing with all of this, I could be on top of my health more."

The COVID-19 pandemic exacerbated survivors' IPV experiences

The COVID-19 pandemic was an intensifying experience for participants. While some participants found positive aspects to the pandemic, including working from home, pursuing hobbies, and having the opportunity to spend more time alone, most explained that the pandemic was a draw on their mental health, often in the form of heightened anxiety or depression. Hima, a 29-year-old demisexual genderfluid person, described this tension:

> The positive is that [the pandemic]'s made things more accessible for me…especially as someone with social anxiety…so, that's been a positive. A negative is that…I feel like I've [gone] like, full out agoraphobic. Like, it's very hard for me to leave the house without someone there.

Furthermore, participants directly attributed the COVID-19 pandemic and stay-at-home orders to new or worsened IPV. Iba believed they would not have gone through their abusive situation if it were not for the pandemic, because "it would have been a lot different if I was going to work, and I was still going out with my friends because…they would have noticed, or my co-workers would have

noticed." Participants living with their perpetrators noticed their relationships deteriorating from being confined to their living space during lockdown periods. Aly, a 31-year-old bisexual cisgender woman, remarked on how spending long periods of time with her perpetrator intensified the frequency and severity of physical and psychological abuse. "I don't think that it is healthy for anyone to be with anyone that much. It causes arguments and…it turns into a big, huge argument and things get violent. It was happening a lot more because we were around each other a lot more."

Stay-at-home orders were accompanied by loss of employment or a reduction in work hours for non-essential workers and those who could not work from home, including many of our participants and their perpetrators. These financial stressors increased the tension at home and sometimes brought violence and abusive behaviour to a head. As Amyra, a 25-year-old lesbian cisgender woman, explained: "I think with COVID and with [my] job loss…there have been more conflicts than normal…since I lost my job, I became more…dependent on her financially and that's when things started getting kind of rocky". Gerald's Story (Fig. 1) shows how the combination of deteriorating mental health, stay-at-home orders, and financial stressors due to the COVID-19 pandemic contributed to his previously positive relationship turning violent.

[Insert Figure 1 about here]

Technology extended the reach and duration of IPV

Outlier analysis of participants who experienced technology-facilitated violence (TFV; n=5) reveals that perpetrators used phone calls, text messages, video calling, social media, and location tracking applications to extend their violent and controlling behaviours beyond in-person interactions. Technology-facilitated violence was particularly useful to perpetrators separated from their victims during COVID-19 stay-at-home orders. Claire, a 23-year-old, pansexual cisgender woman found reprieve

from physical and sexual violence when she was separated from her perpetrator during a COVID-19 lockdown but continued to experience manipulative and controlling behaviours.

> [The pandemic] meant that I no longer [had] to have painful sex or fight in-person. It didn't stop him from… berating me with phone calls and text messages…I had to FaceTime him every night at the same time at 10pm… he still had that control over my daily schedule.

Although perpetrators predominantly used TFV as a mode of control, Maryam's Story (Fig. 2) elucidates how in-person physical and sexual violence can continue to be perpetrated virtually.

[Insert Figure 2 here]

Perpetrators also deployed TFV to extend abusive behaviours beyond the life of a relationship. Sandra, a 21-year-old pansexual cisgender woman, managed to leave the home she rented with her perpetrator, but found that ending her relationship did not stop the abuse; rather, her perpetrator turned to online harassment via social media direct messaging (DM). "Their friends will message me and DM me and stuff and be like, you know, you're terrible, you're such a bad person…Sometimes they [the perpetrator] make, like, fake accounts to like, yell at me."

Colt, an 18-year-old gay cisgender man, regularly experienced sexual coercion and TFV in his relationship. His perpetrator had access to his social media, put a location tracker on Colt's phone, and demanded photo evidence of Colt's whereabouts. Colt tried to use technology to his advantage by sending his partner sexual photos to placate his perpetrator and reduce his risk for sexual violence, but now he is reticent to leave his relationship for fear that these photos could be weaponized as revenge porn. "He has my nudes, obviously. I think that my biggest fear is that he'll probably take it as…revenge, put it out there, or something."

Asexual, bisexual, and pansexual survivors experienced IPV specific to their sexual orientation

Participants who identified as asexual, bisexual, and pansexual described experiencing IPV directly related to their sexual orientation. Both participants who identified as asexual at the time of their IPV experiences revealed that their sexual orientation was used as a tool for verbal abuse. Rudy, a 30-year-old asexual cisgender man, describes being berated by his cisgender female perpetrator for not wanting to engage in "normative" sexual behaviour:

> Our sexual relationship more and more became an issue…it would get more…berating and more like personally insulting as opposed to like, "I wish we could do this [sexually]" but, it was like, "what are you even good for?" and things like that…[her] frustration turned, sort of, into verbal like, insults and berating, abusive type stuff.

More than half of the bisexual and pansexual participants we interviewed (n=6) reported that their perpetrators used bi-erasure – the idea that bisexuality and pansexuality are not real or legitimate sexual orientations – and stereotypes that bisexual and pansexual people are sexually adventurous, promiscuous, and disloyal to justify their abusive behaviours. Claire's Story illustrates these dynamics (Fig. 3). Sandra attributed some of the physical abuse she experienced to her perpetrator's disbelief in her sexual orientation, and their insecurities stemming from that belief:

> There was always so much pushing…I think it's because they were like…they pressured me into…changing my orientation, which is impossible…I don't know why, but I think [my sexual orientation] made them very insecure…even though I'm clearly in a relationship with them, they didn't like that.

[Insert Figure 3 here]

Tamara explained that her perpetrator employed accusations that she was "cheating" with her male and masculine friends to isolate her from her support networks:

> Any of my friends who were men, whether cis, trans, [non-binary], like, it didn't matter. Anyone who was, like, remotely a man, she disapproved of…she was like…'If a straight man hits on you, you're bi, so you're going to leave me for him'… She was very much not concerned with other women and was very much threatened by the men in my life.

Survivors struggled to see themselves as victims of violence

Participants had difficulty recognizing their relationships as abusive. Those, like Maryam, whose perpetrator was her first intimate relationship, did not have the education or experience to distinguish "normal" relationship dynamics from abusive behaviours. "I…thought that these things were normal that you do in relationships. You know, she told me that she loved me, and so, I thought that she loved me. Those words have a lot of power over somebody." Claire's perpetrator was also her first "big" relationship and she had trouble coming to terms with the fact that he was abusing her. Claire did not think her experiences "fit the mold of what an abuse survivor looks like" and attributed contemporary discourses around "toxicity" to not identifying her abusive situation sooner. "At first, I didn't want to accept that it's abuse…maybe it was just toxic. I think that's an issue in our society nowadays, is that we call things 'toxic' very easily, which just helps to blur the lines of what is 'toxic' and what is actually abusive."

Participants also questioned the severity of their experiences, especially when their abuse was predominantly psychological or verbal. As Emily, a 29-year-old cisgender queer woman, explained: "I didn't even really see it as something that was…extreme enough to reach out for help…I always thought, okay, if there's like, [physical] violence or something happening…it needs to get to that point before I reach out for anything or talk to anybody about this." Similarly, Colt struggled to see his perpetrator's controlling and coercive behaviours as abusive, with his perception that IPV is a man-batters-woman dynamic precluding him from being a victim:

> I thought…domestic violence and abuse came through physical altercations where they're actually hitting you…Even all these…domestic violence ads, it was always this woman with a black eye, and I thought it was just, you know, more physical, and nothing that involved, you know, emotional or verbal [abuse], or those being classified as violent traits.

Participants felt negatively about their IPV experiences, but sought to learn from them

An outlier analysis of participants who were in ongoing violence situations at the time of the interview revealed that these survivors felt a mixture of fear, hopelessness, and resignation about their relationships. Colt described feeling three things about his ongoing abusive situation, “Number one: fear…Number two is like, I don’t want to say stupid but, I do feel stupid that I am in this situation…Number three…I’m not happy with what is going on.” Aly expressed feeling hopeless that her long-time physically and psychologically abusive relationship would improve. “I feel sad a lot of the time about it and I’m starting to lose hope…There was a lot of hope there in the beginning that things might get better, but that really isn’t the case anymore. I have given up.”

Participants who left abusive relationships reported anger, frustration, and grief at being a victim/survivor of IPV. Sandra was unequivocal about her feelings that “I regret it 100%. I regret even beginning [the relationship]. I should have just left them a long time ago.” Others were processing internal feelings of shame and culpability for entering an abusive relationship. Claire described her IPV experience as standing in contrast to her perception of herself and others’ perceptions of her:

> A lot of it is guilt and frustration towards myself, where, before that relationship, and even throughout, I considered myself…a strong independent woman…and it felt like that version of myself that I knew didn’t align with this new version of myself who was in this abusive relationship.

Although all participants described feeling negatively about their IPV experiences, many sought to see their abusive relationships as a learning experience. Maryam expressed feeling angry about being a survivor of violence while acknowledging that it was a formative experience for her. “I wish it didn’t happen and I wish I didn’t have to go through that, but I’m also not mad that it happened. I feel angry that I was taken advantage of and that I had to go through that, but I’m not mad about it because I learned a lot of things about myself”. Rick, a 31-year-old gay cisgender man explained that the verbal abuse and attempted physical assault he experienced in a casual sexual relationship has improved his ability to choose future partners. “It’s all part of a learning experience. I mean, you have to take the

good and the bad and it's how you learn from it. So, more being able to tell those cautionary signs and stuff like that and being able to pick up on them better."

Participants discussed how their IPV experiences affected their ability to forge open, trusting relationships in the future. Leo, a 27-year-old pansexual transgender man explained, "It's definitely fucked up my relationships, my future relationships. My love life, kind of, is definitely affected, and I guess, like, how I relate to people." Indeed, many participants expressed reticence to entering a new intimate relationship following their violence experiences. Jenna, a 39-year-old cisgender woman, reflected on what she learned from her past intimate relationships. "I learned a lot about myself, about the world, about my partners, through having relationships, and I've had enough relationships to basically know that I have had enough relationships." This realization culminated in her changing her sexual identity from pansexual to asexual. Participants' breadth of feelings about their IPV experiences and their resilience in the face of violence is exemplified in Leo's Story (Fig. 4).

[Insert Figure 4 here]

Discussion

Our participants represent a diverse group of sexual and gender minorities with multiple intersectional identities whose IPV experiences included physical threats and assault, psychological manipulation, sexual abuse and coercion, and financial abuse. A subset of participants' IPV extended beyond the geographic and temporal bounds of their relationships via TFV. As digital communication and social media continue to become omnipresent in daily life, it stands to reason that TFV may become more common; however, TFV is ill-defined in the literature, where inconsistencies in definition and measurement result in a broad range of prevalence estimates.[27] Therefore, it is difficult to establish a body of work that can inform policy and reporting guidelines to support victims/survivors of TFV. It is

critical that researchers and other IPV experts develop a universal, accepted definition of TFV and validated measures that accurately capture the breadth of TFV types, whether physical, psychological, sexual, or financial.

Participants also reported unique forms of abuse based on their sexual orientations and gender identities, particularly bisexual, pansexual, and asexual participants. Perpetrators' use of biphobic stereotypes to control bisexual and pansexual victims and the weaponization of "normative" sexuality to degrade and berate asexual victims is borne out in the existing literature, though research on these phenomena is scarce.[28,29] Though the experiences of transgender people are not reflected in this study, emerging research suggests that these communities may also experience unique forms of psychological IPV in the form of misgendering and deadnaming.[30] More research about the IPV experiences of bisexual, pansexual, asexual, and transgender people is needed to identify risk and protective factors for IPV and inform policy to address the unique forms of violence these populations face.

Despite variations in frequency, severity, and type of IPV, participants overwhelmingly described experiencing negative mental health outcomes, including new or worsening cases of depression, anxiety, and PTSD. These findings are reflected in the existing literature indicating that IPV may more adversely affect mental health than other traumatic events.[31] Furthermore, the COVID-19 pandemic was an intensifying experience for our participants, who directly attributed both novel and worsening IPV and declining mental health to the fear, financial uncertainty, and loneliness associated with pandemic public health measures, including stay-at-home orders. It is well-established that the COVID-19 pandemic has been associated with increases in the severity and frequency of IPV[19–21,32] and increased feelings of isolation and associated mental health problems, particularly among populations who experience precarious employment and finances.[33,34] Indeed, some participants specifically identified financial stress as a catalyst for their new or intensified IPV experiences. Given that 2S/LGBTQIA+ people in Canada are more likely to experience financial hardship, food insecurity, and housing insecurity

compared to cisgender, heterosexual people,[35,36] it is conceivable that financial stressors may play a larger role in IPV perpetration and victimization among sexual and gender diverse populations.

