Developing LGBTQ programs for perpetrators and victims/survivors of domestic and family violence

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AUSTRALIA'S NATIONAL RESEARCH ORGANISATION FOR WOMEN'S SAFETY

to Reduce Violence against Women & their Children

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ANROWS acknowledges the Traditional Owners of the land across Australia on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present, and future, and we value Aboriginal and Torres Strait Islander histories, cultures, and knowledge. We are committed to standing and working with Aboriginal and Torres Strait Islander peoples, honouring the truths set out in the Warawarni-gu Guma Statement.

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ANROWS acknowledges the lives and experiences of the LGBTQ people affected by domestic, family and sexual violence who are represented in this report. We recognise the individual stories of courage, hope and resilience that form the basis of ANROWS research.

Caution: Some people may find parts of this content confronting or distressing.
Recommended support services include: 1800 RESPECT—1800 737 732 and Lifeline—13 11 14.

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Developing LGBTQ programs for perpetrators and victims/survivors of domestic and family violence

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Acronyms

ANROWS	Australia's National Research Organisation for Women's Safety
DFV/IPV	Domestic and family violence/intimate partner violence
LGBTQ	Lesbian, gay, bisexual, transgender and/or queer
NOSPI	National Outcome Standards for Perpetrator Interventions

Key terms

Behaviour change programs

The glossary for the *National Outcome Standards for Perpetrator Interventions* (NOSPI) (Department of Social Services [DSS], 2015, p. 4) defines men's behaviour change programs as perpetrator interventions which are "usually group-based programmes that work with family or domestic violence perpetrators to enable them to accept responsibility for their violence and make attitudinal and behavioural choices towards non-violence". This definition assumes perpetrators are cisgender males and that victims/survivors are cisgender females. We have adopted the term "behaviour change programs" to refer to programs which are inclusive of lesbian, gay, bisexual, transgender and/or queer (LGBTQ) clients. This includes perpetrators who may be female or non-binary and victims/survivors who may be male or non-binary.

Biphobia

Biphobia, also known as antibisexual, refers to the aversion directed towards bisexual people due to their sexual orientation. Researchers have described the invisibility or erasure of this identity, given the denial of bisexual identity in settings that are both formal (law courts) and informal (family) (Marcus, 2015; Todd, Oravecz, & Vegar, 2016; Yoshino, 2000). Others have described the particular forms of stigma and discrimination unique to the lived experiences of bisexual people, who face a double discrimination from both the heterosexual and the lesbian and gay communities (Brewster & Moradi, 2010; Todd et al., 2016).

Cisgender

Cisgender refers to "individuals who have a match between the gender they were assigned at birth, their bodies, and their personal identity" (Schilt & Westbrook, 2009, p. 461). In other words, the gender these individuals were named at birth, their biological characteristics, and how they feel about themselves are all in alignment.

Domestic and family violence

Within the glossary for the NOSPI, domestic violence is defined as "violence carried out by someone against a person who is currently or formerly their intimate partner. It can include physical, sexual, emotional and psychological and other forms of abuse." (DSS, 2015, p. 1) A defining feature is the repetition or threatening of repetition of these acts over time. Similarly, family violence refers to "violence committed by someone against a family member or members, as well as violence against an intimate partner. It involves the same sorts of behaviours as described for domestic violence." (DSS, 2015, p. 2) Family violence is the preferred term among Aboriginal and Torres Strait Islander communities, as it better captures kinship and extended family relationships (Cripps & Davis, 2012).

In this report, we use the combined terminology of "domestic and family violence" (DFV) to refer to violent and abusive behaviours among partners, former partners, family members, and other intimate and domestic relationships. This encompasses the diverse range of close domestic relationships experienced by LGBTQ communities and is in alignment with NSW policy frameworks (NSW Ministry of Health, 2016).

Genderqueer and non-binary

Richards et al. (2016, p. 2) write,

> some people have a gender which is neither male nor female and may identify as both male and female at one time, as different genders at different times, as no gender at all, or dispute the very idea of two genders. The umbrella terms for such genders are "genderqueer" or "non-binary" genders.

In this spirit, we use the terms non-binary and genderqueer throughout the report to refer to participants or communities who do not identify with the male or female identities, noting the shifting nature of these identities and the preference of some people who understand gender as a spectrum (Monro, 2007).

Identity-based abuse

Understood as a unique aspect of the experience of lesbian, gay, bisexual, transgender, intersex and queer people, identity-based abuse is when an abusive person capitalises on the victim's/survivor's fear of exposure, or experience of discrimination, to control and coerce them. Outing, for example, is a tool of identity-based abuse in that the perpetrator can threaten to disclose their partner's sexuality or gender identity or exploit their fear of forced exposure. This threat may hinder the victim/survivor from turning to family, friends or police for support, and further isolate them (Kulkin, Williams, Borne, de la Bretonne, & Laurendine, 2007). In this report, we use the term identity-based abuse broadly to refer to experiences where a participant's identity has been used to threaten, undermine or isolate them.

Inclusivity

Populations marginalised by social responses to their gender identity and sexual orientation have been excluded from mainstream health promotion, research and service provision; to rectify this, new models are being designed to capture and include these target populations (Mulé et al., 2009). In this report, "inclusivity" describes a set of professional practices which aims to increase the recognition of sexuality and gender diverse populations, and improve practice through workforce development, affirmative promotional strategies or policy review.

Internalised homonegativity

Internalised homonegativity refers to the process by which lesbian, gay and bisexual people internalise negative societal messages about their sexuality, often unconsciously. It is understood to be an important variable affecting the wellbeing of sexually diverse individuals (Berg, Munthe-Kaas, & Ross, 2015). Internalised homonegativity is one of the outcome indicators in the pre- and post-intervention surveys used for this study (Mohr & Fassinger, 2000).

Intersectionality

Intersectionality refers to an analytic framework, or matrix, of structural identities, such as race, gender, disability, ethnicity and, in this case, gender identity and sexuality (Cooper, 2016; Crenshaw, 1989). The concept recognises how these embodied identities can be used as vehicles for oppression, where a singular view from one position (the most privileged) effectively erases others. This presents a distortion of experience, marginalising certain perspectives and ignoring the multidimensional nature of disadvantage.

In this report, we use intersectionality to refer to the ways in which inequities between identities compound experiences of oppression. Identities such as "Aboriginal, transwoman, lesbian" situate the person at three intersecting experiences of marginalisation. Such experiences should not be conflated with those of a "white, cisgender, gay male". Our aim is to acknowledge the complexity of experiences and identities within LGBTQ communities and consider the implications of such "complexities of compoundedness" (Crenshaw, 1989, p. 166) for service delivery and for practice.

Intimate partner violence

Intimate partner violence (IPV) is not separately defined within the NOSPI glossary but is included in the definition of "domestic violence" as "violence carried out by someone against a person who is currently or formerly their intimate partner" (DSS, 2015, p. 1). Others have used IPV to define emotional, physical, sexual and economic abuse which occurs between "heterosexual and homosexual partners", adding that it does not require there to be "sexual relations" (Fulu, Liou, Miedema, & Warner, 2018, p. 4). We adopt the use of the term intimate partner violence in this report to include all forms of intimate partners, since the limit on "heterosexual and homosexual" orientations excludes bisexual, pansexual and queer people. It is combined with domestic and family violence (DFV/IPV) to encapsulate relations that extend beyond the home, such as those "living apart together", family relationships and relatives; and acknowledge relationships structured around polyamory and consensual non-monogamy.

Minority Stress

Minority stress refers to the experience of heightened, ongoing psychological distress and social pressure experienced by members of stigmatised, minority populations. Such groups face additional life stressors compared to the general population, related to experiences of prejudice, discrimination and harassment, including violence and abuse. LGBTQ communities experience minority stress which can lead to internalised homophobia and fear of being outed, and cause a range of negative mental health outcomes (Meyer, 2003).

Misgendering

Misgendering refers to someone using a personal address or pronoun that does not correctly reflect the gender with which another person identifies. In this report, we use this term to include text, program activities and promotional material which assume a cisgender identity or experience and fail to reflect the gender or gender identity of transgender, non-binary and genderqueer people.

Outness

Outness is the extent of disclosure of one's sexual orientation and/or gender identity to social contacts (Whitehead, Shaver, & Stephenson, 2016, p. 3). The Outness Inventory by Mohr and Fassinger (2000) is used in this study as an outcomes indicator in the pre- and post-intervention surveys.

Perpetrator Perpetrator is the term used in the NOSPI glossary (DSS, 2015, pp. 2–3) to describe

> males who commit domestic and family violence against women or children, or who commit sexual violence against women. […] The term perpetrator reinforces the serious nature of domestic, family and sexual violence. The term is intended to cover all men who commit one or more identified acts of domestic or family violence against women and their children, or sexual violence against women, whether or not they have ever been arrested, charged with a crime, or had an intervention order issued against them.

In this report, we use "perpetrator" in a gender-neutral way, to refer to a person who uses violent and abusive behaviours, including control and coercion, against their partner, former partner, family member or housemate. This is because the perpetrators within our proposed programs may be male (both cis and transgender), female (cis and transgender), non-binary or genderqueer.

Perpetrator programs The term "perpetrator programs" is defined by the NOSPI glossary as the

> overarching name used to describe the range of programmes and services that are designed to enable perpetrators to take responsibility for their violence and work towards changing their violent attitudes and behaviours. Perpetrator programmes include men's behaviour change programs and clinical services for perpetrators of sexual violence and sexual assault. (DSS, 2015, p. 4)

As before, the definition carries explicit assumptions that the perpetrator is a cisgender male committing violence against a cisgender female partner, and her children. While this is a common scenario (Phillips & Vandenbroek, 2014), it is not inclusive of the clients targeted within this study. As such, we use perpetrator programs, and perpetrator interventions, to refer to groups or clinical practices where professionals facilitate change by enabling clients to take responsibility for their violent, abusive, controlling and coercive behaviours, and the attitudes which foster these behaviours, regardless of gender or sexual identity.

Transphobia Transphobia refers to a range of negative behaviours and attitudes directed towards transgender people based on their gender identity. It encompasses prejudice or discrimination against transgender individuals, is understood to be pervasive and has been shown to have deleterious effects on the wellbeing of those affected by it (Chakraborti & Garland, 2009).

Victim/survivor This term is used in the NOSPI glossary (DSS, 2015, p. 3) to describe "women and their children who have experienced domestic, family and sexual violence by a male perpetrator". While we acknowledge the prevalence and frequency of violence against women, and that domestic violence is the most common type of violence experienced by women (Phillips & Vandenbroek, 2014), our use of the term victim/survivor is not synonymous with "women and their children".

In this report, victim/survivor refers to people who have experienced DFV/IPV, regardless of their gender, gender identity and/or sexual orientation.

Notes on language

Almost all perpetrator interventions available in Australia target cisgender, heterosexual men.

Lesbian, gay, bisexual, transgender and/or queer (LGBTQ) people wishing to change their violent and abusive behaviours may be unsure of how to find and access appropriate interventions. Moreover, the ways in which people define and/or experience their sex, sexual orientation and/or gender is varied, shifting and complex. As we are conscious of the risks of collapsing individual experiences into overly broad categories, we have approached writing this report through the shared barriers to accessing social services and other supports for sexuality and gender diverse populations.

In this report, when talking about sexuality and gender diverse communities, we use the acronym LGBTQ to discuss the broad range of people and experiences in these communities. However, when we reference research, findings or observations that apply only to subsections of this population, we use an acronym which appropriately captures those groups of people (for example LBQ women would be used for lesbian, bisexual and queer women), or we name the specific populations we refer to.

It is common for research and policy documents to refer to sexuality and gender diverse communities in a broad way, often using the acronym LGBTQI or LGBTI, where the "I" represents people born with a variation of sex characteristics, also known as "intersex". However, in some of these cases, research studies cannot make any clear inferences about intersex people due to insignificant sample sizes. The research team acknowledges the human rights of intersex people and we respect the intersex human rights movement. We acknowledge the distinctiveness and diversity within the intersex community, and the unique needs of this community. Moreover, in line with the Darlington Statement (Androgen Insensitivity Syndrome Support Group Australia et al., 2017), it is considered tokenistic to include intersex communities when there is no meaningful representation of intersex people in the sample. We did not recruit participants who identified as intersex, and so were not able to meaningfully distinguish their unique experiences within this study. As such, we have not included reference to intersex people within the umbrella terms chosen for this report.

Throughout our consultations, research interviews and state of knowledge review, we also noted a wide range of terms in use to describe violent and abusive behaviours within intimate relationships. The most common term in Australia appears to be domestic and family violence (DFV). As this is potentially misleading to laypeople due to the implication that it relates only to relationships involving cohabitation, we have incorporated intimate partner violence (IPV) alongside DFV. This decision is a part of the deliberate inclusion and recognition of relationships in which people are "living apart together" and/or are in other relationship constellations, such as open or polyamorous relationships. We have used this combined terminology of DFV/IPV to encompass behaviours within intimate, family and/or personal relationships which are abusive, and which would be considered coercive and controlling. Another frame of reference is to include relationships in which one party is afraid of the other, and/or unable to leave the relationship for fear of their own safety, or that of the children or pets in their care. Where we directly cite another source, however, we retain the terminology of the author/s to reflect the meaning and scope of their findings or assertions.