Furthermore, heteronormative cultural scripts perpetuating GBV/IPV as a "man-batters-woman" phenomenon implicitly determine who is an acceptable "victim" of violence[37] and affects 2S/LGBTQIA+ people's ability to recognize GBV/IPV within their relationships and communities.[38] Indeed, our participants' difficulty in seeing themselves as victims/survivors of violence suggests that they lacked the knowledge, experience, or education to recognize abusive behaviours in their relationships. Comprehensive school-based sexual health education has the capacity to advance knowledge and increase acceptance of 2S/LGBTQIA+ identities, reduce queerphobic violence, and give students the skills to reduce IPV incidence.[39] Since all participants had completed at least secondary education at the time of interview, this finding suggests participants' school-based sexual health education did not meet their needs, particularly in the province of Ontario. As such, the Government of Ontario must implement a comprehensive sexual health curriculum that includes dimensions of healthy relationships, consent, IPV/GBV, and recognizing abusive behaviours. Such a curriculum needs to be based in a trauma-informed, anti-oppressive framework that explicitly includes 2S/LGBTQIA+ relationships, as recommended in the Sex Information and Education Council of Canada (SIECCAN) Guidelines for Integrating Gender-Based Violence Prevention within School-Based Comprehensive Sexual Health Education.[40]

Limitations

As with any qualitative research, it is neither a function nor a goal of this study to be generalizable; however, we are confident that the results are credible, trustworthy, and transferable beyond the bounds of this study. The main limitations of this study concern recruitment. Almost all participants were living in urban centres at the time of their IPV experiences and our eligibility criteria did not

include French-speaking individuals; therefore, the experiences of rural-residing and French-speaking minority populations in Ontario are not reflected here. Also, we did not capture the experiences of transgender women, Two-Spirit people, or transfeminine people assigned male at birth, despite these populations being at greater risk of IPV. Moreover, our transgender male participant experienced his violence before he began transitioning. Future studies should focus on the IPV experiences of these populations and further explore the role of sexual orientation and gender identity in IPV victimization and perpetration, particularly among bisexual, pansexual, asexual, and transgender people.

Conclusion

Intimate partner violence is a public health problem that disproportionately affects sexual and gender diverse people. However, their experiences are not well recorded in the Canadian context. Our participants experienced multiple, concurrent forms of IPV – physical, psychological, sexual, and financial – both in-person and virtually, which resulted in negative mental health outcomes that were exacerbated by the COVID-19 pandemic. Our results suggest that 2S/LGBTQIA+ people may experience unique forms of IPV related to their sexual orientation and gender identity and that these communities may have difficulty recognizing themselves as legitimate victims/survivors of violence. As such, governments need to implement a queer-inclusive comprehensive sexual health curriculum that empowers 2S/LGBTQIA+ people to identify abuse in their relationships and communities. It should be trauma-informed, anti-oppressive, and include healthy relationship dynamics, gender-based violence, and intimate partner violence. Future research would benefit from the inclusion of language minority groups in Canada and those who reside in rural areas and should explore further the IPV experiences of Two-Spirit, bi/pansexual, asexual, and transgender people, especially transgender women and transfeminine people assigned male at birth.

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Table: Characteristics at the time of the interview of 2S/LGBTQIA+ participants in Ontario who have experienced intimate partner violence (IPV; N=20)

Characteristic		N
Age	18-24	7
	25-29	7
	30-34	4
	35+	2
Racial/ethnic identity	White/Caucasian/Jewish	9
	Asian/South Asian/Chinese	7
	Black/African-American	2
	Mixed/Brown	2
Education	Undergraduate degree or higher	9
	College diploma	3
	Some college/university	7
	High school diploma	1
Sexual orientation	Bisexual/pansexual	11
	Lesbian/gay	5
	Asexual	3
	Demisexual	2*
Gender identity	Cisgender woman	11
	Cisgender man	5
	Non-binary/genderfluid	3
	Transgender (man)	1
IPV experienced**	Psychological/verbal	20
	Physical	13
	Sexual	8
	Financial	4
	Technology-facilitated	5
Different types of IPV experienced	1	2
	2	10
	3+	8
Duration of IPV	<1 year	5
	1-2 years	5
	2-3 years	7
	5+ years	3
Location during IPV experience***	Rural area	0
	Small population centre	1
	Medium population centre	0
	Large urban population centre	19

* Described in combination with other sexual and gender identities
** Participants reported multiple forms of violence
*** As defined by the Population Centre and Rural Area Classification 2016[26]

Gerald is a 20-year-old cisgender gay man living with his long-time boyfriend in a shared apartment. Gerald describes the beginning of his relationship as “amazing, like a dream. Then, when the pandemic hit … it became very difficult”. Due to stay-at-home orders, Gerald started doing his college work from home and his partner had his work hours reduced. “I would say in the first months we had more fights than in our entire relationship. That was a huge flag. I could tell that he was getting very uneasy. I could tell something was wrong…that was kind of…when things started to sour”.

Gerald’s partner would yell at him about minor domestic issues like cleaning and chores. In these instances, Gerald’s partner would “just kind of degrade me…he would say that I’m not doing anything, that I’m just taking up space”. Initially, Gerald did not engage in these arguments, “For the first few months, I would just keep my mouth shut. But, I got fed up with it, so I yelled back, and that’s when things escalated”. Gerald’s perpetrator began slapping and punching him “in the arms, in the body…rarely in the head. That’s only if he was really angry”.

Gerald noticed that the arguments, berating, and physical assaults have gotten better since he returned to in-person classes and his partner resumed his full-time job. Gerald describes his relationship like a rollercoaster, “up in the beginning, down, and then up again”. While this experience has made Gerald feel “frail,” he still loves his partner and has no plans to leave the relationship.

Figure 1. Gerald’s Story

Maryam is a 19-year-old bisexual, cisgender woman who first noticed her perpetrator's troubling behaviours within a month of their relationship. Initially, her perpetrator would direct violence toward herself – punching the wall, punching herself, hitting her head against the wall. But, as her perpetrator got more comfortable in the relationship, she started directing the violence at Maryam.

Maryam's perpetrator would get upset with her if things were not "done right", prompting Maryam to have to guess what was wrong and fix it. The more Maryam got something "wrong" the angrier her perpetrator would get. In person, she would physically assault Maryam, "Basically, I was like a punching bag". Maryam also experienced repeated sexual violence, "Any sexual sort of interaction that we did have, there was some aspect of it that was non-consensual".

When Maryam was unable to see her perpetrator in-person due to the pandemic and lockdowns, the abuse moved virtual. According to Maryam, "It got so much worse when it was online". If her perpetrator was upset, she would coerce Maryam into performing sexually, where "if you want to make me feel better, you'll send me…explicit photos of yourself". Other times, Maryam was coerced into physically harming herself to make her partner "feel better". "I'd have to cut myself or…hurt myself in some way…using my fists or…things that were near me".

Figure 2. Maryam's Story

Claire is a 23 year-old cisgender, pansexual woman whose perpetrator was openly homophobic early on in their relationship. When Claire revealed to him that she was pansexual he accused her of trying to get attention and manufacturing discrimination to counterbalance her privileged status as a white woman.

Throughout their relationship, Claire's perpetrator stifled activities that affirmed her pansexual identity. He found one of her favourite queer-centred television shows "appalling" and insisted they only consume the media he wanted. He forbade her from participating in Pride festivals and events and mocked her for wanting to attend. Claire became isolated her from her interests, her social supports, and her identity. Claire began to question her sexuality and whether he was correct that her pansexuality was attention-seeking. She feels that he was taking that part of her identity away from her, even as he would use her pansexuality to his advantage: "[H]e was very homophobic…[but,] he sort of benefitted from it in that, he wanted to do things like threesomes, and he would say like 'oh, since you're also into women' for instance, 'let's do that, then'…he accepted [my sexuality] when it was to his benefit, but then denied it when it came to my identity outside of like, the bedroom".

Figure 3. Claire's Story

Leo is a 27-year-old pansexual transgender man who experienced psychological and sexual abuse from his long-time partner before his transition. Leo describes the relationship as "toxic" and has since recognized that his perpetrator's behaviours were abusive. Leo describes his perpetrator as a narcissistic manipulator who pushed sexual boundaries and coerced Leo into non-consensual sexual activity.

Leo has conflicting feelings about his IPV experiences. He feels partly angry and frustrated for having been a victim/survivor of violence. Leo is "[f]rustrated at him. Frustrated at myself, for having stuck with it...Frustrated at the world, at the counselors I was seeing at the time that didn't notice anything. Frustrated at my family or friends for not speaking up". Another part of Leo is grieving for his younger self because "I was with him…[for] almost 10 years and I just grieve the person that I might have become", while also recognizing that this experience has formed him into the person he is today: "Throughout this I've kind of learned to be less harsh on myself, more accepting of myself…because I'm now in a safe place I can be who I am".

More recently, Leo feels grateful for the experience because it gave him the skills to help loved ones in similar situations, "It sounds fucked up but, [I feel] grateful because of the experience I've gone through. I've been able to talk to friends of mine who are in similar situations and talk them out of their situations through talking about what I've experienced".

Figure 4. Leo's Story

Chapter 5: Article 2
"Falling through the cracks": Exploring the challenges to serving 2S/LGBTQIA+ survivors of intimate partner violence in Ontario, Canada

We submitted this article to *The Canadian Journal of Human Sexuality* in August 2023. We have formatted this article to meet the formatting requirements of that peer-reviewed journal.

“Falling through the cracks”: Exploring the challenges to serving 2S/LGBTQIA+ survivors of intimate partner violence in Ontario, Canada

Kyle J. Drouillard, MSc(c)[a]
Angel M. Foster, DPhil, MD, AM[a]*

[a]Faculty of Health Sciences, University of Ottawa, Ottawa, Canada
*Corresponding author
Email address: angel.foster@uottawa.ca

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Ethics: We obtained approval for this study from the Social Sciences and Humanities Research Ethics Board of the University of Ottawa.

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Statement: This manuscript has not been previously published and is not under consideration for submission elsewhere.

Bios:

Kyle J. Drouillard, MSc(c) (they/them/iel) is a master’s candidate in Interdisciplinary Health Sciences at the University of Ottawa. They previously completed their Honours’ Bachelor of Science with Specialization in Psychology and a Minor in Social Sciences of Health, also at the University of Ottawa. Their research interests include sexual and gender minority health and well-being, gender-based violence, and comprehensive sexual health education.

Angel M. Foster, DPhil, MD, AM (she/her/hers/anything respectful) is a Professor in the Faculty of Health Sciences at the University of Ottawa where she leads the Collaborative on Interdisciplinary Global Abortion Research. She received her DPhil from the University of Oxford, her MD from Harvard Medical School, and her master’s and bachelor’s degrees from Stanford University. Her research focuses on emergency contraception, abortion, and health professions education.

Abstract

Intimate partner violence (IPV), that is aggressive or abusive behaviour perpetrated by an intimate partner against a current or former romantic partner, is a public health problem that may disproportionately affect sexual and gender diverse (2S/LGBTQIA+) populations. However, these communities' experiences seeking services for IPV in Canada is not well documented. We conducted semi-structured interviews with 20 self-identified 2S/LGBTQIA+ people in Ontario who experienced IPV and 10 key informants from IPV-related services and 2S/LGBTQIA+ community organizations. Sexual and gender diverse IPV survivors were mostly unaware of services they could access for help and confided in their social supports rather than reporting their abuse. Survivors reported wanting access to judgement-free help lines and both in-person and virtual mental health services. Key informants reported that services are inadequately funded through a patchwork of grants and donations that impede their ability to meet community needs. Although gender-based violence organizations are nominally supportive of serving 2S/LGBTQIA+ people, there is institutional anxiety about expanding eligibility and a lack of competency to do so. Moreover, organizational policies and funding mechanisms operate on a second-wave feminist framework that perpetuate 2S/LGBTQIA+ exclusion from services. Intimate partner violence services and 2S/LGBTQIA+ community organizations need to increase their visibility and improve outreach to these communities. Mental health professionals need to regularly screen for IPV, and comprehensive sexual health education that addresses 2S/LGBTQIA+ relationships and abusive behaviours is warranted for IPV prevention. The gender-based violence sector must change to an intersectional feminist framework that includes 2S/LGBTQIA+ people in their mandates.

Keywords: Canada, domestic abuse, gender-based violence, intimate partner violence, LGBTQ, violence against women

Introduction

Intimate partner violence (IPV) is a public health issue characterized by harmful behaviours perpetrated by an intimate partner against a current or former intimate partner (Krug et al., 2002), including physical aggression or threats, psychological abuse, coercive control and controlling behaviours, sexual assault and coercion, financial abuse, spiritual abuse, reproductive coercion, and technology-facilitated violence (Women and Gender Equality Canada [WAGE], 2022; World Health Organization [WHO], 2021). Intimate partner violence is often conflated with violence against women (VAW) and gender-based violence (GBV), since women experience the greatest prevalence of IPV worldwide, with 1 in 3 women experiencing IPV during their lifetime (WHO, 2021); however, IPV can occur in any type of relationship, regardless of the sexual orientations and/or gender identities of the partners (WAGE, 2022).

Indeed, Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other sexual and gender diverse people (2S/LGBTQIA+) may disproportionately experience IPV compared to cisgender, heterosexual people (Breiding et al., 2014; Peitzmeier et al., 2020). Global research indicates that sexual minority women, especially bisexual women, may experience all forms of IPV at greater rates than men (Bermea et al., 2018; Breiding et al., 2014; Campo & Tayton, 2015; Coston, 2017) and sexual minority men may be at a higher risk of IPV compared to cisgender, heterosexual people (Breiding et al., 2014; Dickerson-Amaya & Coston, 2019). Furthermore, transgender and gender diverse people are more likely to experience IPV compared to cisgender people (Garthe et al., 2018; Langenderfer-Magruder L. et al., 2016; Valentine et al., 2017). These trends appear to be true of the Canadian context, as well (Bucik, 2016; Statistics Canada, 2021a, 2021b; TransPULSE Canada, 2021). The limited research on Two-Spirit and LGBTQ+ Indigenous people living in Canada also suggests that these populations may be at a greater risk of IPV compared to settler populations (Ristock et al., 2019).

The COVID-19 pandemic and consequent stay-at-home orders spurred a “shadow pandemic” of IPV that may have trapped victims with their perpetrators and intensified the frequency and severity of

IPV (Haag et al., 2022; Peitzmeier et al., 2022). Consequently, VAW/GBV organizations experienced increased demand and decreased capacity while attempting to pivot services toward more accessible, virtual models (Haag et al., 2022). In the first year of the COVID-19 pandemic, the Government of Canada responded with an injection of CAD100 million in emergency funds to help VAW organizations adapt to COVID-19 public health protocols and better meet the increased demand for VAW services observed throughout the pandemic (WAGE, 2021). Sexual and gender diverse populations were not explicitly included in these funds, despite previous government acknowledgements that these communities may be at particular risk for IPV (Public Health Agency of Canada, 2018). Indeed, the experiences of 2S/LGBTQIA+ people with IPV services and the challenges to serving these populations are not well documented in the Canadian context. This study aims to begin filling that gap.

Methods

We conducted 20 semi-structured, in-depth interviews with 2S/LGBTQIA+ survivors of IPV and 10 key informant interviews with representatives from 2S/LGBTQIA+ community organizations and IPV-related service organizations in Ontario. As we collected data from November 2021 to September 2022 during the COVID-19 pandemic, we conducted all interviews via telephone or audio-only Zoom. The Principal Investigator (PI), KD, a Master's candidate in Interdisciplinary Health Sciences at the University of Ottawa, conducted all interviews following qualitative methods and interview training by AMF, a global sexual and reproductive health researcher and medical anthropologist.

In-depth interviews

Participants were eligible for in-depth interviews if they (a) self-identified as 2S/LGBTQIA+; (b) experienced IPV on/after March 15, 2020; (c) were 18 years of age or older at the time of interview; (d) had access to a telephone or internet; (e) had a safe space to have a discussion; and (f) were sufficiently

fluent in English. We recruited participants with a multi-modal recruitment strategy including both physical flyers posted in public spaces and e-flyers disseminated virtually on social media and online marketplaces including Facebook, Instagram, Twitter, LinkedIn, and Kijiji. Additionally, we circulated the e-flyers and printer-friendly versions to our personal and professional networks to raise awareness of the project.

Those interested in participating reached out to the PI via a dedicated study email address, where they subsequently followed up with a series of questions to determine eligibility. If eligible, the PI sent a digital copy of the consent form and scheduled a mutually convenient time for an interview. Given the sensitive nature of the interview content, and to preserve participants' confidentiality, we obtained oral consent at the outset of each interview and recorded participants' responses on a physical copy of the form. We reminded participants that they could rescind their consent at any time, or refuse to answer questions, without threat of consequence or reprisal.

Interviews ranged from 45 and 180 minutes in duration and consisted of participants' demographic characteristics, relationship history, and IPV experiences before and throughout the COVID-19 pandemic. We also explored participants' knowledge and/or use of IPV-service organizations or 2S/LGBTQIA+ community organizations for support in their IPV experiences. We concluded interviews with a discussion on how IPV-related services and 2S/LGBTQIA+ community organizations could be improved. Upon completion of each interview, we sent participants a CAD40 electronic gift code to Amazon.ca via email.

Key informant interviews

We purposively recruited key informants through publicly available information online – organization websites or social media – and through the personal and professional networks of the study team. We initiated contact with key informants via email or direct message on social media. In

these initial communications, we introduced the study team, described the study objectives and interview process, and attached a digital version of the consent form. If we did not receive a response, we followed up weekly via email or telephone until we received confirmation of acceptance or rejection of our invitation. If a key informant expressed interest in participating, we scheduled an interview at a time most convenient for them.

We sought oral consent from key informants at the outset of each interview and recorded their responses on a physical copy of the consent form. We also offered key informants the option to be identified as a representative of their organization, should direct quotations be used from their interview. We reminded key informants that they could rescind their consent to participate at any time or refuse to answer any questions.

Interviews lasted between 60-120 minutes and comprised key informants' professional and educational background, their current or former involvement in an IPV-related services or 2S/LGBTQIA+ community organizations, the mission of their organization and the services it provides, how IPV-related services and 2S/LGBTQIA+ supports are included in their mandates, how the COVID-19 pandemic affected service delivery, and how their services could better meet the needs of 2S/LGBTQIA+ communities. We did not offer key informants monetary compensation for their participation; rather, we offered a brief report of the study findings upon completion of the project, if desired.

Data analysis

With permission, we audio-recorded all interviews and took extensive handwritten notes throughout. Additionally, KD formally memoed following each interview to reflect on their positionality and interview dynamics, explore content and themes, and identify when we achieved thematic saturation – the endpoint of data collection – when no new themes emerge (Birks et al., 2008). We subsequently transcribed all interviews verbatim. Collectively, interview notes, audio-recordings,

transcripts, and memos comprise the data for this study. We familiarized ourselves with the data and developed a codebook using inductive and deductive techniques (Elo & Kyngäs, 2008). We managed our data with ATLAS.ti (Version 22) software and coded our data for content and themes. KD and AMF met regularly throughout the life of the project to discuss emergent findings. We resolved rare disagreements through discussion. We analyzed the in-depth interviews and the key informant interviews separately, then compared findings to identify concordant and discordant themes.

Ethical considerations

We received approval for this project from the University of Ottawa Social Sciences and Humanities Research Ethics Board. We have organized our results by key themes and elucidate our findings through illustrative quotes from survivors and key informants and narrative vignettes that centre survivors' stories. We have removed or masked any potentially identifying information about IPV survivors to maintain confidentiality and removed identifying information about key informants who did not consent to quote attribution.

Results

Participant characteristics

Survivors were mostly under 35 years-old (n=18), with a range of 18 to 49 years in age. Over half of our participants self-identified as a person of colour (n=11), but the largest single racial demographic was White, Caucasian, or Jewish (n=9). Participants self-identified their sexual orientations as bisexual or pansexual (n=11), lesbian or gay (n=5), asexual (n=3), and/or demisexual (n=2) and reported their gender identities as cisgender woman (n=11), cisgender man (n=5), non-binary or genderqueer (n=3), and transgender man (n=1). None of the survivors we interviewed identified as Two-Spirit, transgender

women, or intersex. Participants were highly educated, with most having completed at least some college or university (n=19) at the time of interview.

Nearly all participants reported experiencing two or more forms of IPV (n=18) and almost half experienced three or more forms (n=8). Every survivor experienced psychological or verbal abuse in combination with physical violence (n=13), sexual violence (n=8), financial abuse (n=4), and/or technology-facilitated violence (n=5). Most participants' IPV experiences lasted three years or less (n=17), with a range from 2 months to 9 years. Five participants were in ongoing IPV situations at the time of the interview. Almost all participants (n=19) lived in a large urban population centre (>100,000 people; Statistics Canada, 2017) at the time of their IPV experiences.

Key informants were representatives from 2S/LGBTQIA+ organizations (n=4) or IPV-related services (n=6) across Ontario and included consultants, program administrators and coordinators, directors, and managers from VAW shelters, sexual assault response centres, advocacy organizations, partner assault response programs, and community centres.

IPV survivors did not access services, but confided in their social networks

The majority (n=13) of survivors in our study were unaware of services they could access for help in their IPV situations. Only a few (n=3) survivors were aware of any 2S/LGBTQIA+ organizations in their communities and none accessed a 2S/LGBTQIA+ community organization for support. Of the participants who were aware of services, four accessed a general crisis line or mental health service, one accessed a sexual assault centre, and two accessed a VAW organization: one for counselling and one for shelter services.

Outlier analysis of survivors who accessed general help lines or mental health supports suggests that such services are ill-equipped to accommodate people in abusive relationships, especially sexual and gender diverse people. Hector, a 25 year-old gay cisgender man, sought help from a local mental

health organization for his ongoing physically abusive relationship with his boyfriend, but did not receive the understanding he needed.

> I felt like they were talking at me but not to me. I didn't feel like I was getting that personalized touch that I wanted, it was very general…I wasn't getting like, the whole empathetic, like, you know, I see you [Hector]…I can see your circumstance, I've gone through a similar circumstance. Like, I wasn't totally getting that reaction that I wanted.

Similarly, Maryam, a 19-year-old bisexual cisgender woman, tried calling a help line to get advice about the technology-facilitated abuse she was experiencing and discovered that they were unable to help with the complexity of her problem.

> They wouldn't really understand how severe it was. Then, it would just come back to…why don't you remove yourself from the situation, or…reach out to somebody for help? And, they kind of repeat that a few times and if I like, express that I can't do that…it just kept feeling like they were trying to push me to do that one thing, like they didn't get that I couldn't do it…You don't think I've already tried that, or thought about it?

Conversely, the three participants who sought help from a sexual assault centre or VAW shelter had overwhelmingly positive experiences. Jenna, a 39-year-old asexual cisgender woman, sought shelter at a VAW organization after her perpetrator physically assaulted her and kicked her out of their shared living space. She explained that the staff gave her the supports she needed to recuperate,

> I just felt like I really redeemed a lot of strength there. I had a private room there. Like, it was welcoming, the staff were welcoming. They didn't like, pry into our issues but they invited us to talk … which was really appreciated.

Crucially, the only participants who accessed VAW services were cisgender women and the two participants who accessed or were offered shelter services were in "heterosexual-passing" relationships. Azalea's Story (Fig. 1) is a significant outlier that exemplifies what the vast majority of our participants did *not* experience regarding service awareness, access, and reporting; indeed, Azalea is the only participant who reported her IPV experiences to police.

Although most survivors (n=17) confided in at least some of their main social supports – often friends, family, and therapists – about their IPV experiences, a majority (n=12) told no one or omitted details due to feelings of shame or a fear of judgement. Colt, an 18-year-old gay cisgender man explained why he did not tell his close friends about his ongoing abusive relationship, "For their own personal safety and just because this is my own problem…I don't really want anyone else being involved in it. I guess I want to say I'm ashamed. Yeah, I'm pretty much ashamed of what my situation is". Survivors who told their social supports often omitted details about the most severe abuse, especially physical and sexual violence. Hector described feeling too embarrassed to tell his close friends and coworkers about the ongoing physical violence he was experiencing, "The physical abuse, I don't tell them about that…I just feel like, if people knew about it, they would think less of me. They would think, oh, he's not a worthwhile person, that he's letting this person do this to him".