Executive summary

Background

While the prevalence of domestic and family violence and intimate partner violence (DFV/IPV) in lesbian, gay, bisexual, transgender and/or queer (LGBTQ) relationships is unclear, such violence is likely to be under-reported (Donovan & Barnes, 2017; Donovan, Hester, Holmes, & McCarry, 2006). Existing DFV/IPV interventions tend to focus on cisgender heterosexual female victims/survivors and male perpetrators, to the exclusion of LGBTQ communities (Cannon & Buttell, 2015). An understanding of the causes and effects of DFV/IPV in LGBTQ communities is limited, and responses to address this violence are scarce.

This study initially sought to tailor and deliver an existing perpetrator group program for LGBTQ people who use violence, including a concurrent tailored support group for victims/survivors. We aimed to investigate LGBTQ clients' experiences of the tailored programs, the barriers and enablers to potential clients accessing such programs, and related workforce development needs of both the DFV/IPV and broader community services sectors. However, due to only a small number of clients engaging in the tailored programs, we revised the focus of the project away from being a pilot study, and instead explored how potential clients of LGBTQ perpetrator and victim/survivor programs may be located and engaged. We also investigated what workforce and sector development would be required for establishing referral pathways into such programs.

The study involved a partnership between Relationships Australia New South Wales (RANSW) and ACON (formerly the AIDS Council of NSW). ACON is New South Wales' leading health promotion organisation specialising in HIV prevention, HIV support and LGBTQ health. RANSW is a community-based, secular, non-profit, non-government organisation which has provided relationship services for more than 70 years. RANSW has been facilitating DFV/IPV interventions since the early 1980s.

In 2016, Australia's National Research Organisation for Women's Safety (ANROWS) invited applications to address new strategic research priorities relating to perpetrator interventions. The project reported here was directed towards the sub-category which sought research about models of diversity (priority 3.3) (Australia's National Research Organisation for Women's Safety, 2017). Through the RANSW and ACON partnership, this project contributes to new knowledge for working with gender and sexuality diverse people affected by DFV/IPV, and seeks to disseminate findings in line with ANROWS's fundamental aim to reduce violence against women and their children.

Research questions

Our original research questions were as follows:

1. Does a tailored DFV/IPV perpetrator program for LGBTQ clients achieve positive outcomes for clients?
2. How do clients perceive and experience these interventions?

Our revised focus included the following questions:

3. How do we locate and engage clients who might benefit from tailored LGBTQ perpetrator and victim/survivor programs?
4. What workforce and sector development is required to establish referral pathways for clients who might benefit from these programs?

Ultimately, this research contributes new knowledge for working with sexuality and gender diverse people affected by DFV/IPV.

Methodology

This study is underpinned by a feminist post-structural theoretical framework (Wendt & Zannettino, 2015). This approach provides an understanding of the operations of power within intimate relationships, and a view of gender and sexuality as socially constructed. This enables us to consider the effects of a predominantly gendered analysis of DFV/IPV on sexuality and gender diverse people and explore experiences of DFV/IPV beyond a binary, male/female heteronormative frame. We believe feminist post-

structural theory offers the best conceptual tools to unpack the uniquely lived and situated experience of LGBTQ people in relation to DFV/IPV.

The research was originally designed as a mixed methods study. This included pre- and post-intervention surveys with perpetrator and victim/survivor group participants, using validated scales to assess outcomes, alongside in-depth interviews and focus groups with a range of stakeholders. Due to low referral numbers, it was only possible to run one victim/survivor program and conduct interviews with five victim/survivor participants. No perpetrator programs were delivered. As mentioned, we therefore revised the design to a more exploratory, qualitative study, by increasing the number of interviews conducted and running focus groups with community members.

In the period between December 2017 and July 2018, we conducted 45 interviews: five with victim/survivor program clients; 20 with community members, including three potential clients who had been referred to the perpetrator program; seven with clinicians and program developers; and 13 with professional stakeholders. We also conducted a series of focus groups at the Pride of Place conference in June 2018, with 50 participants in total. All client participants were based in Sydney and attended RANSW.

While no results can be reported for the tailored group interventions, the survey instruments were designed following an extensive literature review and these are described in the Methodology section to provide information for future studies. This report also provides detail on how the existing RANSW perpetrator and victim/survivor programs were tailored for LGBTQ communities. Notwithstanding the necessary change in focus of the study, the findings outlined here provide significant new knowledge to inform future program development.

Key findings

Our study found that DFV/IPV was perceived by community members and professional stakeholders to be a heterosexual issue that did not easily apply to LGBTQ relationships. In particular, many community members held the view that relationships between LGBTQ people could avoid the inherent sexism and patriarchal values of heterosexual, cisgender relationships, and, by implication, avoid DFV/IPV. Participants also reported that the term "domestic violence" almost exclusively evoked physical harm, as opposed to non-physical forms of violence such as identity-based abuse, and this further distanced the concept from LGBTQ experience.

Community member and professional stakeholder participants believed that minority stress, stigma and discrimination experienced by many LGBTQ people underpin high levels of distress, low self-esteem and a range of mental health issues. These participants also perceived there to be high levels of empathy and a strong sense of solidarity within LGBTQ communities acting as protective mechanisms for individual wellbeing. Under these conditions DFV/IPV was more likely to be excused or minimised, since it could be seen as emerging from distress or trauma rather than being an active abuse of power. A desire to cherish and protect the community from external judgement was seen to increase the likelihood of this view being taken. We heard that people experiencing abuse were reluctant to report their abusive partner for fear of exposing them to hostile judgment.

Diversity of experiences, identities and levels of disadvantage *within* LGBTQ communities was also raised by community members and professional stakeholders. They highlighted the importance of not homogenising LGBTQ communities and ensuring that identity intersections (such as disability and culture) could be taken into account. There was concern regarding the potential for programs to overlook the impacts of differences in experience and how these could impact group dynamics, discrimination between group members and the overall effectiveness of tailored programs. However, many participants ultimately felt that the pressing need for DFV/IPV programs for LGBTQ people took precedence over the potential benefits of taking extra time to design and deliver separate groups by gender identity, or sexuality.

Clients and community members related mixed experiences of mainstream services, expressing caution around seeking their support. They commonly reported a need to explain

LGBTQ sexual practices to mainstream staff, which they found frustrating and uncomfortable. Clinicians in non-LGBTQ-specific services were also perceived by community members to pathologise polyamorous relationships. Mistrust by LGBTQ communities of the police and criminal justice system as a result of historical experiences of discrimination was also noted as a significant factor to be considered in DFV/IPV responses.

The ways in which professionals understand DFV/IPV for LGBTQ communities has implications for how potential clients are identified, directed to and treated within DFV/IPV programs. Professional stakeholders reported that knowledge and confidence in working with LGBTQ people were low within many organisations, including DFV/IPV-specific services. These participants told us referral pathways for LGBTQ people were not well established and dedicated DFV/IPV programs are largely missing. Those who themselves identified as members of the LGBTQ community felt it would be better to be treated by a fellow community member than risk poor service from an uninformed professional. In the absence of tailored programs and inclusive services, some participants described how they were involved in community-led, grassroots interventions.

We heard it would take a long time for services to gain the trust of LGBTQ communities to deal skilfully and sensitively with their concerns. Program designers and clinicians considered courts to be a good source of referral to tailored perpetrator interventions, but this should not be the only pathway. All participants perceived that good quality, regular inclusivity training was a fundamental requirement for professionals working in clinical and judicial settings.

Client participants noted that their knowledge of DFV/IPV and relationships had improved after participating in the tailored victim/survivor program. They felt they were able to better verbalise their emotions and needs, valued the therapeutic relationship with clinicians and other clients and reported feeling less isolated and better supported. The solidarity and camaraderie of the group was particularly valued due to the discrimination many had experienced as a result of the 2017 Australian Marriage Law Postal Survey that took place in Australia during the program.

Discussion, conclusions and recommendations

The findings in this study support those of McNair and Bush (2016) and Turell, Herrmann, Hollan, and Galletly (2012) in highlighting the need to increase LGBTQ community readiness to address DFV/IPV and enable greater help-seeking in the context of minority stress. Consistent with previous research (Campo & Tayton, 2015), this study finds that homophobia, transphobia and heterosexism affect the experience of DFV/IPV among LGBTQ populations. Moreover, these appear to interact with the heterosexual face of domestic violence to further hinder LGBTQ victims and perpetrators being "seen" and recognised as in need of help by their communities and support services (Guadalupe-Diaz & Jasinski, 2016).

The way community members and professionals conceptualise DFV/IPV in sexuality and gender diverse relationships plays a crucial role in improving services for victims/survivors and perpetrators. This and other findings of this study are pertinent to the future development of tailored programs and professional practice with LGBTQ community members. As such, we make the following recommendations:

- Make LGBTQ inclusivity training required learning for all DFV/IPV sector staff, particularly those employed in specialised DFV/IPV roles.
- Advocate that inclusivity training be made mandatory within clinical organisations, and among police and legal professionals.
- Develop referral pathways into LGBTQ-friendly DFV/IPV programs for key professionals, such as court support workers and magistrates.
- Increase the representation of LGBTQ people in promotional material about DFV/IPV.
- Use social media platforms to increase DFV/IPV awareness in LGBTQ communities and use these channels to engage clients for future programs.

- Provide ongoing funding to develop, trial and implement tailored programs. Short funding cycles do not provide adequate time to populate groups within an under-developed community area.
- Ensure programs respond to diverse needs within mixed LGBTQ groups and manage transphobia and biphobia.

This study aimed to develop and implement tailored DFV/IPV programs for LGBTQ people, extend our understanding of how they experience such programs, and provide insights into how to work with sexuality and gender diverse populations affected by DFV/IPV. Due to the small number of clients recruited to the programs, it was not possible to analyse client experiences of the intervention. Despite this limitation, this study provides the largest body of qualitative data on addressing issues for developing and engaging LGBTQ clients in tailored perpetrator and victim/survivor programs to date. This report gives voice to 94 people who were able to describe their concerns and preferences for DFV/IPV program delivery, including insider knowledge from professionals working within frontline mainstream and targeted services. Here, we present our findings with up-to-date policy and practice recommendations to guide future comparable projects. It is our hope that this information will be used to improve services for LGBTQ people experiencing DFV/IPV and increase safety within LGBTQ relationships at risk.

Introduction

This study considers how domestic and family violence and intimate partner violence (DFV/IPV) that occurs in sexuality and gender diverse relationships can be understood, and what responses are appropriate. Although DFV and IPV have received increased attention in recent years (Dowling, Morgan, Boyd, & Voce, 2018; Rollè, Giardina, Caldarera, Gerino, & Brustia, 2018), the focus has been on addressing intimate abuse between cisgender, heterosexual people with greater attention paid to male perpetrators (Rollè et al., 2018). This is for good reason. Research has shown that the majority of perpetrators are cisgender, heterosexual men who are violent and/or abusive towards their cisgender, female partners and former partners (Australian Institute of Health and Welfare [AIHW], 2018). While men are more likely to be victims of street-based violence by a stranger, their aggressors are also most often heterosexual, cisgender men (Cox, 2016; Flood, 2006).

When men are victimised within their intimate and family relationships, perpetrators again tend to be cisgender, heterosexual men (Flood, 2006; O'Halloran, 2015). Research that focuses on preventing and intervening to reduce harm has argued that toxic forms of masculinity, including patriarchal and sexist attitudes, have played a role in facilitating this violence (Jewkes et al., 2015; World Health Organization [WHO], 2009). Therefore, prevention and intervention efforts have emphasised the significance of rigid gender roles in contributing to violence against women, with the aim of disrupting patriarchal and misogynistic attitudes in order to reduce community tolerance for domestic and family violence and increase men's motivation to change their own and others' behaviour (Walden & Wall, 2014). This gender paradigm, however, has a heterosexual bias and has been criticised for failing to recognise both similarities and differences among relationships, including lesbian, gay, bisexual and transgender (LGBT) persons[1] (Cannon & Buttell, 2015). Furthermore, there is often no representation of intersex people within the limited available information.

Gender and sexuality indicators (that is, questions on service intake forms which ask clients about their gender, gender identity and sexuality) are not currently in general use within community-based services in Australia. This means that the extent to which LGBTQ people are using mainstream services, let alone perpetrator programs, is unknown. Moreover, the prevalence and nature of DFV/IPV within LGBTQ communities cannot be captured. Collecting gender and sexuality indicators could enable increased knowledge and greater awareness of DFV/IPV within LGBTQ communities at a sector level. However, clinicians are not funded to record this information and there is no cross-agency database which collects information about gender or sexuality. Very little is known beyond a basic understanding that DFV/IPV does occur within LGBTQ relationships, and that there is a lack of inclusive programs available for people wishing to change their violent and abusive behaviours or access victim/survivor support.