Most survivors who confided in their social supports described sympathetic and well-meaning reactions from their networks. But, these reactions often included unsolicited advice to leave the relationship or disclosures about long-standing disapproval of the perpetrator, which survivors found to be unhelpful. Claire explained that her friends' post-hoc divulgence that they "always knew [her perpetrator] was a "bad guy" shifted blame for her abusive relationship onto her.

> [They say] "I always knew he wasn't right for you," which I have always told them is unproductive because then it almost puts…the pressure on me to have also known it in the moment, which, even though I did, I didn't accept it, so it's not helpful that they knew it because, regardless, I was still with him for three years.

[Insert Figure 1 about here]

Survivors want judgement-free services and need systemic supports

When probed about what types of services would be useful, our participants suggested primarily on-demand telephone and chat lines, group therapies, and one-on-one counselling. Survivors

stressed that such services should be judgement-free and staffed by people competent to handle IPV issues. Gerald, a 20-year-old gay cisgender man, believed group therapy with other IPV survivors could have mitigated judgement because of shared experiences. “I would like to be around other people because then it means no judgment because obviously people in my situation would not judge my situation. We could kind of gather around and just talk and just be open and no judgement and just talk to each other”. Colt would have preferred one-on-one counselling with a counsellor or therapist equipped to recognize, discuss, and coach him through his ongoing IPV experiences, “I don’t want to feel like I’m doing this alone…I want a second head. I want tips. I want suggestions on how I should talk…my way out of this with my boyfriend and, I mean, I want to be able to express my feelings to someone who actually…has experience in this”.

Key informants reported safety as the most important need among their clients, which they link to systemic issues and structural supports. Carling Miller, Executive Director of Kind Space, a 2S/LGBTQIA+ community organization based in Ottawa, elucidated that violence prevention begins with meeting the basic needs of the community: “People getting their basic needs met goes a long way to…stopping a lot of violence that happens…housing, food insecurity, universal basic income, you know, actual practical, tangible things are going to do the bulk of the work there”. Sandra’s Story (Fig. 2) demonstrates how an abusive relationship can impact survivors’ financial and housing security, and underscores a community need for affordable housing.

[Insert Figure 2 about here]

Community organizations need to improve outreach

Survivors communicated that services and community organizations need to increase their visibility through better advertising. Despite being an active member of her community, Claire, a 23-

year-old pansexual cisgender woman, was unsure how to begin to find services that could have helped her through her IPV experiences. “I think the biggest [improvement] for me, then, would be in their awareness, in their outreach…I consider myself someone who is like, quite aware of the goings on in [city] and the different organizations that exist. But, I have, like, no idea where I would start even if I wanted to look for help in [city]”. Key informants recognize that their organizations need to improve outreach, but lack the resources to focus on promotion, as Jenna Kelly, Manager of Counselling Services at Sexual Assault and Violence Intervention Services (SAVIS) of Halton explained, “More folks don’t know about supports for intimate partner violence because it’s just like, overwhelmed, and organizations have stopped doing outreach…the demand is greater than the resources and supports allow. So, maybe that’s contributed to folks not talking about what they do”.

Survivors recommended a variety of means that they would like to learn about IPV-related services and 2S/LGBTQIA+ community organizations. Many survivors thought that they would be likely to learn about services through internet-based advertising, especially on popular social media platforms. Indeed, most key informants reported that their organizations have websites and a social media presence, but their services can be missed if community members do not actively seek them out. A representative from a 2S/LGBTQIA+ organization remarked, “We’ve made ads on our website, we have social media, but if people aren’t following us on social media or hitting that site…it’s easy to miss that those services do exist”. Other survivors want to see local IPV and 2S/LGBTQIA+ services physically advertised in their communities. Survivors suggested that physical flyers or advertisements on public transit, bus shelters, bulletin boards in community centres, schools, and college and university campuses, and flyers or brochures in clinical settings would be ideal opportunities for them to learn about services. However, Carling Miller, Executive Director of Kind Space, recognizes that advertising too widely could compromise the safety of their communities.

> For queer things and, I think, intimate partner violence-related things there’s kind of like…this very much historical, practical, safety need of not being too visible, you know? In part because

> you don't want people to be able to track people down, you know, safety is the key piece there…how can people know about you while also like, balancing the need for safety and anonymity in the work that you're doing? So, I think that's just a tension that we have.

Survivors want in-person and virtual services, but delivery is a challenge

The IPV survivors we spoke with had strong individual preferences for either in-person or virtual services. Those who reported a preference for virtual services cited flexibility, a desire for anonymity, and that accessing a service in-person can be intimidating. Survivors suggested email, text message or direct messaging, videoconferencing software, and telephone access as options. Crucially, survivors desired a variety of ways to access virtual services. Aly, a 31-year-old bisexual cisgender woman would have preferred accessing a service via telephone, "I think over the phone would be easiest. I just find it easier to talk to someone when you are not face-to-face with them for stuff like that". In contrast, Rudy, a 30-year-old asexual cisgender man, perceived telephone access as a barrier, "I always like when you have a live chat on a website. That's sort of what I like because talking with somebody orally, verbally on the phone can be daunting". Even survivors who reported a preference for in-person services wanted the option to make initial contact virtually before going to a physical location. As Maryam explained, "If there was an Instagram account to like, [direct message], that would be really helpful…initially that's probably how I would want to do it, then eventually go in-person to check it out or see what it's about."

Key informants recognize that both clients and staff prefer hybrid models of delivery since the onset of the COVID-19 pandemic and that such models offer both parties flexibility in access and provision. However, hybrid services are resource-heavy, since providers need to staff a brick-and-mortar building for clients who prefer in-person services while accommodating service providers preferring to work from home. Moreover, Jenna Kelly of SAVIS of Halton was concerned that providing counselling services from home would remove a key peer-support opportunity for staff that could negatively impact their well-being, "My concerns are always like, what is the impact of doing trauma work from your

house without having colleagues around you? We talk about—in this field we talk about self-care, we talk about vicarious trauma, compassion fatigue, burnout. This, to me, is like, ripe for that".

Insufficient and restrictive funding is a barrier to meeting community needs

Key informants reported being proud of their work but acknowledged that they are not meeting the needs of their communities. Their organizations are chronically underfunded and they are consistently working beyond their capacity. A representative from a VAW shelter remarked, "I'm always going to point to funding. Like, we turn away, on average, 5000 individuals from [our] shelter every year. So, like, at its very numerical core, that is our biggest challenge". Key informants explained that their services are funded through a combination of grants from federal, provincial, and municipal governments, private foundations, and non-profit organizations, and are supplemented with donations and fundraising efforts. A representative from a 2S/LGBTQIA+ organization described this piecemeal funding as "a Frankenstein of grants. It's a monster. There are so many different funding streams…you're piecing it together as one ends and you're hoping another will begin". They continued to explain that this contributes to the precarity of programming, staff, and the organization itself. "It's going to be either we get more funding and we'll continue the project, or it won't exist…it's all going to be based on, do we get another grant, do we get another pocket of funding…kind of thing".

Moreover, funding requirements are restrictive and limit organizations' ability to allocate resources to basic operations like rent, utilities, and personnel. Keri Lewis, Executive Director of Interval House Ottawa, a VAW shelter, explained that long-time annualized funding from the Province of Ontario does not meet the core operating costs of the shelter with the difference made up through municipal and not-for-profit grants and fundraising.

> For the municipal funding…we need to submit a full application and sort of justify our existence and need in the community, and then for other grants, it's tricky because you need to come up with new and shiny programs and ideas and rules…that's fine sometimes, but a lot of the

> time…we are just trying to manage our basic functions and provide our core services…there are really no grants for that.

Insufficient and restrictive funding causes IPV organizations to focus on reactive services to address emergency situations and the immediate needs of their clients. A key informant from a VAW community organization suggested that funding structures limiting organizations' ability to conduct prevention-oriented work perpetuates violence "because if there is no money for prevention work and no money to really address root causes [of violence], then what are we changing, you know?".

Emergency COVID-19 funding from federal and provincial governments was similarly restrictive to "new and shiny" initiatives for organizations to adapt to public health measures, including grants for personal protective equipment, hiring new staff, and adjustments to maintain social distancing. A former representative from a VAW shelter recalls that the requirements to receive COVID-19 funding were "loose" and "as long as we could prove that [an expense] was tied to COVID and that's why we were doing it, we would get reimbursed". Conversely, a representative from a 2S/LGBTQIA+ community organization described how diverting funds to the COVID-19 pandemic further restricted her ability to maintain normal operations. "It was already bad, like, the restrictions that they put on funding, but the COVID restricted funding was beyond ridiculous…it all needed to be funnelled into either hiring new staff or like, equipment…it was like, not helpful at all if you're struggling to be able to pay your rent, especially if you didn't qualify for any of the other relief funding".

Restrictive funding mechanisms prevent community partners from collaborating toward common goals of preventing and addressing IPV. Keri Lewis of Interval House Ottawa explained, "the way that funding works forces people to work in really siloed ways and/or to compete for resources…there is a finite amount of resources and we are all trying to run our programs and be the best we can". The siloed nature of community services particularly impacts 2S/LGBTQIA+ people seeking help from abusive relationships, as they can get passed between VAW shelters and queer community organizations, as a representative from a 2S/LGBTQIA+ community organization recalled:

> Something that I realized was happening a lot in the past was, anytime somebody walked into the shelter who was queer, we would immediately say: call [2S/LGBTQIA+ organization], without even asking what the person's needs were, without even attempting to support them where they were at, we would just immediately say, call [2S/LGBTQIA+ organization]. Likewise with housing, we have housing providers, people, or agencies, whose main focus is to support with housing services calling us saying, "Hey, can [you] support this queer/trans person with their housing needs?" whereas, like, it's quite literally their job. People are people. It's one thing to say, "Hey, do you have any suggestions of safe spaces for those people?" as opposed to just like, "Here's a queer person, you deal with it".

Although the COVID-19 pandemic intensified IPV experiences for survivors and stretched organizations further beyond their capacity, some key informants reported that the pandemic presented an opportunity to innovate and expand services. Keri Lewis of Interval House shared the lifelong lesson she learned about inter-organization collaboration from launching Unsafe at Home, a secure text and chat line for victims of violence, in partnership with Kind Space in Ottawa. "We can do pretty cool things if we partner and instead of trying to do things in siloes…with the text and chat line, we saw how quickly we could mobilize to provide a lifesaving service just by having conversations with one another. So, I think that is something that will stay with me forever". Importantly, this service is open to women and 2S/LGBTQIA+ people, "it is primarily women using the service, but there is a fair number of men as well who have used the service, which is good to see that people are reaching out and feeling comfortable".

Fear and discomfort prevent VAW and GBV services from serving 2S/LGBTQIA+ clients

Key informants reported that institutional anxiety within the VAW sector prevents organizations from expanding services – especially shelter services – to transgender women and transfeminine non-binary people fleeing violence. When considering barriers to serving 2S/LGBTQIA+ people in their organizations, many participants reflected on the hard-fought, second-wave feminist roots of the VAW movement, and a reluctance to deviate from a model that already exists on a "shaky foundation". As one VAW service representative explained:

> I think there is sort of a misnomer that…violence is only done by men to women and, I think not only is that statistically untrue…like, the majority of perpetrators are still men but, it is more complex, and we know that violence within the queer community absolutely happens. But, it challenges…the foundations of feminist, sort of, approaches to this work…the rhetoric is men's violence against women…it almost, like, feels like you're taking away their *raison d'être*…that's a very second-wave [feminist] take on it and there's been movements in the thinking around that, and just, many individuals within the work haven't caught up to that thinking.

Funding requirements for VAW shelters also perpetuate second-wave feminist discourses around IPV by prioritizing cisgender women. As Keri Lewis of Interval House Ottawa explained, "The province has what is called 'shelter standards', and under those standards all shelters are required to provide services to anyone female-identifying. So, that's the bar. Our bar is higher than that". Consequently, there is some concern that expanding services to 2S/LGBTQIA+ people could affect funding streams.

> I remember the community engagement worker saying, "you know, I think it's great that we want to be more inclusive; but, from a funding perspective, when I apply for grants, we say we are a women's shelter. Like, our population is women"…flagging the fact that the grants that we're applying for, like, if we change our mission statement, or if we change who we are serving, that could also impact the types of grants that we are going to be applying for.

Institutional fears of expanding services to transgender women and transfeminine non-binary people manifest as anxiety that serving these communities will dilute efforts and "take away" services from cisgender women. Keri Lewis of Interval House Ottawa elucidated that "there is some fear that…we already can't meet the need…and so, broadening eligibility puts more pressure on a service that's already overstretched…that there just won't be enough space; but I think that a lot of that fear is not really based on reality". Moreover, there are interpersonal fears that including transgender women and transfeminine non-binary people in VAW shelters may make other clients (i.e., cisgender women) uncomfortable. A key informant from a VAW shelter highlighted a need to disentangle clients' feelings of discomfort from a perceived lack of safety.

> There's a lot to unpack there, and we are going to provide this [transgender] woman with services, and comfort for other folks is not the same thing as them being safe. And, that's the

> work that we have in terms of our counseling now is to help them understand that and work through that with them [and] not to deny this person services because other people are uncomfortable.

Key informants wholly agreed that 2S/LGBTQIA+ people need IPV services, and that the sector needs to work through these fears to meet community needs. While some suggested that dedicated IPV services for queer and trans people may be warranted, representatives from 2S/LGBTQIA+ community organizations warned that their communities are so small and interconnected that victims and perpetrators may access the same services, leading to tension and safety concerns.

> In non-queer kind of relationships, when one person leaves, they always have very specific spaces that they can rely on. Whereas, in queer communities, because they are so few and far between, people end up struggling to fit into services that could be with somebody that has been abusive to them, it could be with somebody who they've been abusive to, and there's been that kind of a dynamic in those relationships, and being able to navigate through those dynamics … is always an ongoing issue.

A key informant from a VAW organization summarized the views of other key informants by emphasizing that the VAW sector needs to welcome 2S/LGBTQIA+ communities into their services because an abolitionist approach to social work requires inclusion of all victims of IPV.

> If our goal as an organization is to end intimate partner violence…all of this lives within the patriarchy, and intimate partner violence also exists in other groups that are all also victims to patriarchy. So, it's all connected. We can't end the one without the other. And so, trying to be exclusionary is actually not really going to be helpful…As staff, we need to understand our society and serve those who…need those services.

VAW organizations want to serve 2S/LGBTQIA+ people, but lack the capacity

Despite these tensions within the VAW sphere, all key informants and their organizations are nominally supportive of serving transgender women and transfeminine non-binary people; however, there is a disconnect in many organizations between their capacity to serve 2S/LGBTQIA+ communities and outreach. A key informant explained that her VAW organization advertises 2S/LGBTQIA+ inclusivity in their services, but internally doesn't have their "ducks in a row": "It's the usual debate around like,

flying the [Pride] flag versus, are you actually, really, sort of, safe internally because on our social media, for example…we are waving the flag, and…I sit very uncomfortably with that because if someone ends up in our shelter service, that isn't always safe". She continued on a personal note, sharing that "waving the flag" without the requisite competence can perpetuate harm and alienate 2S/LGBTQIA+ people seeking help from IPV, "[Queer people] are like, frankly, falling through the cracks…[As a queer woman], I don't know that I would go to [my employer]…for domestic violence [services]…no one would overtly be an asshole, but they don't understand the dynamics I'm facing".

Indeed, our key informants from 2S/LGBTQIA+ community organizations discussed an expectation among sexual and gender diverse people that non-2S/LGBTQIA+ services are unlikely to be safe and affirming. This observation was echoed by a representative from a VAW organization, who warns against "waving the flag" if a VAW service is ill-equipped to meet the needs of 2S/LGBTQIA+ people. "We can say that we are a safe space, but…the LGBTQ community, they know which services are safe and are trauma-informed, and sure, any service can say that on their website. They can put up a trans flag, or whatever flag they want; but, in your actions, if you actually are not, people will know about this". This holds true among 2S/LGBTQIA+ perpetrators of IPV, as well. A key informant formerly from a partner assault response (PAR) program described their organization as wanting to be inclusive, but that its displays of Pride flags is "lip-service…it ultimately doesn't represent more than following a trend", and that the program is ill-equipped to give 2S/LGBTQIA+ perpetrators the support they need to avoid committing further acts of violence. "I would notice for some of them, they would go back in the closet once we went into the group [sessions]. Like, I would do their intake and they would come out, and they'd go in the closet if they were…in a group". Conversely, some VAW/GBV services may have the knowledge and capacity to help 2S/LGBTQIA+ survivors of IPV, but lack effective outreach strategies to target these communities. "There isn't a clear show, I think, on the part of a lot of mainstream service

providers that they are being inclusive, and that they do have the competency and capacity…and they're not promoting that they do, which is also a problem".

While key informants discussed the importance of expanding VAW/GBV services to transgender women and transfeminine non-binary people, they admitted that there is little recourse for gay, bisexual, asexual, transgender, and transmasculine men who are experiencing IPV, as demonstrated in in Rudy's Story (Fig. 3).

> Realistically, when it comes to cis[gender] men or transmasculine men, there really is no service…the [City] should be able to place anybody that is in an intimate partner violence situation, [but] we know that doesn't happen with single women or women with families as it is, so I would imagine that there is even that extra barrier to a transmasculine man or a cisgender man trying to get those services.

All key informants emphasized that improving queer competency in VAW/GBV organizations is important for the inclusion and safety of 2S/LGBTQIA+ people. Representatives from VAW/GBV organizations solicited inclusivity training from 2S/LGBTQIA+ advocacy groups or expressed an intent to do so. However, a former representative from a PAR program reported that training only goes so far and believes that 2S/LGBTQIA+ representation among staff is necessary. "I admit, I'm not going to ask all staff to learn about what meth is, or what slang is used, or how it appears on Grindr profiles, or things like that…you can only train so much. So, like, having real people there who are queer…[is important]". Indeed, many key informants reported having queer and non-binary people on staff; but, Jenna Kelly from SAVIS of Halton described rejecting a grant from a prominent not-for-profit organization because it perpetuated pay inequities that harm historically marginalized communities.

> There was an opportunity for funding that would…bring diversity into our team, and it was for LGBTQ2, BIPOC-identified folks…the budget that was for the pay…was incredibly low…how terrible would it have been to say we're going to hire someone to represent folks in Halton and then pay them less than what other counsellors are making?".

[Insert Figure 3 about here]

Discussion

Our aim for this study was to capture the experiences of 2S/LGBTQIA+ IPV survivors with IPV-related services and 2S/LGBTQIA+ community organizations. But, most of our participants who experienced IPV were unaware of any services they could access for help. Indeed, only three participants – all cisgender women – accessed an IPV-related organization. Therefore, our participants recommended that community organizations improve their visibility and raise awareness of their activities. Moreover, participants who experienced IPV had strong preferences for both in-person and virtual services, suggesting that 2S/LGBTQIA+ community organizations and IPV-related services should consider implementing hybrid models of care and programming. However, key informants stressed that advertising and hybrid services need to be balanced with discretion and safety of their clients, and the well-being of staff who could experience stress, burnout, and vicarious trauma from working alone in an online environment.

Most of the survivors we interviewed did not report their IPV experiences to professionals with a duty to report, or the police – save one bisexual cisgender woman in a "heterosexual" relationship – even when given the opportunity. This finding raises questions about analyses from the Statistics Canada Uniform Crime Reporting survey, which suggests that sexual diverse people in same-sex relationships experience IPV at rates proportional to their prevalence in society (Whitehead et al., 2020). Indeed, other prevalence data indicates that 2S/LGBTQIA+ people in Canada experience IPV at disproportionate rates compared to cisgender, heterosexual people (Bucik, 2016; Ristock et al., 2019; Statistics Canada, 2021a, 2021b; TransPULSE Canada, 2021). It is well-known that IPV is under-reported to police (Statistics Canada, 2021c) and that 2S/LGBTQIA+ people have a distrust of police due to historical and ongoing experiences of discrimination and victimization, including in IPV reporting (Shields, 2021). Rather, our participants primarily confided in their support networks, including friends, family, and therapists. Emerging research supports this finding (Kurbatfinski et al., 2023).

Therefore, it is imperative that professionals and the general public be equipped with the education and knowledge to recognize violent and abusive behaviours within their own personal and professional relationships and their communities. Mental health professionals should be trained to recognize IPV, incorporate screenings in their intake processes, and continue to screen throughout treatment as they build rapport and trust with their clients (Doyle et al., 2022). Furthermore, mental health practice around IPV should be trauma-informed, client-centred, and culturally competent and sensitive to the needs and experiences of 2S/LGBTQIA+ communities (Doyle et al., 2022; Henry et al., 2021). Additionally, provincial governments should implement comprehensive school-based sexual health education that is trauma-informed, anti-oppressive, and includes GBV and IPV, healthy relationship dynamics, and recognizing abuse, as per the Sex Information & Education Council of Canada's Guidelines for Integrating Gender-Based Violence Prevention within School-Based Comprehensive Sexual Health Education (Sex Information & Education Council of Canada, 2023). This is especially important for members of 2S/LGBTQIA+ communities, who have particular difficulty recognizing IPV in their own relationships and among their peers (Canadian Women's Foundation & Wisdom2Action, 2022).

Regarding service providers, key informants identified restrictive and piecemeal funding as a significant barrier to the sustainability and activities of their organizations. Inadequate funding from federal, provincial, and municipal governments needs to be supplemented with grant applications to non-profit organizations, fundraising, and donations, which puts community organizations in a constant state of precarity. Since our key informants reported that most of their funding already comes from provincial sources, we recommend that the Government of Ontario increase annualized funding for VAW/GBV services and introduce similar annualized funding streams for 2S/LGBTQIA+ organizations. Annualized funding should meet at least the core operating costs of these organizations, including rent, utilities, and minimum staffing requirements. Adequate, predictable funding may allow existing

organizations to divert resources from grant writing and fundraising to launching new programs and fostering inter-organizational collaboration to better meet the needs of their communities and facilitate the founding of 2S/LGBTQIA+ organizations across the province.

While key informants from VAW/GBV organizations are nominally supportive of including 2S/LGBTQIA+ people in their services, they noted a discrepancy between their ideals and the actual policy and practice within their organizations and the VAW sector more broadly. Offering shelter or counselling services to queer and transgender people without the requisite competence perpetuates harm and can promote disengagement with services (Lim et al., 2023). While some key informants suggested IPV services dedicated to 2S/LGBTQIA+ communities as a possible solution, queer community organizations are already overtaxed and may similarly lack the capacity to address GBV/IPV. Moreover, key informants from 2S/LGBTQIA+ community organizations remarked that their communities are small and interconnected such that victim and perpetrator may access the same service, potentially affecting the perceived and actual safety of IPV survivors. So, existing VAW/GBV organizations must update their policies and be trained to competently and safely serve 2S/LGBTQIA+ people in their services (Furman et al., 2017).

In updating policy and implementing staff training to improve 2S/LGBTQIA+ competency in VAW/GBV organizations, service providers must recognize that queer and transgender people may live at the intersections of marginalization based on race, Indigeneity, immigration status, homelessness, engagement in remunerative sex work, and incarceration, all of which affect IPV/GBV experiences (Canadian Women's Foundation & Wisdom2Action, 2022). There is no one-size-fits-all training or policy, and organizations need to be sufficiently engaged in their communities to know the populations they serve. Also, key informants recognized the importance of having 2S/LGBTQIA+ representation on staff. Violence against women and gender-based violence services should consider hiring 2S/LGBTQIA+ people at fair, competitive wages to avoid perpetuating financial inequities these populations already

experience (Kia et al., 2020). However, service providers must recognize that 2S/LGBTQIA+ people are not a monolith and that mere representation of some of these communities does not necessarily translate to competence in serving all 2S/LGBTQIA+ clients (Lim et al., 2023).

These training and staffing recommendations extend to PAR programs, which need to better equip themselves with the knowledge and competency to address IPV within queer and trans communities. These programs need to provide safe and affirming spaces, in policy and practice, where 2S/LGBTQIA+ perpetrators feel comfortable discussing their identities and relationship dynamics. Fostering safe spaces and facilitating the inclusion of 2S/LGBTQIA+ perpetrators in PAR programs is crucial to preventing future violence, and a failure to do so perpetuates the violence that these programs purport to interrupt.