Previous research suggests that the stressors associated with belonging to a sexual minority group interact with the negative impacts of DFV/IPV for LGBTQ people to exacerbate vulnerabilities, increase risk for complex trauma, and create additional barriers to service access (Stiles-Shields & Carroll, 2015). Community readiness to address DFV among people of diverse sexual orientations and gender identities is reported to be low, with victims/survivors feeling isolated, helpless and silenced (Bornstein, Fawcett, Sullivan, Senturia, & Shiu-Thornton, 2006; Walters, 2011). Should potential clients seek access to interventions, they will be met with inequities, including barriers related to their sexual orientation and gender identity which can further endanger and isolate them (Calton, Cattaneo, & Gebhard, 2016; Oswald, Fonseca, & Hardesty, 2010). Barriers to accessing services exist at societal, institutional and individual levels, and include inequitable and ambiguous legislation; judgemental and prejudiced social and cultural attitudes; inadequate theories of domestic violence dynamics; heterosexist language; implicit and explicit attitudes of clients, staff, and legal authorities; stigma; risk of outing; community ties; and re-victimisation (Calton et al., 2016; Duke & Davidson, 2009). There is a pressing need, therefore, for an improvement in access to services for LGBTQ people.

1 As noted earlier, when we reference research, findings or observations that apply only to subsections of the LGBTQ population, we use an acronym which appropriately captures those groups of people, or we name the specific populations we refer to.

While DFV/IPV is known to exist in LGBTQ communities, there is limited knowledge about its nature and causes, or how to respond effectively to it. Issues related to gender inequality and rigid gender roles have been widely cited as major influences on the perpetration of domestic violence, with violent behaviour being conceptualised as an outworking of patriarchal attitudes (Bettman, 2009; WHO, 2009). If domestic violence is a consequence of male dominance and patriarchy, it is argued that such violence should not exist within lesbian relationships and should be rife throughout male same-sex relationships, although the evidence does not point to this (Ferreira & Buttell, 2016). A clear message emerging from previous research is that there is a need to develop and implement inclusive behaviour change programs (Calton et al., 2016). To do so requires researchers and clinicians to work together to facilitate effective prevention and intervention with all types of DFV (Langhinrichsen-Rohling & Turner, 2012), and organisations seeking to offer equitable interventions to establish themselves as inclusive services (Duke & Davidson, 2009).

There is little to guide program developers or policymakers wishing to design inclusive interventions for clients who identify as lesbian, gay, bisexual, transgender or queer (LGBTQ), or those who engage in relationships with people of diverse sexual orientations and/or gender identities. Entering a service which delivers perpetrator programs for cisgender, heterosexual men results in the explicit and/or implicit exclusion of LGBTQ clients who are female, whether cisgender or transgender. It also forces clients into making difficult decisions about whether to disclose their gender identity or sexuality. Furthermore, should they continue with the program, they are then required to position themselves in group discussions and planned exercises which assume the aggressor to be male. The extent to which this occurs, or whether it achieves any positive outcomes for LGBTQ clients, is currently unknown.

The original aim of this study was to extend our knowledge about working with sexuality and gender diverse communities affected by DFV/IPV through practice-based research that designed and delivered a tailored perpetrator program and victim/survivor support group. Throughout the project we sought to better understand the nature of violence and abuse within LGBTQ relationships, and inform the optimal design of such programs.

Barriers to providing perpetrator interventions for LGBTQ people have been identified, such as a lack of information to guide professionals, and practitioners' lack of confidence and experience when working with this cohort (Barnes & Donovan, 2016; Donovan, Barnes, & Nixon, 2014; Donovan, Hester, Holmes, & McCarry, 2006). Through this study, we gathered in-depth interview and focus group data from clients, community members and stakeholders. With low numbers of clients entering the tailored group programs, the client sample for the research was too small to yield meaningful analysis. Additional data were therefore gathered from a broader cohort of LGBTQ community members and professional stakeholders. This broader data set refocused the research aims to address questions directly related to the engagement of LGBTQ clients and workforce development needs, both of which represented significant gaps in the literature.

As such, this report gives voice to 94 people who were able to describe their concerns and DFV/IPV program preferences, and includes insider knowledge from professionals working within frontline mainstream and targeted services. We present findings based on the largest qualitative data set available in Australia and internationally regarding DFV/IPV interventions for LGBTQ people, with up-to-date policy and practice recommendations to guide future comparable projects.

The study involved a partnership between Relationships Australia NSW (RANSW) and ACON (formerly the AIDS Council of NSW). ACON is New South Wales' leading health promotion organisation specialising in HIV prevention, HIV support and LGBTQ health. RANSW is a community-based, secular, non-profit, non-government organisation which has provided relationship services for more than 70 years. RANSW has been facilitating DFV/IPV interventions since the early 1980s.

In 2016, Australia's National Research Organisation for Women's Safety (ANROWS) invited applications to address new strategic research priorities relating to perpetrator

interventions. This project was directed towards the sub-category which sought research about models of diversity (priority 3.3). Through the RANSW and ACON partnership, this project contributes to new knowledge for working with gender and sexuality diverse people affected by DFV/IPV, and seeks to disseminate findings in line with ANROWS's fundamental aim to reduce violence against women and their children.

Research aims and questions

The initial research aim was to develop and deliver a tailored DFV/IPV perpetrator program with an accompanying victim/survivor support group for LGBTQ communities and extend our understanding of how clients experience such programs. Ultimately, this would contribute new knowledge around working with sexuality and gender diverse people affected by DFV/IPV.

Our original research questions were:

1. Does a tailored DFV/IPV perpetrator program for LGBTQ clients achieve positive outcomes for clients?
2. How do clients perceive and experience these tailored interventions?

However, due to the small number of clients engaged for the tailored group programs in this study, the perpetrator program was not delivered and only one victim/survivor group went ahead. We therefore revised the focus of the project to include the following questions:

3. How do we locate and engage clients who might benefit from tailored LGBTQ perpetrator and victim/survivor programs?

To answer this question, we first explored how a range of stakeholders conceptualised DFV/IPV and related factors. We then examined the factors involved in locating and engaging clients, including help-seeking behaviours. Finally, we researched victim/survivor program participant experiences.

4. What workforce and sector development is required to establish referral pathways for clients who might benefit from these programs?

To answer this question, we extended the examination of conceptualisations of DFV/IPV and related factors to professionals in the field, and explored their awareness of and attitudes toward programs and interventions.

Overview of the report

In the next section, we survey the current state of knowledge of DFV/IPV in LGBTQ communities and interventions for LGBTQ perpetrators and victims/survivors. This includes a review of best practice in LGBTQ perpetrator programs, help-seeking and the clinical engagement of perpetrators, and professional awareness and attitudes for working on interventions. Within this review, we included material concerning the conceptualisation of DFV/IPV and its applicability to LGBTQ communities.

This project involved adapting RANSW's perpetrator and victim/survivor programs to make them suitable for members of the LGBTQ community. In the Methodology section, we set out our theoretical framework and the models we drew on to tailor these programs. We describe how we made the changes to the original RANSW programs, with full details provided in Appendix A. We then cover our recruitment procedure into the programs, including the promotional strategies used, and describe the participants' profiles. The pre- and post-intervention surveys designed to assess program outcomes are briefly mentioned, with further detail provided in Appendices C, D and E, to guide future consideration of the use of standardised measures as part of an effectiveness study. Due to the small number of respondents and inconclusive results, this information is not presented as findings. To conclude the section, we detail our data collection and analysis methods, as well as ethical considerations.

In the Key findings section, we present the research findings based on substantive qualitative analysis pertinent to the research questions. This section examines the experiences of the Surviving Abuse group program participants, considerations relevant for future program development, and how DFV/IPV is perceived within LGBTQ communities and by professionals more broadly.

The final part of the report discusses the findings and draws conclusions about their implications for future practice, policy and research on DFV/IPV interventions within LGBTQ communities.

State of knowledge review

Review approach

This research originally aimed to develop and deliver a tailored DFV/IPV perpetrator program, with an accompanying victim/survivor support group, for LGBTQ communities. We specifically sought to understand whether a tailored perpetrator program could achieve positive outcomes; how LGBTQ clients perceive such a program; how to engage and support referral of potential clients to both perpetrator and victim/survivor groups; and the implications for workforce and sector development.

The current evidence base for programs tailored for LGBTQ people is sparse. There is also a lack of consensus across studies relating to terms and definitions for DFV/IPV. Furthermore, major differences exist in the communities targeted by different studies. For example, most studies focus on lesbian, gay and bisexual communities, and there is a lack of research on the experiences of intersex people and those who are non-binary, trans, gender diverse and genderqueer.

We found that although LGBTQ perpetrator interventions, and research around them, are emergent at best, the scant literature does provide a little information which can be used to inform program developers and clinical practice. In this review, we outline this information and highlight knowledge gaps which could guide future research.

Terminology

We have used the combined terminology of DFV/IPV to reflect the lived experiences of LGBTQ people (see the Notes on language and Key terms sections). However, in this State of knowledge review, we use the terms chosen by each particular publication, where applicable, to prevent the conflation of different terminologies. Different terms carry varying conceptualisations, and these have implications for understanding the nature of those behaviours. Similarly, in this study we use LGBTQ (lesbian, gay, bisexual, transgender and queer) to both represent the communities that we focus on and to retain consistency with the policy requirements of both RANSW and ACON. However, the focus or conceptualisation of communities within the publications reviewed is varied and, at times, contentious. Again, in each case we use the terminology or acronym adopted by each author/s, where applicable. This prevents confusion, and highlights instances where particular community members are not included in studies.

Scoping review methodology

The research team conducted a scoping review, which aims to assess the state of knowledge across academic and clinical fields by reviewing literature relevant to the key research questions. Colquhoun et al. (2014) define a scoping review as

> a form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence, and gaps in research related to a defined area or field by systematically searching, selecting, and synthesizing existing knowledge. (pp. 1292–1294)

The approach taken in a scoping review is different from a systematic review, which aims to encapsulate and demarcate papers based on quality or rigour, excluding those which do not fit certain criteria, such as sample size or the use of control measures. Where systematic reviews are generally used to test a hypothesis by assessing and analysing the results from selected research, scoping reviews are useful for research projects which are required to comprehensively map evidence across a range of different and incongruous study areas (O'Brien et al., 2016). Our purpose was to understand the field of enquiry related to LGBTQ DFV/IPV and to map the conceptual and theoretical literature.

The literature in this field is relatively new and exploratory. In particular, controlled trials of perpetrator programs or other interventions are rare and, as such, a systematic review would be unproductive. However, a narrative-style review may lack a standardised approach to assessing the quality of information in the literature. A scoping review therefore offered a rigorous process to establish a full understanding of emergent findings, predominant debates and gaps in knowledge, validated by the expert advisory panel for this study.

Arksey and O'Malley (2005) suggest six stages of a scoping review, including identifying the research question; identifying relevant studies; study selection; charting the data; collating, summarising and reporting the results; and consulting with stakeholders to inform or validate study findings.

Following this framework, the research team reviewed materials relevant to the research questions, including peer-reviewed articles and grey literature (unpublished reports that are available in the public domain outside of academic or commercial formats). Materials that were not written in English were excluded from the review.

Search terms and sources

Searching within a 16-year parameter (2003–2018), we used the following terms in various combinations: domestic violence; family violence; intimate partner violence; perpetrator intervention; perpetrator program; perpetrator treatment; LGBT*; lesbian; gay; bisexual; trans; queer; same-sex; transgender.

To access publications, we used the University of New South Wales' library search engine, and targeted databases: Soc Index; PsychINFO; OVID; MEDLINE; Scopus. In addition to formal academic databases, we explored the former Australian Domestic and Family Violence Clearinghouse (which closed in 2014), and Australian Government databases, including the Australian Institute of Family Studies and ANROWS. Finally, we replicated the search using publicly available databases, such as Google and Google Scholar, in order to access grey literature. This yielded a modest literature (less than 2000 papers). During the initial review phase (which ceased on 10 December 2018), we also checked the contents pages and reference lists of key publications to ascertain additional relevant texts that were not identified through the primary search strategies. An update of the literature review during August 2019 yielded additional publications. We excluded all papers from the review that did not relate to DFV/IPV or lesbian, gay, bisexual, transgender, intersex and/or queer communities.

Review findings

While there is a growing body of literature on DFV/IPV in lesbian, gay and bisexual relationships, and emerging research for transgender and queer-identified people, this review found no published research specifically related to intersex communities. The findings therefore relate only to LGBTQ communities. To date, the literature indicates a range of barriers to locating, attracting and engaging potential LGBTQ clients to DFV/IPV programs. The literature also reflects conceptual complexities in how "domestic violence" is perceived by different LGBTQ communities. Tailored LGBTQ programs are scant, and they also tend to focus on cisgender, same-sex attracted clients. In addition, the current evidence base provides little information about the perceptions and experiences of professionals who might work on these programs.

Little is known about the needs of LGBTQ communities that might benefit from DFV/IPV perpetrator programs. Moreover, there are knowledge gaps for certain populations within LGBTQ and intersex communities. In our scoping review we found limited research related to transgender and queer people's use of violence and a significant lack of material focusing on intersex experience. A recent Our Watch (Australian) report on family violence prevention for LGBTI people (Lay, Leonard, Horsley, & Parsons, 2017) draws together what is known in Australia, with the authors also noting limited evidence and a specific gap in knowledge regarding intersex people (pp. 13–14). The two largest studies in North America exploring lesbian women's experiences of DFV/IPV (Renzetti, 1992; Ristock, 2002) are almost 30 and 20 years old, respectively, and focus largely on victims. More recently, the Coral Project that took place in the United Kingdom between 2012–2014 (see Barnes & Donovan, 2016) has produced the largest body of research evidence to date on the use of abusive behaviours in LGBT relationships, and practitioners' perspectives on effective responses to perpetrators. This is perhaps the most comprehensive study relevant to our current research.

The social context of intimate partner violence in LGBTQ relationships

The heterosexual face of domestic violence

There is a consensus across research studies that there is a focus in policy and research on heterosexual men's perpetration of violence, and that this is appropriate because violence against women by their male intimate partner is prevalent (Cox, 2016) and domestic violence (authors' term) is the most common form of violence against women (Phillips & Vandenbroek, 2014). This violence leads to harmful effects such as poor physical and mental health (Australian Institute of Health and Welfare [AIHW], 2018), homelessness (Tually, Faulkner, Cutler, & Slatter, 2008) and statutory child removal (AIHW, 2017).

Much of the public awareness of and focus on violence against women can be attributed to the advocacy of feminists who identified the frequency with which women were leaving their partners due to their experiences of violence and abuse (Bowen, 2018). Feminist theorists have highlighted the ways in which violence against women is systemic and rooted in patriarchal social structures (Michau, Horn, Bank, Dutt, & Zimmerman, 2015). It is, therefore, perceived by some to be a "heterosexist problem" (Russell, 2016). Moreover, during the past 40 years, there have been significant practice and policy developments designed to address these issues, in the United States, the United Kingdom and Australia. The focus, understandably, has been upon preventing violence against women in their relationships with men through primary and tertiary interventions.

Conceptualising DFV/IPV as primarily about men's violence against women has implications for locating, engaging and developing programs for couples, dyads and families who do not fit the cisgender, heterosexual paradigm. Cannon and Buttell (2015, p. 65) demonstrate the limits of this gender paradigm. They critique contemporary perpetrator interventions for their heteronormative bias—that is, the limitations of "normative expectations, constraints and demands of heterosexuality". Further, there is an ongoing debate about the prevalence of domestic violence and intimate partner violence in LGBTQ relationships. For example, Badenes-Ribera, Frias-Navarro, Bonilla-Campos, Pons-Salvador, and Monterde-i-Bort (2015) have demonstrated the significant issues with current data collection, including client outcome indicators, due to failures in capturing the gender or sexuality of clients using domestic violence services. In addition, Rollè et al. (2018) have written about the silence surrounding intimate partner violence in LGB communities, which has prevented open public discussion. They conclude that it is now imperative to create space in which to have these discussions.

Determining victim and perpetrator is particularly challenging when individuals share a gender, as they do in same-sex relationships. It is likely that gendered factors interact to obscure the dynamics of perpetration, and complicate treatment processes and behaviour-change interventions. Such factors should be considered in program tailoring and workforce development (Lay et al., 2017). Lesbian relationships are positioned as utopian since they are assumed not to replicate patriarchy and male power. Both victims/survivors and perpetrators may rationalise the violence as part of mental illness or past trauma or offer other psychological explanations. Female perpetrators are subsequently rendered helpless or blameless, and beyond responsibility or agency, by their victim and service providers responding to the violence. Wendt and Zannettino (2015) also point out that these gendered ideas intersect with pathologising discourses about sexuality and gender diversity, which label same-sex and queer relationships and practices as unnatural and inherently dysfunctional.

A comprehensive Australian study explored intimate partner abuse for lesbian and same-sex attracted women through the qualitative accounts of victims/survivors (Wendt & Zannettino, 2015). This work highlighted the importance of acknowledging the influence of misogyny and patriarchal notions in conceptualisations of DFV/IPV between women. Lesbian and same-sex attracted women are as exposed to dominant discourses about gender as heterosexual women. Wendt and Zannettino argue that when both partners identify as female, expected norms of feminine behaviour tend to obscure the violence (2015, pp. 174–182). Assumptions such as that women are inherently non-violent, violence enacted by a woman is not dangerous, or heightened emotionality is to be expected with women, operate to "hide the dynamics of power and control" (p. 185).

The extent or nature of the problem of DFV/IPV in LGBTQ relationships is still largely unknown, particularly for some members of LGBTQ communities, such as non-binary people (Donovan & Barnes, 2017). Despite this, Donovan et al. (2006, pp. 19–23) have asserted that "domestic abuse" happens in same-sex relationships and current service provision is unable to meet the needs of LGBTQ communities. Some of the problems that have been identified are awareness issues, such as a lack of surveillance data that includes gender and sexuality data points.

While client engagement is understood to be a significant challenge facing services that provide perpetrator interventions to cisgender, heterosexual men (New South Wales, Department of Attorney General and Justice, 2012), there are a range of additional factors which further hinder LGBTQ clients from help-seeking and engaging with perpetrator programs. Indeed, Donovan et al. (2006) have highlighted the conceptual barriers that LGBTQ clients face in applying "domestic violence" to their situation.

Identity-based abuse

Previous research has failed to provide accounts directly from perpetrators, insofar as what is known about perpetrators has been derived through talking to victims/survivors or professionals. Published reports indicate that DFV/IPV perpetrated by lesbian, gay, bisexual and transgender people shares similar patterns of behaviour as DFV/IPV in cisgender, heterosexual relationships, such as isolating, belittling and controlling tactics. These tactics of oppression also involve behaviours specific to LGBTQ communities, including patterns of "homophobic control" within the relationship (Badenes-Ribera et al., 2015, p. 48), or "identity-related abuse" (Riggs, Fraser, Taylor, Signal, & Donovan, 2016, p. 4). These forms of abuse include threatening to reveal the partner's sexual orientation to others (Davis et al., 2015; Gehring & Vaske, 2017; George et al., 2016), and threatening to reveal a partner's HIV status to others (Walters & Lippy, 2016). More implicit uses of identity-based abuse include reinforcing internalised homophobia (Badenes-Ribera et al., 2015), or using a person's feelings of shame and guilt about their sexuality to coerce them (Horsley, Moussa, Fisher, & Rees, 2016).

Identity-based abuse can be operationalised through structural and institutional forms of discrimination to control and coerce a partner. Examples include using a victim's fear that the police are homophobic or transphobic and will not support the victim, to discourage help-seeking (Gehring & Vaske, 2017); undermining the victim by naming their experience "mutual abuse"; or saying that women cannot abuse women (Gehring & Vaske, 2017). Perpetrators may mobilise the relatively small size of marginalised communities to control their partner by using tactics such as threatening to isolate a partner from a limited number of LGBT-friendly spaces or events in the area in the event of the relationship ending (Walters & Lippy, 2016). Ristock (2002) also draws attention to particular risks of DFV within a person's first LGBT relationship where they may not yet have disclosed the relationship or their sexuality and they are vulnerable to greater isolation and fear of discrimination. Other researchers have pointed to a lack of trust that LGBTQ communities have in mainstream services as the main reason sexuality and gender minorities do not seek help (McNair, Andrews, Parkinson, & Dempsey, 2017).

Some research has been undertaken to explore the ways in which DFV/IPV can be perpetrated against transgender people. Studies have found that preventing a transgender person from taking their hormone medication or expressing their gender identity in preferred ways (Horsley et al., 2016; Riggs et al., 2016), or targeting non-conforming gender identities by belittling their appearance, are forms of "identity-related abuse" (Riggs et al., 2016, p. 4) experienced by transgender people. Other examples include "consistently using the wrong pronoun when referring to them, and fetishising or ignoring bodily boundaries" (Tesch & Bekerian, 2015, p. 392 as cited in Riggs et al., 2016). The context of structural discrimination and different forms of identity-based abuse suggest that DFV/IPV cannot be addressed with what Lorenzetti, Wells, Logie, and Callaghan (2017) have called "heteronormative interventionist approaches", or in a service system which lacks tailored and inclusive programs.

There is a tendency for studies to focus on lesbian and gay rather than bisexual, transgender, intersex, non-binary and queer identities. Despite this, there are community resources produced by LGBTQ anti-violence organisations

worth considering. For example, an American service which specialises in preventing violence against transgender people produced a guide entitled "Trans-specific power and control tactics" (FORGE, 2013). This resource covers all of the patterns described in the literature, and some additional behaviours. The guide outlines "tactics used by trans partners" that include, but are not limited to:

- claiming they are just being "butch" or that "it's the hormones" (to explain their violent behaviour)
- demanding a greater share of clothing/grooming funds because their safety is at stake
- stating that trans people are superior because they do not limit themselves to a restrictive binary and sex role stereotypes
- charging their partner with "not being supportive" if they ask to discuss questions of transitioning timing and/or expense (FORGE, 2013).

Recent research (Scheer, Woulfe, & Goodman, 2019; Woulfe & Goodman, 2018) supports the findings of more anecdotal investigations and grey literature by reporting on the nature and prevalence of identity-based abuse for LGBTQ people. For example, queer- and bisexual-identified respondents reported levels of identity-based abuse three times higher than their lesbian and gay counterparts. Identity-based types of abuse are often central to the way dynamics of power and control manifest themselves in LGBTQ relationships. Indeed, a recent study (Roch, Morton, & Ritchie, 2010, as cited in Yerke & DeFeo, 2016) suggests that transphobic emotional abuse which targets transgender-specific vulnerabilities was by far the most common abuse reported (73% of participants).

Institutional and structural abuse

As well as recognising specific types of abuse that affect LGBTQ people, the literature highlights certain structural challenges. These include (but are not limited to):

- a lack of awareness about LGBTQ perpetrators and victims/survivors among LGBTQ people who experience violence, as well as people who provide support—including trained DFV/IPV workers (Calton et al., 2016)
- a lack of effective communication from services through which to attract sexuality and gender diverse clients to perpetrator programs, given that domestic violence is seen as a heterosexual problem
- a lack of trust in institutions or services among LGBTQ communities (Noto, Leonard, & Mitchell, 2014)
- most services target male perpetrators and female victims (Cannon & Buttell, 2015), which automatically excludes female perpetrators and male victims of DFV/IPV.

Some research has been conducted to understand the ways in which experiences of social marginalisation intersect with relationship dynamics to increase the risk of being a perpetrator or victim of DFV. Longobardi and Badenes-Ribera (2017) undertook a systematic review on this topic, albeit one focused on sexual minorities and not gender diversities. Their findings indicate that risk factors associated with being in a sexual minority should be considered during program development for DFV/IPV interventions. This is consistent with other empirical research which has found that minority stressor variables, including internalised homophobia and discrimination, are positively associated with both increased perpetration and victimisation, mediated by relationship quality (Balsam & Szymanski, 2005; Carvalho, Lewis, Derlega, Winstead, & Viggiano, 2011; Gehring & Vaske, 2017). Furthermore, research studies have repeatedly highlighted the risks and factors related to experiences of stigma, discrimination and minority stressors (Rollè et al., 2018), such as social isolation, ostracism from family, and the lack of appropriate services (Lorenzetti et al., 2017). Common tactics in domestic violence such as isolating the victim may be compounded by the relative isolation of sexuality and gender minorities (Walters & Lippy, 2016).

Authors have drawn attention to environments of generalised social hostility experienced in the daily lives of LGBTQ people. These might include homophobic attacks in public, the negative effects of national issues such as the marriage equality debate during the 2017 Australian Marriage Law Postal Survey (Verrelli, White, Harvey, & Pulciani, 2019), or the controversy surrounding the Safe Schools anti-bullying initiative in Australia.[2] Such experiences have heightened marginalisation and compounded isolation for LGBTQ people

2 See more in Benjamin Law's *Quarterly Essay* article, "Moral Panic 101", from September 2017. https://ebookcentral-proquest-com.ezproxy.une.edu.au/lib/une/reader.action?docID=4832656&ppg=5

in Australia (Horsley et al., 2016). The effects of minority stressors need to be taken into account for both DFV/IPV program tailoring and program engagement as marginalisation and stigma can negatively impact help-seeking, increasing the risks that LGBTQ people face (Messinger, 2017). Such findings suggest that while there may be a lack of information obtained directly from perpetrators to guide program development, there is an emerging body of evidence which provides important insights that can be integrated into interventions and explored through the therapeutic process.