Key informants from VAW/GBV organizations identified second-wave feminist frameworks in policy and funding streams as a mechanism that privileges cisgender, heterosexual women as "legitimate" victims of IPV and acts as a barrier to serving 2S/LGBTQIA+ people. This phenomenon has already been elucidated in existing research on VAW service provision in Ontario (Furman et al., 2017). We echo the recommendations from Furman and colleagues (2017) that the VAW sector needs to evolve from a second-wave feminist framework to an intersectional feminist framework that expands their services and advocacy to 2S/LGBTQIA+ people, including transgender women, transfeminine gender diverse people, and Two-Spirit people. However, our key informants recognized that gay, bisexual, and asexual cisgender men, transgender men, and transmasculine gender-diverse people experiencing IPV have little or no supports or services, despite also being at a higher risk for IPV than cisgender, heterosexual counterparts. An intersectional approach to IPV requires acknowledgement that IPV/GBV transcends female gender identity or feminine gender expression, and that queer and transgender men or masculine people also experience IPV. Part of this expansion requires a deliberate shift in policy language that is more inclusive of non-cisgender female identities. Inclusive language in

provincial funding streams and grant applications would ensure that services that are already inclusive are not disincentivized to serve 2S/LGBTQIA+ people, and may prompt other VAW organizations to expand their eligibility to sexual and gender diverse people. Moreover, a change in language would signal to 2S/LGBTQIA+ communities that they are welcome to access help from these services.

The results of this study are not generalizable; indeed, it is neither a goal nor a function of qualitative research to be so. However, we are confident that our methods were sufficiently rigorous, credible, and trustworthy that our findings have significance beyond the immediate bounds of this study. Our limitations primarily concern recruitment. We did not interview survivors from rural areas or French-speaking minority communities in Ontario, and we did not capture the experiences of people who are Two-Spirit or intersex, or transgender women and transfeminine non-binary people. Furthermore, the key informants we interviewed represented less than half of all organizations we contacted for participation and were all supportive of 2S/LGBTQIA+ inclusion in their services. These interviews may not fully capture the views of the VAW/GBV sector or 2S/LGBTQIA+ community organizations in Ontario. Future research should focus on the experiences of transgender women and transfeminine non-binary people with IPV services, with particular attention on people from rural and linguistic minority communities.

Conclusion

Intimate partner violence is a significant public health problem that affects 2S/LGBTQIA+ people in Canada. However, the help-seeking experiences of these populations with VAW/GBV services and 2S/LGBTQIA+ community organizations have not been well documented. Indeed, this study does little to account for those experiences, since the only participants to access such services were cisgender women, who are already well-represented in the VAW sector. Survivors want services to increase their visibility in their communities and want access to non-judgemental therapies with competent providers.

While many in the VAW/GBV sector may be nominally supportive of serving 2S/LGBTQIA+ people, the second-wave feminist underpinnings to VAW/GBV organizations contribute to an institutional anxiety about “expanding” services to non-cisgender women. Policy and funding mechanisms must adopt an intersectional feminist approach to VAW/GBV service provision, and staff need training to improve their queer and trans competency. Furthermore, education is paramount to preventing IPV. A comprehensive sexual health curriculum that includes healthy relationship dynamics, recognizing abuse, and 2S/LGBTQIA+ relationships could empower individuals experiencing abuse and their communities to recognize IPV and promote help-seeking.

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Azalea is a 21-year-old pansexual, cisgender woman who experienced IPV perpetrated by her heterosexual, cisgender male partner. Early in the relationship, Azalea's partner started being physically aggressive, forcefully grabbing and pulling her, leaving bruises on her arms. Azalea first recognized his behaviour as abusive when he started "raising his hand" to her, threatening to strike her. On two occasions, Azalea experienced prolonged physical assaults by her partner, in which he would pull her hair, kick her, punch her in the head, and step on her. Throughout the relationship, the perpetrator regularly sexually assaulted her and coerced her into sexual acts.

At the conclusion of the relationship, Azalea experienced severe emotional distress and was contemplating taking her own life. She contacted a crisis line operated through a local violence against women organization, who helped her contact a community-based victim service, which got her in touch with a local mental health care provider and case worker who helped her file a police report. As she gave her statement to the police, she was warned that she could also be held criminally liable for any crime she may have committed in the relationship. Azalea found this strange. "It was a little funny to me because…I was making a statement about someone abusing me, and like, sexually assaulting me, and they're telling me that I can get in trouble for anything that I've done. It's kind of, in a way, saying that like, I could be in trouble for asking for [help]".

Although she felt supported by the VAW organization and her case worker, Azalea found working with the police frustrating, where "playing telephone" with them caused her file to be delayed. "I wanted to talk to…a certain cop about it, but they were always sending like, people who didn't know what was going on, and I just wanted it to be like, the same person every time…it was all getting jumbled up…I was on queue because I wasn't on top priority because…my case was given the wrong title".

Azalea feels that the police need to communicate with each other better about ongoing cases, and that "if you're going to talk to a client, know your client". She felt supported by the local violence against women organization she accessed and would recommend it to other people experiencing IPV, including 2S/LGBTQIA+ people.

Figure 1: Azalea's story

Sandra is a 21-year-old pansexual cisgender woman who experienced physical, psychological, and sexual violence – in-person and online – by her perpetrator. Sandra's relationship started out well, but it "went to shit" within the first few months when her partner started acting possessive and jealous whenever Sandra would speak to anyone besides her partner or immediate family. Consequently, Sandra's partner demanded her social media logins and access to her online chat history. About a year into their relationship, Sandra and her perpetrator moved into an apartment together.

The abuse turned physical within a couple of weeks of moving in together. Sandra and her perpetrator would get into arguments about domestic chores. Sandra's partner made more money than her and paid more rent; they expected Sandra to do all the housecleaning and for dinner to be ready by the time they came home. "If it wasn't up to their expectations or…I didn't kiss their feet as soon as they came home…they would definitely get physical". Sandra's perpetrator would often slap and push her, even punching her once.

Sandra told her social supports about the violence in her relationship. They all agreed that she needed to leave the shared apartment before ending the relationship to prevent a "very physically violent" response from her perpetrator. Sandra informed her landlord about the abuse and her intent to leave the apartment and break the lease agreement. Sandra gradually moved her things out of the apartment, back to her parent's house, and informed the landlord when she was ready to leave. Following the terms of the lease agreement, the landlord kept her security deposit.

Since moving out, Sandra has been bombarded with phone calls from the landlord, maintenance workers, and the building manager about her breaking the lease agreement, threatening her with lawsuits and financial penalties. "My landlord was obviously really pissed because … I didn't give them a good enough reason apparently, because abuse isn't a good enough reason to break a lease". Sandra's credit score and her ability to secure another apartment has been affected. Sandra realizes that "there's a lot of people who don't really have that luxury, like, they can't just go back to their families" and that others in her situation could end up homeless. Sandra wishes she had access to housing services for 2S/LGBTQIA+ people, and legal advice on dealing with the fallout of breaking her lease.

Figure 2: Sandra's story

Rudy is a 30-year-old asexual cisgender man who experienced physical, psychological, and financial abuse by his perpetrator. Rudy met his perpetrator at a gathering with mutual friends, and they hit it off. She quickly became "interweaved" in his "long-time group of friends". Early in their relationship, Rudy was forthright about his sexual orientation and that "there might not be much on the sexual front". Initially, she thought he was joking, but decided she wanted to pursue the relationship.

Rudy thinks his perpetrator had problems with alcohol. She would binge drink, leading her to shift from "anger and crying and then just incoherent" and sometimes accidentally injure herself. Over the course of their relationship, Rudy's social support network changed. His roommates wanted him to move out, and some friends stopped talking to him. Rudy later discovered that his partner was spreading rumours to his friends that he was physically abusing her, passing off her injuries from drinking to "bit by bit…prune my relationships". When Rudy's friends alerted him to this, he tried to give her the benefit of the doubt. "It's difficult to even talk about because every spousal abuser says that their partner is lying…I thought I'd bring it up to her, and she denied all of it".

As their relationship progressed, Rudy's perpetrator's "acceptance, or not, of our sexual relationship more and more became an issue…it would get more like, not just frustrating but like, berating and…personally insulting…it was like, 'what are you even good for?' and things like that". She was also stealing from him and gaslighting him into believing he owed her money, which later affected his ability to leave the relationship. The abuse came to a head when she would bring strangers back to their apartment after a night of drinking. When Rudy tried to get them to leave, his perpetrator "would then get in my face and she would then be shoving me…fully against the wall".

Rudy confided in his social support networks about his abusive relationship but was unaware of any services he could access for help. Rudy searched for services online, but "when I searched up like, partner abuse and what to do, especially in a living situation where you're living in an apartment, you're financially dependent. I obviously understand that there is a lot of male-on-female partner abuse, but I…found literally nothing…on female-on-male partner abuse…I don't want to give that impression [that it should be all about men], but…there's a bit of that kind of stigma, there".

Figure 3: Rudy's story

Chapter 6: Discussion

Our findings suggest that 2S/LGBTQIA+ people's IPV experiences are both common and unique to those of cisgender, heterosexual people, and that VAW/GBV/IPV services and 2S/LGBTQIA+ community organizations are not meeting the complex needs of these communities. This chapter explores the findings from the study, including the experiences and health outcomes of 2S/LGBTQIA+ survivors of IPV and the barriers to serving these populations in the VAW/GBV/IPV sector and in 2S/LGBTQIA+ community organizations. We continue by providing recommendations to improve services and outcomes for 2S/LGBTQIA+ IPV survivors, a discussion of the implications of this work, and an examination of future directions. We conclude with a reflection on positionality in qualitative research, a statement of contribution, and a final conclusion.

6.1 Integration of results

The collective findings from this project demonstrate that IPV is a complex social and health issue, particularly among 2S/LGBTQIA+ people. The themes that emerged from this work suggest an interweaving of individual, interpersonal, and sociocultural dynamics that contribute to the IPV experiences of 2S/LGBTQIA+ people, their perceptions of their experiences, and consequent health outcomes. Furthermore, a combined lack of knowledge among survivors and a lack of capacity among service providers are barriers to access and provision of queer- and trans-competent interventions.

6.1.1 Intimate partner violence is ill-defined

Intimate partner violence is inconsistently defined in the literature, and tends to be used interchangeably with spousal abuse/violence, domestic abuse/violence, and dating abuse/violence, despite nuanced differences between types. This finding concurs with research suggesting that there currently exists no consensus around IPV definitions or conceptual frameworks (Burelomova et al.,

2018). Intimate partner violence may occur between spouses, whether common-law or institutionally married, among those in short-term or long-term dating relationships, and among casual sexual or romantic partners. Moreover, domestic abuse may include violence committed between family members not in an intimate relationship (WAGE, 2022a). Definitions become further complicated considering that IPV is often conflated with VAW and GBV, which implicitly exclude some populations from being considered "legitimate" victims of violence (Little, 2020). "Violence against women" suggests a male perpetrator assaulting or controlling a female partner and excludes sexual minority cisgender men and transgender people, and "gender-based violence" implies power disparities based on gender as a contributing factor to experiencing or committing violence, suggesting an inapplicability in same-sex or same-gender relationships. Also, there is no universal acceptance of which behaviours constitute IPV. Although physical, psychological, and sexual violence are commonly recognized forms of abuse (Burelomova et al., 2018; Krug et al., 2002), other definitions may include financial abuse, spiritual abuse, stalking, reproductive coercion, and TFV, and are expansive beyond cisgender, heterosexual relationships (WAGE, 2022a). While IPV must be operationalized as a practical matter for research and practice, narrow definitions of survivors, perpetrators, and acts may not capture the full context of this complex and nuanced phenomenon.

6.1.2 Survivors experience multiple, concurrent forms of violence

Our participants experienced physical assault or threats of violence, psychological abuse and coercive control, sexual violence or coercion, financial abuse, and technology-facilitated violence (TFV). Though each individual experience was unique, and varied in severity, frequency, and type, all participants we interviewed experienced some form of psychological violence in conjunction with other forms of abuse, most commonly physical violence. Almost all survivors we interviewed reported experiencing two or more forms of violence in the same relationship, and nearly half reported

experiencing three or more types of IPV. Indeed, victims of IPV often concurrently experience multiple forms of IPV in abusive relationships (W. Kim et al., 2022; Krebs et al., 2011).