Research has also highlighted how professional perceptions affect the way perpetrators and victims/survivors are treated, depending on their gender and sexuality. For example, Russell's (2016) work has shown that heterosexual male perpetrators were viewed by police as a greater threat than their gay male or lesbian female counterparts, with victims/survivors of male perpetrators viewed as more credible. Their perceptions play a role in the referral and engagement pathways of potential clients to LGBTQ perpetrator interventions.

Lessons for practice

Need for culturally relevant strategies

Cannon and Buttell (2016, p. 970) identified studies in which researchers recommended that DFV/IPV interventions should develop specific, "culturally relevant curricula" for different categories of perpetrators. Rather than applying a "one-size-fits-all" approach (p. 969) that identifies patriarchy and male power as the cause of DFV, such curricula should be designed to respond to diverse experiences and uses of power evolving from different social locations (such as race, gender or class). This post-structural feminist and intersectional view is a departure from the well-known Duluth model (Domestic Abuse Intervention Programs, 2019) that emerged in the US in the early 1980s as a multi-agency, coordinated approach to preventing domestic violence. Understanding men's violence as emanating from patriarchal socialisation, the Duluth model aimed to address men's behaviours through their attitudes to women (Pence & Paymar, 1993). Although widely used, the model has been criticised as it cannot be applied to violent relationships between gay men or lesbian women (Cook, 2009).

Alternatively, it has been suggested program designers could develop programs for LGBTQ communities that are robust enough to tackle all sexual orientations and gender identities (Langenderfer-Magruder, Whitfield, Walls, Kattari, & Ramos, 2016). Regardless of which theoretical approach is adopted, interventions and any associated tools should use inclusive language, research approaches, and practice (Langenderfer-Magruder et al., 2016). The particular forms of abuse experienced by sexual minorities (Goldberg-Looney, Perrin, Snipes, & Calton, 2016; Lorenzetti et al., 2017), transgender people (Riggs et al., 2016) and other gender identities should also be acknowledged. For example, Walters and Lippy (2016, p. 709) suggest that clients would benefit from interventions specifically addressing the increased risks associated with one's first same-sex relationship, including questioning a partner's "true sexuality" and expecting them to prove their sexual orientation.

One recent study by Riggs et al. (2016) offered guidance on how to tailor programs for transwomen. In it, the authors offer a series of simple questions to help services assess their level of inclusivity, including:

- What is on offer for transgender women affected by domestic violence?
- How are these offerings designed, developed, described, evaluated and advertised?
- Have transgender women been consulted with regard to their service needs?
- What are the gaps and shortcomings?
- Do agency brochures and other documentation make it clear that transgender women are welcome into programs and will be treated in a non-discriminatory manner?
- Will the work of the service be reported in the press, from local transgender-inclusive magazines to national and international representations? (p. 15)

While this information is for service providers wanting to ensure that their services are transgender-inclusive, it could be used as a model for starting a conversation about the meaningful inclusion of LGBTQ people in general.

In addition to studies that have been conducted using political and philosophical frameworks, researchers adopting a psychological approach have explored predictors and risk markers in order to make recommendations about optimal interventions. For example, a recent meta-analysis reported that predictors of perpetration of DFV/IPV included internalised homophobia for men and fusion (or enmeshment) for women (Kimmes et al., 2017). The findings also indicated that DFV/IPV victimisation is a risk marker for DFV/IPV perpetration, and alcohol dependence was a stronger risk marker for men in same-sex relationships than for women in same-sex relationships (Houston & McKirnan, 2007; Kimmes et al., 2017). Craft, Serovich, McKenry, and Lim (2008) assert the importance of understanding the particular dynamics of same-sex partner violence for developing or adapting prevention interventions. In their study of men and women who had used violence in a same-sex intimate partnership they found that perceived stress emanating from family, financial, work and relationship factors, as well as insecure attachment, were positively associated with the perpetration of violence. Together, these research findings provide ideas about how program developers could refine their interventions. This information is also useful for workforce development and could be integrated into strategies to help staff avoid incorrect assumptions based on hetero-centric ideals, sensitising professionals to identity-based tactics of oppression.

Based on the findings of this review, client interventions and workforce development activities would be advised to complement existing programs with material that addresses identity-based abuse. One example of materials that could be used is the "gay, lesbian, bisexual, and trans power and control wheel" (see Roe & Jagodinsky, n.d.) which includes tactics of oppression relevant to LGBT people adapted from the Duluth power and control wheel. The eight Duluth tactics of control are illustrated by examples of identity-based abuse relevant to LGBT relationships. "Using privilege" replaces "using male privilege", and all eight tactics are presented within the broader context of heterosexism, homophobia, biphobia and transphobia. In learning about identity-based forms of DFV/IPV, program designers who already use the Duluth wheel are then equipped to tailor their existing programs to the needs of LGBT clients. By a similar token, narrative perpetrator interventions (Jenkins, 2009) may draw on information about identity-based abuse as part of tailored approaches to inviting ethical reflection on the use of power in personal relationships.

Implementing tailored programs

The Coral Project has produced a large body of research evidence on abusive behaviours in lesbian, gay, bisexual and/or transgender relationships, which included practitioner perspectives on effective responses (Barnes & Donovan, 2016; Donovan et al., 2006; Donovan et al., 2014). The project found that while professionals had little experience working with LGBT perpetrators, they could describe innovations and information that were useful in guiding other perpetrator interventions, for example in terms of program content and viability. In discussing program development, the professionals spoke about what aspects of existing perpetrator programs were transferrable, and tended to view cognitive behavioural elements and communication skills training as valuable across sexuality and gender identities.

There was disagreement among professional participants as to the extent that a feminist, gendered analysis was considered relevant to LGBT perpetrators. For example, Barnes and Donovan (2016) report that "some participants viewed behaving abusively and seeking power and control to be generic human issues irrespective of gender and sexuality" (p. 327). Therefore, these professionals concluded that with some minor adjustment of materials to include lesbian and gay themes, existing interventions were applicable. However, other professionals in the study disagreed, saying that gender operates differently in LGBT relationships. Further professionals described tensions between advocating a feminist, gendered approach and the difficulty of operationalising these principles without referencing heterosexual masculinity and femininity. Professionals who adopted a middle view perceived existing interventions as valuable and applicable, but would need additional content to respond to LGBT minority experiences.

In terms of benchmarking tailored programs, Barnes and Donovan (2016) highlight that current minimum standards for interventions are grounded in empirical evidence relating

to heterosexual men, with a lack of corresponding evidence for lesbian, gay, bisexual and transgender-specific group programs. While the lack of expertise among practitioners in working with these communities was not thought to be insurmountable, the practitioners in Barnes and Donovan's (2016) study expressed concerns that they would offend clients or use the wrong language. Given the need for programs which are inclusive of all genders and sexual orientations, most practitioners agreed that an experimental approach was required. Some had started working with specialist agencies to increase referrals and get advice about resources and appropriate language. In these working relationships, they found the knowledge transfer to be reciprocal, noting that agencies working with lesbian, gay, bisexual and transgender clients were not equipped with adequate knowledge about DFV/IPV to work safely with either victims/survivors or perpetrators (Barnes & Donovan, 2016). Similarly, other researchers have recommended increasing the number of LGBTQ people employed within DFV/IPV organisations, saying that these staff members should be involved in the design and implementation of programs for their own community client groups (Cannon & Buttell, 2016; Riggs et al., 2016). However, there remains a lack of evidence that can be used to guide modifications to perpetrator programs established for the heterosexual population, such as modified screening to assess for differing risk factors.

Barnes and Donovan (2016) noted that their qualitative interviews with practitioners inspired lengthy discussions about the practicalities of implementing tailored programs. A major conundrum was whether gay and bisexual men (cis and trans) could be integrated into existing heterosexual men's behaviour change programs. Concerns were raised about the safety of these men and their potential reluctance to make disclosures in a group with heterosexual men, which might inhibit any benefits from group processes. Three practitioners provided examples of situations where clients who were gay and/or transgender men had joined a group. In most instances, the other heterosexual clients had not been made aware of the client's identity or orientation. Such cases required the group to be supplemented with individual, concurrent work with the client to explore issues specific to sexuality and gender identity that could not be disclosed to the group. This scenario is only open to men who can or will "pass" as a heterosexual, cisgender male (Barnes & Donovan, 2016). Given the complete lack of programs for women, regardless of sexual orientation or gender identity, this option is unavailable for those wishing to change their abusive behaviours.

Barnes and Donovan (2016) also provide information about the perceived practicalities of implementing separate cohort programs. Key debates among practitioners centred on whether service provision should be separated by sexuality or gender and whether the gender or sexuality of the facilitators would be relevant. These considerations were inseparable from questions about whether to direct resources to develop and provide tailored LGBT programs for what may be only a small number of clients, while demand for heterosexual men's groups was a pressing issue. Perspectives on whether the gender and sexuality of facilitators was important were influenced by the individual style or approach of the group worker. For example, some practitioners thought professional expertise was the most important factor and self-disclosure about their sexuality would not be usual practice. Others argued that having LGBT facilitators would build trust and rapport with clients within a sexuality and/or gender minority and therefore disclosure would be relevant.

In this scoping review, we have highlighted the significant challenges in locating and engaging LGBTQ clients, and in designing and implementing tailored interventions for perpetrators from LGBTQ communities. While the focus on domestic violence perpetrated against women in heterosexual dyads is understandable, the gendered conceptualisation of DFV/IPV that characterises most interventions is inappropriate for LGBTQ people. The expectation that clients from sexual and/or gender minorities can attend mainstream programs is largely rejected. The research highlights the importance of services overtly positioning themselves as inclusive in order to address critical perceptions, including a lack of trust that LGBTQ minorities may have in mainstream agencies. Finally, the review identified a range of workforce development needs required to enable staff to adapt their expertise for the benefit of LGBTQ clients who attend tailored programs, particularly in terms of awareness and attitudes of professionals working on such programs.

Methodology

Theoretical framework

This research is underpinned by a feminist, post-structural theoretical framework (Wendt & Zannettino, 2015). A traditional feminist perspective understands DFV/IPV as an abuse of power within relationships, supported by a social context where power is distributed unequally to men through patriarchal social structures, operating to control women and preserve men's dominant position (Dobash & Dobash, 1979). The evidence that women are overwhelmingly the victims/survivors of male violence in intimate relationships necessitates a focus on this gendered analysis. In the feminist tradition, Crenshaw's theory of intersectionality (1989) has advanced this thinking to make visible the collective experiences of other groups in society that are oppressed through hierarchies of structural disadvantage, due to factors such as disability, race and sexuality. Through this theoretical lens, we can consider the effects of minority stress and use of discrimination/stigma as a tool of abuse in LGBTQ relationships.

In short, feminism and intersectionality help us understand how structural power can be used in the private sphere of domestic relationships. However, a fixed view of gender relations is not enough to explain DFV/IPV in same-sex and gender diverse relationships. Post-structural feminist researchers such as Wendt and Zannettino take the position that identity is socially constructed and therefore the way gender is performed and understood is negotiable through "discourses" of femininity and masculinity (2015, p. 7). In other words, while social structures and cultural norms afford greater power to cisgender men, the polarised and totalising position that all men and all women have the same experience of this power differential is unhelpful. Drawing on Bradley (2013), they write:

> Post-structuralism enables us to examine how individual women and men are actively involved in "doing gender"; that is creating and recreating our identities as gendered and sexual beings. But at the same time feminism, born from modernity, reminds us to keep examining how gender is constrained by the structures and cultures that are our contexts. (Wendt & Zannettino, 2015, p. 9)

We believe this feminist post-structural framework provides us with an understanding of the operations of power in intimate relationships, and conceptual tools to unpack the uniquely lived and situated experiences of DFV/IPV for LGBTQ people.

Methods

Our study followed a mixed methods design in order to answer the original research questions related to the effectiveness of a tailored intervention and understanding of client experience. The design included quantitative analysis of standardised measures of client change, and qualitative analysis of in-depth semi-structured interviews and focus groups conducted with a range of stakeholders. This was designed to enable the study to determine whether positive outcomes were achieved through the group programs delivered by ACON/RANSW, as well as broaden our understanding of the experience of DFV/IPV for LGBTQ communities and the barriers to and enablers for LGBTQ people attending programs. Mixed methods research has been conducted previously to evaluate the effectiveness of the mainstream perpetrator program and victim/survivor group previously delivered by RANSW, from which the tailored programs were developed (Broady & Gray, 2017; Broady, Gray, & Gaffney, 2014; Broady, Gray, Gaffney, & Lewis, 2013; Gray, Broady, & Hamer, 2019). Using a similar research design would enable comparison of data and testing of a range of additional outcomes scales for future application.

We were able to administer pre- and post-group surveys to the clients of the victim/survivor program and conduct in-depth interviews with both the clients and clinicians to gather their perceptions of what worked well, and how we might improve this program. The perpetrator program did not go ahead.

Because tailored LGBTQ programs were harder to populate than anticipated, we undertook additional qualitative interviews and focus groups with community members and professional stakeholders to gather more information on how

to engage LGBTQ clients and what kind of workforce and sector development might support effective referral pathways. The design of our study, therefore, shifted from a program evaluation to an exploratory study, informed by a "nested" research approach (Halcomb & Hickman, 2015; Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005). That is, the majority of client and stakeholder data was qualitative, and the quantitative survey methods applied only to the victim/survivor group client cohort.

As the number of clients in the victim/survivor tailored program was ultimately too small to produce an appropriate sample, we do not report findings from the quantitative data. However, information about the surveys and selection of scales is outlined within this Methodology section to explain our choice of outcomes indicators, as a guide for future program developers. The quantitative data are provided in Appendix C as information only, to demonstrate our analytic approach. We do not draw any conclusions from the survey responses themselves.

Program tailoring

As identified in the State of knowledge review, while men's behaviour change programs do not explicitly exclude gay, bisexual, transgender and queer men, they can be inappropriate due to being based on heteronormative assumptions (Cannon & Buttell, 2015). It is within this context that ACON and RANSW collaborated to tailor two existing "mainstream" DFV/IPV programs that are regularly delivered by RANSW as part of its Family Safety Model (see Shaw, Bouris, & Pye, 1996):

- Taking Responsibility—an 18-week men's behaviour change program
- Women: Choice and Change—a corresponding 8-week program for victims/survivors of DFV/IPV.

The tailored group program for perpetrators could not be implemented in the timeframe of the project, so it is yet to be tested and further adapted in response to any findings. The victim/survivor group, Surviving Abuse, has been delivered, but requires replication.

In this section, we describe the program development process undertaken in the first phase of this project. This includes an outline of the original RANSW perpetrator and victim/survivor programs, and an overview of the changes undertaken during the tailoring process. Details of adaptations to each session are provided in Appendix A.

We include our tailoring strategies for the perpetrator program, even though it was not trialled. We share what we learnt through the process in order to help guide future developments. There are very few DFV/IPV programs specifically for people who are part of LGBTQ communities, so we advise that program developers include an evaluation component as part of their delivery, in order to track client outcomes.

Program models

The mainstream Taking Responsibility perpetrator program and Women: Choice and Change victim/survivor program are based on three theoretical models. The application of these models to DFV work with men is outlined in the Australian Government publication, *Introduction to working with men and family relationships guide* (King et al., 2009). In short, the mainstream perpetrator and victim/survivor programs operate from the position that all people have (subconscious) learned beliefs and behaviours that sit within a sociocultural context, where certain privileges are structurally reinforced. To address the sometimes harmful effects of these on self and others requires not only bringing both the learned behaviours and social constructs to consciousness, but also learning new thoughts and behaviours, including, for example, self-regulation, self-care and empathy for others. In this way, the three models—social learning theory, cognitive behaviour therapy, and a feminist sociocultural approach—are combined and outlined below.

Social learning model

Social learning theory proposes that social behaviours are learnt in early childhood and learned behaviours are maintained by various reinforcing events and social beliefs (Bandura, 1977). A key part of the Taking Responsibility

program is empathy development, where clients experience the thoughts and feelings that their partner may have had in various situations. Building empathy and focusing on the experience of another person supports changed beliefs and actions for clients in the perpetrator program. In the victim/survivor group, social learning theory is used to "unpack" and challenge negative self-talk learned from childhood or as a consequence of a long-standing abusive relationship.

Cognitive behaviour therapy model

Cognitive behaviour therapy interventions are designed to change dysfunctional learned behaviour by addressing unhelpful thinking and emotions, as a foundation for building new skills (Hofmann, 2011). This helps users of violence learn to identify their triggers, beliefs and the consequences of their actions. It supports victims/survivors to manage negative effects of violence, such as anxiety and depression, and increase self-care within the context of safety planning.

Feminist sociocultural model

The feminist sociocultural approach argues that DFV/IPV is a result of patriarchal structures and beliefs (Dobash & Dobash, 1979). As King et al. (2009, p. 102) explain,

> gender role socialisation results in rigid sex roles based on male privilege and entitlement that lead to unreasonable and unfair expectations of women and a lack of empathy and consideration for women's needs, feelings, beliefs and values.

For the perpetrator and victim/survivor programs, this understanding is explored through an examination of gender role stereotypes and attitudes that are either driving violent behaviours or undermining safety and self-care of victims/survivors.

Program modifications

To make RANSW's perpetrator and victim/survivor programs applicable to people from LGBTQ communities, ACON's DFV coordinator and group work practice specialists collaborated with RANSW through a combination of workshops, working meetings and desk reviews. Particular attention was paid to the removal of language and exercises that presume the gender of a perpetrator or victim/survivor, or make assumptions about sexuality and sexual practices. Both programs were informed by the underlying principle that DFV/IPV involves an abuse of power through a pattern of controlling behaviours that can include intimidation, coercion, emotional abuse, financial abuse, sexual abuse, physical abuse, isolation and psychological manipulation. The fundamental principle of addressing accountability for violence and abuse of power in relationships remained central to the tailored programs.

The tailoring process involved adding content to the programs that reflected the lived experiences of LGBTQ people and invited participants to discuss what it means to identify as LGBTQ. This includes how LGBTQ experiences and self-perceptions may intersect with DFV/IPV and hinder or enable change. In tailoring both the perpetrator and victim/survivor programs, we aimed to provide clients with an opportunity to consider how they may draw upon the skills and knowledge they have gained from their own experiences of discrimination and/or victimisation. These experiences were framed as a resource to support desired changes to negative and potentially destructive behaviours in current and future relationships. Each program therefore includes content related to discrimination and social stigma commonly experienced by LGBTQ people and the impact of this on individual wellbeing (see LeBlanc, Frost, & Wight, 2015; Perales & Todd, 2017). By acknowledging and working with the impacts of discrimination, we do not mean to suggest that controlling and coercive behaviours are excusable or caused by these experiences. Many LGBTQ people engage in relationships which are not abusive despite their experiences of trauma, homophobia, biphobia and transphobia, a point which is reinforced in both programs. However, we hope that greater awareness of the way that such experiences can impact an individual's thoughts and behaviours will help clients to identify problematic patterns in their responses to others and gain skills to manage their own strong emotions, and thereby engage in safer and more respectful relationships. This includes enhancing accountability within relationships for people who perpetrate abuse.

In summary, the modifications made to the existing programs for both perpetrators and victims/survivors aim to change the use of language and exercises that make assumptions about the gender, gender identity and sexuality of participants—in particular, the assumption that perpetrator participants are heterosexual, cisgender males and victims/survivors are heterosexual, cisgender females. In both programs we propose that in the first instance, participants should be invited to discuss what it means to identify as LGBTQ and how this can intersect with experiences of DFV/IPV to hinder or enable change. Further, clients should be provided with an opportunity to discuss their experiences of discrimination and victimisation as part of debriefing these experiences but also to draw upon the strengths they have used to survive such experiences. We aim to provide clients with an opportunity to explore the impact of minority stress while perpetrators maintain accountability for their behaviours, which is a fundamental understanding central to both of the original programs.

The program goals are facilitated through the use of group discussion, drawing heavily on narrative approaches as described by Jenkins (2009). Narrative approaches are particularly well suited to working with perpetrators while maintaining client engagement and factoring in the consequences of trauma experiences (Jenkins, 1990, 2009). Both of the tailored programs retain a strong focus on raising awareness of tactics of power and abuse in relationships. The programs also involve opportunities for clients to explore how dynamics of power and abuse play out in their relationships, including how such dynamics interact with social norms about gender. The use of psychoeducation and narrative group processes in the tailored programs mirrors the mainstream program approaches that aim to raise awareness of DFV/IPV issues, increase participants' insight into themselves and the impact of DFV/IPV on others, and develop skills for safe, equitable and respectful relationships.

A detailed description of modifications to the content of each session is provided in Appendix A.

Recruitment procedure

We used a process of convenience sampling (Bryman, 2015) followed by snowball sampling (Patton, 2002) to recruit participants to the study, through a range of access points. The following research participant groups were successfully recruited: clients of the tailored victim/survivor program (called Surviving Abuse); clinicians and program developers involved in the LGBTQ DFV/IPV programs; LGBTQ community members, including people referred to the tailored perpetrator program; professional stakeholders; and conference delegates.

Clients of the Surviving Abuse tailored program

Clients of the victim/survivor group program were recruited through referrals from counsellors and psychologists, as well as self-referral as a result of information gained via friends, staff at ACON or the social media campaign. RANSW staff were asked to disseminate information about the study to potential participants who phoned the RANSW intake/information line specially implemented for this project. Clinical intake officers based at RANSW also sought clients' permission to forward their contact details to the researchers. The researchers then contacted clients prior to the group commencing to invite them to the study. Clients who agreed to take part in the research were provided with information sheets and consent forms for the pre- and post-survey.

Surveys were administered at the opening of the first and penultimate sessions of the programs by a member of the research team. Responses were handled confidentially, and the data stored separately from the clients' clinical files. The survey also included a written invitation to take part in the qualitative interview aspect of the study. Survey participants were informed that participation in the survey did not oblige them to undertake an interview, and participating in an interview did not compel them to complete a survey. This process was based on the procedures in place for program evaluations at RANSW, and was designed to alleviate any concerns relating to confidentiality, as well as personal and family safety. Moreover, we presumed that different clients might prefer different modes of participation and that some

would prefer a survey over an interview, or vice versa. The clients were also offered an opportunity to arrange their participation via a practitioner rather than directly through the research team, should they feel more comfortable doing so. However, this option was not used.

ACON and RANSW clinicians and program designers

To recruit clinicians and program designers to the study, a group email was disseminated via RANSW administration staff. This invitation allowed the participants to respond directly to their preferred interviewer to prevent conflict of interest. Participant information and consent discussions were undertaken before the interview, to ensure that clinicians and program designers had informed understanding of the research processes to increase their comfort in providing data in a professional setting and to clarify de-identification procedures and the dissemination of findings.

LGBTQ community members including potential clients referred to the tailored perpetrator program

LGBTQ community members who had expressed an interest in the topic of DFV to ACON staff, or who had contacted ACON to discuss the advertised programs, were invited by ACON staff to participate in the research. Professionals at ACON sought the individuals' permission to forward their contact details to the research team. Following the ethics protocol, information sheets and consent forms were provided to those interested in taking part. Given that some of the community members knew one of the research officers, they were also given an opportunity to choose an interviewer not known to them. Detailed discussions were held to establish informed consent and preferred interview mechanisms. Many of the community members we spoke to preferred telephone interviews over face-to-face interviews, for convenience.

Four potential clients for the perpetrator program were placed on a waitlist for the group, which was due to go ahead in March 2018, but did not proceed due to insufficient numbers (the minimum number of participants required was six). These four were invited to take part in the study by the clinical intake officers at RANSW. The potential clients of the perpetrator program had been initially directed to RANSW by police or magistrates, having received apprehended violence orders, and did not self-direct or see the social media promotional materials. This was the first time RANSW held a waitlist for LGBTQ clients awaiting a tailored perpetrator program. Three of these potential clients agreed to take part in the research and have been included in the community sample.

A safety protocol was undertaken during the initial stages of the interviews with community members to ensure the participant was not currently at risk and was protected from a potential perpetrator. While the community members were not identified clients of services, it was possible for some that their interest in the research was due to a lived experience of DFV, and this protocol was a precautionary measure. This was a brief and strategic process which clarified the interviewees' location and the privacy of the conversation.

Following interviews, one community member withdrew consent for their data to be included in the analysis.

Professional stakeholders

During the program promotion phase of the study, the research team made contact with a wide range of professionals who might refer clients to the tailored programs, including legal workers, counsellors and other professionals. During the last phase of data collection, these professionals were invited to take part in the study as external stakeholders. A summary of the interview schedule was provided to the professional stakeholders along with copies of the information statement and consent forms. In addition to this convenience sample, snowball sampling was undertaken whereby the researcher asked the participant if they knew of other professionals who might like to take part in the study. A series of individual face-to-face and telephone interviews were conducted throughout April–May 2018. Finally, after a presentation was given at the LGBTIQ Women's Health Conference in Melbourne (July 2018), a delegate approached the researchers and requested to provide an interview at a later date. This delegate, an identified community member, was interviewed by phone in late July 2018.