Sexual and gender diverse people may experience unique forms of IPV related to their sexual orientation and/or gender identity, called "identity abuse" (Woulfe & Goodman, 2021). Plurisexual (i.e. bisexual and pansexual) people may experience IPV by which perpetrators leverage biphobic stereotypes of infidelity, disloyalty, and promiscuity to justify abusive behaviours (Corey et al., 2022). Perpetrators physically assaulted and attempted to isolate victims from their support networks to coerce participants into adopting a monosexual orientation or to reduce perceived threats that their plurisexual partner may "cheat" on them. One participant explained how her perpetrator simultaneously gaslit her into questioning her pansexuality while also using her sexual orientation to his benefit, as a tool of sexual coercion. Similarly, asexual people may experience violence directed at their lack of "normal" sexual behaviour (Lund, 2021). Two asexual participants explained that they were berated by their perpetrators for their lack of sexual desire, and one was physically assaulted by his partner. While similar identity-related abuse is also recorded among transgender populations through misgendering, deadnaming and threats of outing (Maclin et al., 2022; Peitzmeier et al., 2020; Scheer J.R. & Baams L., 2019), these phenomena are not represented in this work.

The prevailing discourse around COVID-19 and IPV is that stay-at-home orders trapped IPV victims with their perpetrators (A. M. Campbell, 2020); some of our participants explained that their perpetrators wielded technology, including phone calls, text messages, location tracking applications, and social media to extended the reach and duration of their abusive behaviours. Participants who experienced TFV described experiencing novel or more severe forms of abuse when separated during lockdown periods. Though TFV was primarily used for psychological manipulation and controlling behaviours, participants also reported physical and sexual TFV.

6.1.3 COVID-19 and mental health

The COVID-19 pandemic is associated with increases in the frequency and severity of IPV (Peitzmeier et al., 2022) and a concurrent disruption of community services as providers shifted from in-person to virtual modes of delivery (Carrington et al., 2021) that resulted in a "shadow pandemic" of IPV (Haag et al., 2022). In concert with these findings, our survivors directly attributed the pandemic to experiencing new or worsening IPV and key informants reported being stretched beyond their capacity during lockdown periods.

Our participants also reported declining mental health throughout the COVID-19 pandemic, consistent with existing research suggesting that social isolation due to COVID-19 pandemic stay-at-home orders is associated with negative mental health outcomes (Lin, 2023). Poor mental health is associated with IPV victimization (Iverson et al., 2013; Spencer et al., 2019; Stein et al., 2022) and perpetration (Sesar et al., 2018; Spencer et al., 2019). Indeed, IPV may have a more significant impact on mental health than other traumatic experiences (Lagdon et al., 2014) and those who experience multiple, concurrent forms of IPV – like the majority of our participants – may experience even worse mental health outcomes (W. Kim et al., 2022). Most of our participants also attributed their IPV experiences to poor mental health status, with some receiving new diagnoses of depression, anxiety, and PTSD.

Survivors reported feeling angry, frustrated, and regretful about their abusive relationships and explained that their IPV experiences affected their ability and desire to develop healthy, trusting relationships in the future. While acknowledging that their experiences were distressing and damaging, most survivors described their IPV as a learning experience and a source of self-development. Also, participants described a new confidence in detecting abusive behaviour in others' relationships and in future partners. These reactions are reflected in existing literature elucidating the resilience of IPV survivors to focus on positive outcomes of their IPV experiences including in self-perception,

relationship attitudes, and purpose, including through advocacy for others (Crann & Barata, 2016; Ulloa et al., 2015).

Our participants overwhelmingly wanted mental health supports in the form of help lines, counselling services, and group therapy. Regardless of individually preferred modes of therapy, our participants emphasized that such services should be staffed by non-judgemental staff competent in IPV. Also, our participants expressed individual preferences for in-person or virtual services, consistent with findings described elsewhere (MacGregor et al., 2022). However, most of our survivors would prefer to make initial contact with services virtually. Key informants recognized a preference among some staff and clients for in-person or virtual options, while acknowledging that implementing hybrid services is costly and needs to be balanced with client safety and the mental well-being of staff.

6.1.4 The "legitimate victim"

Sexual and gender diverse communities have difficulty recognizing IPV and GBV within their relationships and in their communities (Canadian Women's Foundation & Wisdom2Action, 2022) due, in part, to cisnormative, heteronormative sociocultural scripts that a "legitimate victim" of IPV is a cisgender, heterosexual woman experiencing physical or sexual violence at the hands of a man (Little, 2020). Our participants struggled to see themselves as victims of violence and discussed varying reasons for not fitting the mold of an abuse survivor, including their sexual orientation or gender identity, the types and severity of abuse they experienced, or a combination of these factors. These dynamics are reflected in the lack of service awareness among most of our survivors, despite the vast majority of participants being from large urban centres that are more likely to have VAW/GBV services or 2S/LGBTQIA+ community organizations. Rather, our participants sought support primarily from their personal support networks. This preference for informal networks over formal services among 2S/LGBTQIA+ people experiencing IPV is reflected in emerging research (Kurbatfinski et al., 2023).

Similar to Furman and colleagues' (2017) findings, our key informants explained how the second-wave feminist roots of the VAW movement act as a barrier to serving 2S/LGBTQIA+ people by privileging cisgender, heterosexual women in funding mechanisms, policies, and staff training. Indeed, of our seven participants who accessed a service related to their IPV situation, only three cisgender women accessed a VAW service for counselling or shelter services, and only one of these women reported her physical and sexual violence to police.

Key informants from VAW services are supportive of including transgender women and transfeminine non-binary people in their organizations but may lack the cultural competence to do so. Some key informants reported that their services have – or, are developing – policies, training, and staff prepared to accept sexual and gender diverse people but have not performed adequate outreach to raise awareness of their services and inclusivity among these communities. Other key informants from VAW/GBV services expressed concern that their organizations are "waving the [Pride] flag" by claiming that their services are accepting of 2S/LGBTQIA+ people without having the requisite policies or training to ensure these clients' safety. Key informants from 2S/LGBTQIA+ organizations explained that sexual and gender diverse communities expect to experience discrimination from health and community services, and that ill-prepared service providers can perpetuate systemic oppression and harm that may lead to disconnection from health and community services (Lim et al., 2023).

Moreover, a perceived lack of cultural competency may lead some service providers to turn away 2S/LGBTQIA+ people who try to access services. One key informant described experiencing these dynamics in her previous work at a VAW shelter and in her current capacity at a 2S/LGBTQIA+ organization. Rather than serving 2S/LGBTQIA+ people, service providers referred them to a queer community organization that may not have the ability to provide effective services. While some key informants suggested that services dedicated to 2S/LGBTQIA+ IPV survivors may be warranted, key informants from 2S/LGBTQIA+ organizations remarked that queer and trans communities are so small

and interconnected that perpetrators and victims may access the same service, deterring victims from seeking help.

Importantly, some key informants described tensions and anxieties within the VAW sector about including transgender women and transfeminine non-binary people in their mandates. These anxieties stem from institutional memory of the struggle to develop and maintain VAW and shelter services, manifesting as a fear that expanding eligibility may stretch already overburdened services beyond their capacity and negatively impact their primary population, cisgender women. Key informants also described concerns within their organizations that including transgender women and transfeminine non-binary people in their services could make these cisgender, heterosexual women uncomfortable; however, key informants overwhelmingly believe that these anxieties are not rooted in reality. They continued to explain that eradicating IPV/GBV is unattainable unless all populations subjugated by patriarchy – including 2S/LGBTQIA+ people – are included. Despite this latter revelation, key informants from VAW organizations recognized that sexual minority men, transgender men, and transmasculine non-binary people experiencing IPV are unlikely to find support from VAW/GBV services and transitional housing programs.

6.1.5 Financial instability affects survivors and services

Some participants described increased relationship stress related to financial changes and precarious employment as contributors to their abusive experiences. Generally, financial stressors have been associated with perpetrating physical IPV (Schwab-Reese et al., 2016), and employment insecurity and low socioeconomic status have been directly attributed to IPV risk throughout the COVID-19 pandemic (McNeil et al., 2023). Also, changes to financial or employment status during the pandemic were associated with decreased mental health status (Beland et al., 2022), which may be a risk factor for IPV perpetration and victimization, as previously described. Moreover, 2S/LGBTQIA+ people in Canada

are more likely than cisgender, heterosexual people to experience financial insecurity (Kia et al., 2020); therefore, these stressors may play a larger role in IPV victimization and perpetration within these communities. Our key informants from 2S/LGBTQIA+ community organizations identified access to food, housing, and income as the most important needs in their communities and suggested that meeting these basic needs is integral to reducing violence and giving 2S/LGBTQIA+ survivors the ability to leave abusive relationships.

Key informants indicated that their organizations operate on a patchwork of funding from federal, provincial, and municipal government grants and private grants from non-profit organizations but remarked that these funds do not meet even their core operating costs. As such, their services need to be supplemented with donations and fundraising campaigns. These funding mechanisms often require novel programming and are not applicable to regular service operations. This piecemeal funding forces organizations into constant precarity, where they must allocate resources to securing funding to remain solvent and continue meeting community needs.

Key informants from VAW/GBV organizations reported that emergency COVID-19 funds were crucial to accommodating clients and expanding services while adhering to pandemic public health protocols. While representatives from VAW/GBV services described these emergency funds as easily obtainable with any pandemic-related justification, key informants from 2S/LGBTQIA+ organizations found that pandemic-related funding was inaccessible and highly restrictive, as it required novel programming or expenses, and could not be applied to normal operations like rent, utilities, and staffing costs.

6.2 Recommendations

6.2.1 Universal definitions and conceptual frameworks

It is impossible to address IPV without defining the problem. Intimate partner violence is differentially described with variations in types of violence (e.g. physical, psychological, sexual, financial, spiritual), relationships in which violence occurs (e.g. marriage, dating, casual), modalities of violence (i.e. in-person vs virtual), and who is a perpetrator and a victim (e.g. women, men, sexual and gender diverse people). Technology-facilitated violence is specifically poorly defined despite its increasing relevance in a digital society (Kim & Ferraresso, 2022). Moreover, IPV is often conflated with spousal abuse, domestic violence, gender-based violence, and violence against women, which can implicitly exclude certain populations, especially 2S/LGBTQIA+ people. Researchers, service providers, health professionals, and others who work in IPV must develop an inclusive, comprehensive, and universal definition and conceptual framework for IPV and TFV to guide their scholarship and practice. Given that IPV and TFV are relevant to many disciplines, including public health, psychology, sociology, public policy, and criminal justice, a definition should be developed with a transdisciplinary approach in consultation with IPV experts across disciplines and a diverse group of IPV survivors, service providers, and advocates.

6.2.2 Education is the best prevention

Our participants struggled to accept themselves as victims of violence due to the type or severity of their abuse, and/or their sexual orientation and gender identity not “fitting the mold” of an abuse survivor. Participants lacked the knowledge, experience, or self-compassion to recognize abusive behaviours in their relationships. Moreover, participants described confiding in their social support networks about their IPV experiences, but most did not describe these networks effectively intervening to help survivors stop the violence or leave their relationships. Comprehensive school-based sexual

health education that is trauma-informed and anti-oppressive, which includes healthy relationships, 2S/LGBTQIA+ relationships, gender-based violence, IPV, and recognizing abuse is crucial for prevention as it is effective in promoting acceptance of sexual and gender diversity and reducing the incidence of IPV (Goldfarb & Lieberman, 2021). Comprehensive sexual health education may give abuse survivors the tools to recognize abusive behaviours in their relationships, make potential perpetrators aware of healthy and unhealthy responses to stress, and give support networks and communities the skills to recognize abuse in their communities. Therefore, the Government of Ontario should implement a comprehensive sexual health curriculum in public schools, following the Sex Information and Education Council of Canada (SIECCAN) *Guidelines for Integrating Gender-Based Violence Prevention within School-Based Comprehensive Sexual Health Education*.