Pride of Place conference delegates

During the final phase of the project, the research team attended the Pride of Place conference at the University of Sydney (June 2018), and convened a symposium. At this event, we invited delegates to take part in discussions at five tables, and these discussions were recorded with permission. The audio files constituted the focus group aspect of this study. Information and consent procedures were undertaken, during which it was made clear there was an option for delegates to opt out of data collection, by situating themselves at the three tables which did not have audio recorders. Through this mechanism, delegates could take part in the symposium without feeling coerced to participate in data collection.

Consultation and promotion

To support service providers wishing to facilitate tailored DFV/IPV programs for LGBTQ communities, we describe the promotional activities we employed, the challenges we faced, and the consultation activities we undertook to enhance referral pathways.

The first phase of the study, throughout 2017, adopted a two-pronged approach to promotion and client engagement:

1. internal referral pathways within RANSW and ACON
2. a public-facing, social media campaign.

The messages in the promotional materials for both internal and external audiences were developed in stages, with the aim of refining the language and incorporating feedback in real time. Consultation was undertaken with staff based at Thorne Harbour Health (formerly the Victorian AIDS Council) who advised on the use of non-shaming language to engage perpetrators, particularly those who may not see themselves as such. Hence, we used the terms "experiencing violence" or "hurting the ones you love". Indeed, use of the term "perpetrator" was limited to internal communications and report content, whereas promotional and clinical texts avoided this term due to its perceived lack of suitability. It was thought to trigger potential shame that individuals who use violence might feel, or lead to the negative labelling of potential clients, thereby hindering client engagement in the program. For the victim/survivor group, the language in promotional materials focused on surviving abuse, understanding violent behaviour and learning about respectful relationships, within a safe and inclusive space. For both programs we emphasised that the content was tailored to the unique needs of LGBTQ communities.

The Commonwealth Government's decision to hold a national postal survey on same-sex marriage equality during 2017 invited additional and unwelcome attention to the lives of LGBTQ-identified people (Kolstee & Hopwood, 2016). By August 2017, the debate had intensified, and negative portrayals of same-sex and queer relationships were becoming prevalent across social and mainstream media, potentially exacerbating existing experiences of minority stress (LeBlanc et al., 2015) for people of diverse sexual orientations and gender identities. A more strategic approach to engaging clients was then adopted, focused on raising awareness with professionals within and external to RANSW and ACON who would act as referral pathways. This reduced our reliance on public-facing activities to engage clients, given the uniquely threatening nature of this political context, which it was presumed would discourage individuals from seeking support for challenges within a same-sex relationship.

Over the course of 8 months, the research team conducted a series of in-service presentations and clinical briefings (listed in Appendix B) with the aims of increasing knowledge and awareness about DFV/IPV in LGBTQ communities and educating the community services and DFV-related sectors to enable robust referrals. Appendix B outlines the actions undertaken by the research team with support from the ACON DFV coordinator who developed the promotional material.

In the next section, we describe the participants we were able to recruit for this study, many of whom we engaged during our promotional activities.

Data collection

Data were collected from five different sources:

- clients of the tailored victim/survivor program, Surviving Abuse
- clinicians and program designers from ACON and RANSW
- LGBTQ community members (including people referred to the tailored perpetrator program)
- professional stakeholders
- delegates from the Pride of Place conference.

Three methods of data collection were used: in-depth interviews, focus groups, and written surveys using standardised measures.

Interviews

All interviews were voluntary, confidential and conducted by a member of the research team. We chose a semi-structured, in-depth methodology (Bryman, 2015) to enable the interviewer to explore emerging concepts and issues named by the participant. The interviews were guided by an interview schedule (see Appendices F and G), audio-recorded, transcribed verbatim and de-identified, and participants were assigned pseudonyms.[3]

The interviews aimed to gather information about the perceptions and experiences of participants in relation to DFV/IPV within LGBTQ communities. Clients described their experiences of the group program, and were provided an opportunity to tell their stories, share their experiences of DFV/IPV, and make recommendations for future program development. Clinicians and program designers were invited to share their experiences of the program, how they perceived and experienced working with LGBTQ clients, how they understood DFV/IPV for LGBTQ communities, and their recommendations for further program development.

Individuals in the community member cohort were also invited to share their experiences of DFV/IPV, living as an LGBTQ person, examples of help-seeking and clinical encounters, periods where they had not sought help, and what worked for them in their positive clinical encounters. In addition, we invited participants to communicate their preferences for future programs, and their preferred referral pathways. Likewise, externally based (non-ACON and non-RANSW) professional stakeholders were invited to share their experiences of working with DFV/IPV, their understanding and awareness of LGBTQ communities, how these factors intersect, and their recommendations for locating, engaging and intervening with clients who might benefit from a tailored program.

Focus groups

The focus groups conducted with Pride of Place conference delegates invited participants to discuss their responses to three open questions:

1. How do you understand the term "domestic violence"?
2. What are the implications of the current service system for LGBTQ communities?
3. In an ideal world, how should we run programs for LGBTQ communities?

These data were handled like the qualitative interview material; that is, the discussions were audio-recorded with permission, transcribed verbatim, and stored by the research team at RANSW.

Surveys

Although we do not include results of the victim/survivor group client surveys here due to the small sample, we offer the following information on the process of data collection and choice of validated scales. This is intended to support future consideration of the use of validated measures in LGBTQ DFV/IPV group programs. Our reflections on the survey responses for the small sample are provided in Appendix C.

The pre- and post-intervention surveys (see Appendices D and E) consisted of scales used in evaluations for the

3 In these findings, the clients are identified only by their age; the professionals by their area of work; and the community members by their sexuality, gender and age—except in circumstances where further anonymisation might be required. Pseudonyms have not been given to all group workers.

Family Safety programs facilitated at RANSW for cisgender heterosexual clients, based on program logic models. We also included additional validated scales that reflect our findings from the State of knowledge review. Key issues specific to LGBTQ experiences of DFV/IPV highlighted in the literature review guided our search for and choice of these validated scales. For example, measures were chosen that responded to our hypothesis that minority stress would be a factor for these participants, as indicated in the literature. The pre-surveys were also designed to gather detailed data about age, cultural factors, gender, sexuality, relationship status, and relationship style, such as monogamous or polyamorous constellations. With this information (using a combination of ACON-recommended sexuality and gender indicators, and free choice questions), the research would be able to make diverse experiences visible in the findings. Post-surveys did not include these demographic data but included two additional sections to collect data on client satisfaction with the program and information on the working alliance with the group facilitators. These latter measures were standard evaluation measures for RANSW groups (described below).

In order to enable respondent matching along five time points (pre-intervention, immediately post-intervention and at 3-month, 6-month, and 12-month follow-ups), we used a unique identifier that would enhance the privacy of the respondent and be easily remembered. The pre-survey was used at time 1 and the same post-survey was used at times 2 and 3.

To disseminate the group program surveys, a researcher attended the first group session. A large plain envelope was provided to a client-volunteer, who collected the surveys while the professionals were out of the room. Upon completion of the survey, the client-volunteer invited the professionals to re-enter and sealed the surveys in the envelope. As such, a client who did not wish to take part in the survey could confidentially return a blank survey. This process was repeated at the penultimate session of the group program, along with an invitation to all clients to take part in a qualitative interview which was then arranged directly with the researchers via email and telephone.

Validated scales

This research originally intended to assess the outcomes of perpetrator and victim/survivor group participants via surveys using a suite of validated scales. Due to small sample sizes, the results of the surveys cannot be generalised and are therefore presented in Appendix C for information only. However, we detail the validated scales in Table 1 below, as these may be useful for future consideration of standardised measures in effectiveness studies.

Other measurement tools

At the follow-up time points, all scales were repeated to measure change. We also included a standard client satisfaction survey and the Working Alliance Inventory (Hatcher & Gillaspy, 2006) to gather information about clients' satisfaction levels and the extent to which they had formed a working alliance with their group facilitators.

The client satisfaction survey

This satisfaction measure is not a validated scale but is based on standard customer service questions used at RANSW, adapted for use with the group program:

- Overall, how useful did you find the service?
- How likely is it that you would recommend the service to a friend?
- How satisfied or not satisfied were you with the program?

These questions were measured using a Likert scale from 1 (not at all useful/likely/satisfied) to 5 (very useful/likely/satisfied). As before, survey responses were treated as individual cases and measured as low, medium or high levels of satisfaction, and then grouped for comparison. This survey is used across RANSW services and programs, through practice evaluation and periodic snapshot surveys, as well as in other comparable organisations, which enables comparison of scores with other interventions.

Table 1 Validated scales

Concept	Source	Rationale	Scale	Scoring
Gender equity	2009 and 2013 *National Community Attitudes towards Violence against Women Survey* (NCAS) (McGregor, 2009; Webster et al., 2014)	• Low support for equality between genders has a strong relationship to attitudes that are accepting of violence against women (Broady et al., 2014; McGregor, 2009) • Some members of LGBTQ communities may not hold attitudes that support equality between genders, and "gendered positioning" can influence both victim and perpetrator behaviours (Wendt & Zannettino, 2015, p. 215)	Eight statements regarding equality between men and women, on a scale of 1 (strongly disagree) to 5 (strongly agree)	Responses converted into a score of 100 and categorised as high (>90), medium (75–90) or low (<75) in support for gender equity
Social support	Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet, & Farley, 1988; Zimet, Powell, Farley, Werkman, & Berkoff, 1990)	• DFV/IPV can have a socially isolating effect (Broady et al., 2014; Morgan & Chadwick, 2009) • Facilitating community connections and reducing social isolation is a key aim within group programs for perpetrators and victims/survivors of DFV/IPV	Twelve statements regarding social contact with family and community members, on a scale from 1 (very strongly disagree) to 7 (very strongly agree)	Responses categorised as high, medium or low and group scores categorised for comparison with other cohorts
Self-esteem	Rosenberg Self-Esteem Scale (Rosenberg, 1965)	• Low self-esteem has been associated with the use of violence in intimate relationships (Broady et al., 2014) • While it can be a contentious assertion, most literature suggests that low self-esteem is a risk factor for violent behaviour (Walker & Bright, 2009) • Research about victimisation by an intimate partner has also been shown to have a deleterious effect on the victim's/survivor's self-esteem	Ten statements about the self are measured on a scale from 1 (strongly disagree) to 4 (strongly agree)	Negatively worded items reverse-scored and answers summed to give a total score
Psychological distress	Kessler Psychological Distress Scale, or Kessler 10 (Kessler et al., 2003)	• Poor mental health outcomes for people who have been victimised within a violent and abusive relationship are well documented (AIHW, 2018) • There is also evidence to suggest that high levels of psychological distress increase risks associated with the perpetration of DFV/IPV (as reported in Broady et al., 2014) • LGBTI people have reported poorer mental health than the general population (Leonard et al., 2012)	Individuals report the frequency of ten indicators of distress occurring over the past 30 days, from "none of the time" to "all of the time"	Higher scores indicate higher levels of psychological distress

Concept	Source	Rationale	Scale	Scoring
Internalised homonegativity and need for privacy	Outness Inventory and subscales from the Lesbian and Gay Identity Scale as described by Mohr and Fassinger (2000)	• We hypothesised that the level of outness regarding gender identity and sexual orientation would be an indicator of social isolation and this may be connected to both victimisation and perpetration of violence • In addition, self-reported levels of positive or negative lesbian and gay identity may be connected to self-acceptance, psychological distress, and outness which could affect experiences of DFV/IPV	• 41 items in the client surveys invited responses about levels of outness and identity • A 7-point scale measured the extent to which different types of associates are aware of the respondent's identity (outness) or the extent to which the respondent agrees with the statement • Each scale included N/A so that respondents could opt out of an item if they chose	• Responses measured, and categorised in individual cases as low, medium or high, and then grouped for comparison • "Outness relating to sexual orientation" scores were categorised as low, medium or high to indicate the extent to which someone was out, their need for privacy and the extent to which they had internalised homo/bi/transphobic attitudes
Stigma	Minority Stress Scale (Meyer, 1995, 2003) and Stigma Scale (Link, 1987), adapted for use with "homosexual men" (Martin & Dean, 1987)	• Experiences of stigma and discrimination relating to gender diversity and sexuality are reported as key issues facing LGBTQ people experiencing DFV/IPV, particularly in terms of isolating couples and hindering help-seeking (Campo & Tayton, 2015) • Minority stress describes the effects of ongoing social stigma and discrimination on smaller, marginalised populations • Measuring minority stress would therefore provide an indication of whether the group program had a positive effect on reducing the participant's sense of stigma	• 11 statements that present scenarios about the acceptance of LGBTQ people • Responses are measured using a scale from 1 (strongly disagree) to 6 (strongly agree), including N/A for respondents to opt out at each item should they choose	Individual scores measured as low, medium or high, and group responses categorised for comparison across time points

Working Alliance Inventory

As with post-group surveys at RANSW, we used a validated scale, the Working Alliance Inventory, to measure the strength of the therapeutic relationship between the client and their group facilitator (Horvath & Greenberg, 1989). The revised short form (WAI-RS) comprises 12 items covering three components of this relationship: agreement on goals, agreement on tasks to achieve the goals, and bond between practitioner and client (Hatcher & Gillaspy, 2006). A reliable correlation between the working alliance and achievement of therapeutic outcomes has been reported (Horvath & Symonds, 1991).