Furthermore, our participants reported mental health professionals among their support networks, but similarly described many of these supports as ill-equipped to intervene or offer appropriate therapeutics for their experiences. Mental health practitioners need to be trained in identifying and responding to IPV in their practice and implement IPV screening for clients throughout their treatment plans. Ongoing screening is essential, since survivors may not be immediately comfortable sharing their IPV situations with their therapists due to fear of judgement, a perceived lack of safety, or shame (Doyle et al., 2022). As with comprehensive sexual health education, mental health professionals need to be trauma-informed, anti-oppressive, and culturally competent to work with sexual and gender diverse people without perpetuating systemic harm (Doyle et al., 2022; Henry et al., 2021).

6.2.3 Centralized funding streams

Key informants described securing piecemeal funding from a variety of public and private sources. Those from VAW/GBV organizations revealed that they received most of their stable,

annualized funding from the Government of Ontario; representatives from 2S/LGBTQIA+ community organizations did not report receiving such predictable funding. We recommend that the Government of Ontario increase annualized grant monies for VAW/GBV organizations to meet at least their core operating costs, including rent, utilities, and staffing. Financial security may allow VAW/GBV organizations to focus more on community outreach and prevention and advocacy efforts, rather than grant writing and fundraising. Furthermore, the Government of Ontario should implement similar annualized funding for 2S/LGBTQIA+ community organizations, with an intent to facilitate the founding of more such organizations and sustain the activities of existing organizations. These monetary solutions may also incentivize collaboration between the VAW/GBV sector and 2S/LGBTQIA+ advocacy groups to better meet their communities' needs and achieve common goals. The success of the secure text and chat line, Unsafe at Home, developed during the COVID-19 pandemic in Ottawa and founded as a collaboration between Interval House – a GBV shelter – and Kind Space, a 2S/LGBTQIA+ community organization, is testament to what may be achieved with inter-organizational collaboration.

6.2.4 Intersectional feminist frameworks

We echo the recommendations set forth by Furman and colleagues (2017) that existing second-wave feminist frameworks guiding the VAW sector in Ontario should be replaced with inclusive, intersectional feminist frameworks that explicitly include 2S/LGBTQIA+ people in funding mechanisms, policies, and staff training. Such a transition also requires a change in language. Given the nominal support that key informants have for serving 2S/LGBTQIA+ people in their organizations, the VAW/GBV sector needs to shift to inclusive, gender diverse language that implicitly includes any person who may experience IPV. Inclusive language in grant applications and organizational policies signals to service providers that they should expand their provision beyond cisgender, heterosexual women, could

incentivize services to include 2S/LGBTQIA+ people, and may signal to 2S/LGBTQIA+ IPV survivors that they can safely access the service.

6.2.5 Hybrid services

Our participants have strong individual preferences for accessing services in-person or virtually; moreover, our participants described wide variation in which service modality feels safest to them (e.g. in-person, videoconferencing, telephone, text/chat line). Therefore, IPV and 2S/LGBTQIA+ community services should consider retaining online services, even as they resume in-person services in a "post-pandemic" world. However, our key informants stressed that hybrid workplaces and service delivery is stretching their capacity and affecting staff cohesion and productivity. Services must strike a balance between online and in-person capacity and will require funding increases to establish dedicated online and in-person staff and services, training for online platforms, and increased workload. Moreover, service providers working remotely will need ongoing supports to prevent vicarious trauma and burnout.

6.3 Significance and future directions

As of this writing, there is little peer-reviewed research on the IPV experiences of 2S/LGBTQIA+ people in Canada and the perspectives of service providers on how to better meet the needs of these communities. This thesis aimed to begin filling that gap by documenting the IPV experiences of sexual and gender diverse people in Ontario throughout the COVID-19 pandemic. We explored participants' relationship dynamics and IPV experiences, their perceptions and reflections on their abuse, how their experiences affected their life, and their awareness of and/or experiences with VAW/GBV and 2S/LGBTQIA+ organizations. Also, we documented the perspectives of service providers to determine

the barriers to serving 2S/LGBTQIA+ people experiencing IPV and identified ways that services could be improved.

Our dissemination strategy for this work involves three main activities. First, we intend to submit three articles for publication from this thesis. We have submitted Chapter 4 to *Perspectives on Sexual and Reproductive Health* and Chapter 5 to *The Canadian Journal of Human Sexuality*. As the scoping review manuscript is still in preparation, we have not determined a journal for submission, but we intend to report on the implementation of the protocol detailed in Chapter 3. Second, we intend to deliver a report to key informants as per our agreement for their participation. We also intend to distribute this report to any other interested parties including interview participants, researchers, advocacy organizations, and community members. Third, we have been presenting our results at national and international conferences. To date, we have presented findings at the *Canadian Sex Research Forum*, the *Society for the Scientific Study of Sexuality*, *Preaching to the Choir* (an LGBTQ+ psychology and social sciences conference), and *Sexuality and Social Work* conferences.

6.4 Limitations

The results from this study are not generalizable; indeed, generalizability is neither a feature nor a goal of qualitative research. However, we are confident that the data collection and analytical methods are rigorous, the results credible, and the findings transferable beyond the bounds of this study.

We did not offer participants the option to participate in French. While the PI is professionally functionally bilingual in French and English, they believe their colloquial knowledge of French was not sufficiently adequate to engage participants in equal quality as they might in English. The PI feels that it would have been a disservice to Francophone participants to facilitate a lesser-quality interview than

they could English-speaking participants. For these reasons, French-language minority Ontarians' experiences are not captured in this work.

Also, 2S/LGBTQIA+ people are not a monolith. While these communities have sexual and gender diversity in common, the variation in sexuality and gender is rich, vast, and unique to every individual. Sexual and gender diverse people live at the intersections of many identities, and the totality of their experiences are not represented in this work. As an exploratory study, this project cast a wide net. Crucially, we did not capture any experiences of Two-Spirit people, transgender women, bisexual men, or intersex people. Also, our one transgender participant experienced his IPV before he socially transitioned. Future studies designed to capture and document the experiences of 2S/LGBTQIA+ people with IPV should focus on members of specific sexual and gender diverse communities to further draw upon the similarities and differences between these groups.

6.5 Positionality and reflexivity

In qualitative research, positionality refers to the social, political, historical, cultural, economic and educational categories of the researcher that are reflected in and by positions of social power including race, ethnicity, sex, religion, (dis)ability, national origin, formal educational attainment, socioeconomic status, sexual orientation, and gender identity, among others (Louis & Barton, 2002). Positionalities define the researchers' worldview and their assumptions about social reality, knowledge, and human nature, which in turn affect the development of research questions and objectives, the content and structure of interview guides, interview dynamics, and how data is interpreted and analyzed (Holmes, 2020; Robinson & Wilson, 2022).

Reflexivity is the practice of becoming aware of these positionalities and their effects on research and analysis (Bukamal, 2022). Reflexivity is an intrinsic component of the "ethic of care" in qualitative research, where researchers exercise self-awareness of those positionalities that reflect

inequities in social power between researcher and researched (Reich, 2021), not for the sake of 'objectivity' or eliminating bias, but to acknowledge positionalities as a component of the work (Bukamal, 2022).

To that end, I am a white, non-racialized, university educated, assigned male at birth, non-binary, queer, masculine presenting, Anglophone, Canadian-born descendent of English and French colonists. These myriad identities affect my experiences and my worldview. They are reflected in my thoughts and actions as a qualitative researcher. While I am a member of 2S/LGBTQIA+ communities, my status as an insider/outsider is dynamic depending on the positionalities and the context of each individual participant, which affects rapport, interview content, observations, and interpretations (Mason-Bish, 2019). In an effort to consistently reflect upon positionalities and their effects, we integrated memoing as a reflexive tool into the research design and analytic process (Elo & Kyngäs, 2008).

6.6 Statement of contribution

I have submitted this thesis as partial fulfilment of the requirements for the Master of Science in Interdisciplinary Health Sciences program at the University of Ottawa. As PI, I conceived the research questions, designed the study, prepared study instruments, sought ethics approval, recruited participants, conducted all interviews, led the content and thematic analyses, and authored manuscripts for submission to peer-reviewed journals.

Dr. Angel M. Foster guided me throughout the life of the project, ensuring the scope of the study was appropriate for the duration of the Master of Science in Interdisciplinary Health Sciences program. As preparation for data collection, she facilitated an intensive qualitative methods workshop about in-depth interviews, writing interview guides, content and thematic analysis, and memoing. Subsequently, Dr. Foster offered practical interview training through a directed study documenting

people's experiences with medication abortion in the United States where she facilitated progressive exposure to semi-structured in-depth interviews from observation to supervised interviews to peer-supported interviews to independent interviewing. She held weekly meetings with the entire research team to discuss sexual and reproductive health issues and ongoing projects to build community and support networks. Additionally, we met regularly to discuss the project, wherein she gave feedback on proposals, study instruments, REB applications, interpretation of findings, conference presentations, and manuscripts.

6.7 Conclusion

Intimate partner violence is a complex public health problem that puts victims at risk for myriad negative physical and psychological health outcomes. Although 2S/LGBTQIA+ people in Canada disproportionately experience IPV compared to cisgender, heterosexual people, their experiences are not well recorded in the peer-reviewed or scholarly literature.

Our study documented the experiences of 2S/LGBTQIA+ people with IPV in Ontario, explored how the COVID-19 pandemic affected their IPV experiences and access to support services, and identified ways that services could better meet the needs of these populations. Our participants are a diverse group of sexual and gender minorities who experienced physical, psychological, sexual, and financial abuse, identity abuse, and TFV that extended the reach and duration of IPV. Survivors found it difficult to recognize themselves as victims of violence because they did not meet narrow sociocultural standards of a "legitimate" victim. Participants describe negative mental health outcomes due to their IPV experiences and the COVID-19 pandemic, which also intensified their abuse situations. While participants recognize their IPV experiences as distressing, they sought to view their experiences as learning opportunities and use their knowledge to advocate for themselves and others in future relationships.

Survivors were mostly unaware of VAW/GBV services or 2S/LGBTIQIA+ community organizations or services they could access for support in their abusive relationships; rather, participants confided in their social networks. Survivors primarily want access to mental health practitioners that are non-judgemental and competent to address abusive relationships and need systemic supports to meet basic needs. Participants have strong preferences for online and in-person services, but service providers stressed the importance of balancing convenience with client confidentiality and staff well-being. Violence against women organizations and 2S/LGBTQIA+ community organizations operate through a patchwork of grants that does not meet their basic operating costs and must supplement their budgets with donations and fundraising. Furthermore, second-wave feminist frameworks are pervasive in the policies, training, and funding mechanisms of the VAW sector, which acts as a barrier to expanding services to 2S/LGBTQIA+ people. While VAW service providers may be supportive of serving transgender women and transfeminine non-binary people, they may lack the cultural competence to do so.

The Province of Ontario must implement trauma-informed, anti-oppressive comprehensive sexual health education that includes abusive relationships, GBV/IPV, and 2S/LGBTQIA+ relationships to improve these communities' ability to recognize IPV. Similarly, mental health professionals need to be trained in recognizing IPV, 2S/LGBTQIA+ cultural competence, and implement regular IPV screenings into their practice. Also, the Government must increase funding for VAW/GBV services to meet at least their core operating costs and extend similar annualized funding to 2S/LGBTQIA+ community organizations. Funding mechanisms, policies, and training in the VAW sector need to shift from a second-wave feminist framework to an intersectional feminist framework that is inclusive of sexual and gender diversity.

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Appendix A: REB Approval Letter

10/07/2023

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	S-05-21-6906
Titre du projet / Project Title	Exploring LGBTQ2S+ people's experiences with intimate partner violence during the COVID-19 pandemic in Canada: A multi-methods qualitative study
Type de projet / Project Type	Thèse de maîtrise / Master's thesis
Statut du projet / Project Status	Renouvelé / Renewed
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	08/08/2021
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	07/08/2024

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Kyle DROUILLARD	École interdisciplinaire des sciences de la santé / Interdisciplinary School of Health Sciences	Chercheur Principal / Principal Investigator
Angel FOSTER	École interdisciplinaire des sciences de la santé / Interdisciplinary School of Health Sciences	Superviseur / Supervisor

Conditions spéciales ou commentaires / Special conditions or comments

550, rue Cumberland, pièce 154 Ottawa (Ontario) K1N 6N5 Canada
550 Cumberland Street, Room 154 Ottawa, Ontario K1N 6N5 Canada

613-562-5387 • 613-562-5338 • ethique@uOttawa.ca / ethics@uOttawa.ca
www.recherche.uottawa.ca/deontologie | www.recherche.uottawa.ca/ethics