Data analysis

Qualitative data

Analysis of qualitative data was managed using the qualitative software NVivo and undertaken in three stages. First, a preliminary coding frame was constructed using topics from the interview schedule and trialled by the research officer. After five manuscripts had been coded, the consultant and the research officer met to review the coding reports, establish consensus relating to the coded material, and develop additional codes which emerged from the interviews. The coding frame was then updated, and the entire data set coded. The coding reports were then read by the researchers who met again to discuss the emerging themes and implications of the research questions and the practical application of any findings. Analysis ultimately enabled the researchers to identify key messages about:

- how clients of the victim/survivor program perceived and experienced the groups
- how DFV/IPV perpetration is perceived and experienced within LGBTQ communities
- potential role of formal services in facilitating behaviour change and increasing the safety of community members
- approaches and concerns of professionals who work in this sector, and those who refer their clients and service users to potential group programs, with a focus on workforce development needs.

For the client and clinician interviews, we were guided by interpretive description (Thorne, 2008, 2016; Thorne, Kirkham, & O'Flynn-Magee, 2004). Building on grounded theory methods, interpretive description is a non-categorical methodology which aims to extend the analysis beyond description through the development of broad categories of meaning, rather than relying on line-by-line coding. Interpretive description is a sensitising framework and draws upon the researchers' knowledge of the issues at hand. For the professional stakeholder and community interviews, a process of thematic analysis (Braun & Clarke, 2006; Clarke & Braun, 2017) was conducted for each group, using open coding to generate recurring themes across the interviews. This was seen as more conducive to the exploratory aspect of the study. Preliminary findings were shared with the clinical teams and advisory panel through pre-set quarterly meetings and tested via early conference presentations. These feedback mechanisms were primarily used to test our interpretation of the findings, and the extent to which the recommendations were consistent with practice wisdom and community perspectives. Recommendations could then be developed for practice and program development, with the researchers confident that the project was relevant and beneficial for LGBTQ people experiencing DFV/IPV, and for services more broadly.

Quantitative data

The sample providing quantitative data for this study was too small to provide generalisable findings. As such, we have not included information about analysis of these data in the body of the report. We provide this information in Appendix C as an illustration of our analytic approach, for consideration in designing future trials of tailored programs.

Participant profile

Over 8 months (December 2017–July 2018), the research team collected 45 interviews from clients of the victim/survivor program (n=5); community members, including potential clients referred to the perpetrator program (n=20); clinicians and program developers (n=7); and professional stakeholders (n=13). However, one participant from the

community sample revoked consent after their interview and their data were subsequently sealed. As such, the qualitative interview findings in this report are drawn from 44 in-depth interviews. We also conducted a series of focus groups at the Pride of Place conference in June 2018, with 50 participants in total. In addition to these qualitative interviews and focus groups, we administered surveys to the ten clients who attended the victim/survivor program. As the sample was too small, we have not drawn conclusions but have outlined the client responses to the surveys for informative purposes in Appendix C.

Survey participants

Of the ten people who attended the victim/survivor program, nine completed a pre-intervention survey, three responded at program completion and two at the 3-month follow-up. No surveys were returned after this time.

Interview and focus group participants

There were five different cohorts of participants who attended qualitative research interviews:

- victim/survivor program clients
- LGBTQ community members, including three people referred to the perpetrator program
- clinicians and program developers from ACON and RANSW
- professional stakeholders external to ACON and RANSW
- focus group participants from the Pride of Place conference.

Victim/survivor program clients

Five clients of the Surviving Abuse group undertook an interview, including four cisgender women and one cisgender man. The participants identified as lesbian (n=1), gay (n=1), bisexual (n=1) or queer (n=2). All participants were born in Australia and identified as Anglo–Australian. The full client cohort in the Surviving Abuse program was more culturally diverse than the interview sample. This means that the client interview data can be interpreted as lacking cultural and linguistic diversity and perspectives from non-Anglo heritage communities.

The five interview participants ranged in age from mid-20s to mid-50s, and most interviewees were between 27–39 years, which largely reflects the client cohort. Those who undertook an interview tended to live in share housing and were single (n=4) at the time of the interview. The client participants also tended to be in low-income paid positions ($0-499 per week). One participant was a parent to dependent children in their care. One participant was living with a disability. We did not recruit individuals who identified as intersex.

Clinicians and program developers

Seven clinicians and program developers who held group worker/facilitator, supervisor and program developer roles within ACON and RANSW were interviewed. These participants had worked in their roles for between one and 25 years and had all undertaken extensive study and training prior to their current position, with all but two having completed postgraduate qualifications. They were mostly cisgender women (n=5) and identified as heterosexual (n=3), lesbian (n=1), gay (n=1), bisexual (n=1) and queer (n=1). All clinician and program developer participants were born in Australia and identified as Anglo–Australian. None of the clinicians or program developers identified as intersex.

LGBTQ community members including people referred to the perpetrator program

Of the 20 LGBTQ community members who took part in an interview, one identified as a transgender woman, one as a transgender man, three as non-binary or genderqueer, ten as cisgender women, and five as cisgender men. We did not recruit individuals who identified as intersex. When invited to describe their sexual orientation, one participant identified as lesbian, three participants identified as gay, four as bisexual and 12 as queer.

The participants ranged in age from 24–56 years, with the majority aged between 20 and 40 years (n=17). Participants

tended to be born in Australia (n=17) and half identified as Anglo–Australian (n=10). Two participants identified as Aboriginal. There were eight participants from a culturally and linguistically diverse background, including non-English speaking European countries (n=5), Middle Eastern countries (n=2) and the African continent (n=1). The majority of community participants tended to be in relationships at the time of the interview (n=16); four were single. Of the people in relationships, eight participants indicated that they were monogamous, and eight participants described their relationship as polyamorous or consensually non-monogamous.

Professional stakeholders

Between March–July 2018, 13 professional stakeholders who were external to RANSW and ACON took part in an interview. The professional stakeholder participants worked in a wide range of roles, including court settings (n=1), NSW Police (n=3), a community legal centre (n=1), justice advocacy (n=2), domestic violence counselling (n=2), a men's group program (n=1), men's referral services (n=2) and women's health (n=1). This sample included people who had been in their professional role between one and 14 years. Gender and sexuality indicators were not collected from the professional stakeholder sample.

Focus groups

The focus groups were facilitated as part of a workshop at the 2018 Pride of Place conference in Sydney. Participants sat at five tables which included ten delegates each, meaning that a total of 50 conference delegates provided data for analysis. Demographic data were not collected from these participants. However, the majority of participants presented as female, and tended to be academics, students or professional stakeholders.

Ethical considerations

Approval for the conduct of the study was provided by the RANSW Human Research Ethics Committee (EC00416) on 23 May 2017 (project ref: RG02177) and the ACON Research Ethics Review Committee (RERC) on 18 May 2017 (project ref: 2017/07). At each stage of data collection and analysis, advice and endorsement were secured from the project's academic advisory panel, whose members are listed in the acknowledgements section.

Blair (2016) has written on specific ethical considerations for research with LGBTQ populations. She reminds us of the history of persecution and pathologising of LGBTQ people, asserting the need for researchers to protect the "safety, dignity and confidentiality" (p. 376) of such participants. Key issues may include risks of harm from being identified as part of the community in a social or cultural context that is hostile to LGBTQ people. There is also a risk of heterosexist bias in the research through assumptions about experience and use of concepts and language that replicate heterosexual norms. Inattention to diversity within LGBTQ communities can lead to homogeneous findings that elide the multiple and nuanced aspects of lived experience. These and other issues related to personal biases and motivations of the research team (some of whom were members of LGBTQ communities) were considered in the design of this research. When the issue of DFV/IPV is considered, there are additional concerns for the safety of participants and ensuring the research process does not create distress.

We addressed these ethical considerations through strict confidentiality and privacy provisions, including having a mix of identity positions represented in the research team; external oversight by an expert academic advisory committee; review and checking of findings at community-focused conferences; specific protocols for clinical support and follow-up of clients and research participants as appropriate; and the strict separation of research data from clinical processes.

Extra care was required to carefully explain that the research study did not compel clients to take part in data collection, and that the interviews and surveys were voluntary and confidential. Care was also taken to explain how researchers would protect their participants' privacy, as some participants were known to the research team. Participants were invited to ask questions and raise their concerns at each stage of the recruitment and data collection processes. We were also

diligent in providing participants with a choice about who they would be interviewed by, so they could elect a researcher not known to them. Similarly, given that the research and clinical teams worked closely together, the invitation to participate was sent via group email and provided the participants with an opportunity to approach the interviewer directly. In this way, the participant could be interviewed by a researcher less known to them. The data were handled confidentially and stored separately from clinical or organisational/ management files.

Key findings

In this section, we turn our attention to the findings based on interpretive description and thematic analysis of the extensive qualitative data generated from the interviews and focus groups. This section is structured as follows:

- how the Surviving Abuse victim/survivor group program is perceived and experienced by clients, clinicians and program developers
- how considerations of DFV/IPV experienced by LGBTQ people and raised by clients, clinicians and program developers are relevant to future program development
- how DFV/IPV is perceived and experienced within LGBTQ communities more broadly
- how DFV/IPV is perceived by professional stakeholders, including clinicians and program developers
- how help-seeking and client engagement are affected by perceptions and experiences of DFV/IPV.

The direct experiences of clients of the victim/survivor program, and the broader conceptualisations of DFV/IPV by LGBTQ community members and professional stakeholders, are important for understanding how to locate and engage clients who might benefit from such programs. Various interpretations of DFV/IPV by all study participants and an analysis of community members' help-seeking behaviours and experience with services help us elucidate the workforce and sector development required to establish referral pathways for clients.

Detailed information on surveys and outcomes measures that can be used to evaluate programs tailored to LGBTQ communities are presented in the Methodology section, and a summary of client responses to these surveys is offered in Appendix C. While we do not report survey results as findings due to the small sample size, we include our reflections about the performance of the surveys and their suitability to the population in Appendix C.

Ultimately, our overall findings contribute to what is known about what works for clients who identify as members of LGBTQ communities, their preferred style of intervention, and the particular complexities facing LGBTQ people experiencing DFV/IPV.

Participant experiences of the Surviving Abuse group

In this section, we discuss the experiences of clients of the tailored Surviving Abuse group, members of LGBTQ communities, and the clinicians and program developers who worked on the program. The Surviving Abuse program helped clients gain knowledge and awareness about DFV/IPV and they described being able to apply this knowledge to their own relationships. Participants also described high levels of distress they and their friends experienced in their ordinary lives, which they attributed to the lived experience of identifying as lesbian, gay, bisexual, transgender and/or queer. As such, participants recommended considering elevated levels of distress when designing and implementing group programs for LGBTQ victims/survivors. Finally, participants reflected upon how differences between members of LGBTQ communities and, sometimes, prejudiced attitudes should be managed in group programs; the implications these would have for service provision; and impacts on fostering safe and therapeutic spaces that enable positive client outcomes.

Client perspectives

Client participants in the Surviving Abuse group compared their perceptions and experiences of the program with previous experiences in therapy. One participant, Asha (client, 20s), was relatively inexperienced as a client of clinical and therapeutic interventions. However, the other clients interviewed for this study had previously experienced multiple interventions. These participants exhibited a more detailed understanding of domestic violence, including controlling and coercive behaviours, and their help-seeking was more assertive. The client participants reflected on the ways in which the program helped them increase their knowledge of different forms of abuse, and how their experiences of abuse affected their mental health, quality of life and the functioning of their current relationship. For example, one participant said, "My knowledge about domestic violence is broader now. I see how complex it is." (Summer, client, early 30s)

The client participants valued what they learnt through the group program: "In the first half of the program, I worked really hard to accept what had happened to me … and hearing

the definitions of abuse and all the different types of abuse was really useful." (Jarrah, client, late 20s) Having greater knowledge of abuse was thought by the client participants to enable them to describe their experiences better. For example, "It was good developing the language about DV, more language, and hearing other peoples' experiences. … It was good to name the behaviours." (Savannah, client, late 30s)

Client participants appeared to undergo a process of knowledge enhancement regarding the definitions of abuse, starting at the intake phase and extending throughout the group program, which ultimately broadened their awareness of DFV beyond physical abuse. Having greater knowledge of multiple forms of abuse also provided reassurance for the victim/survivor group clients who were interviewed, in relation to their reactions to controlling and coercive relationship dynamics, and their actions to subvert the gas-lighting and manipulation they had experienced. For example, Asha (client, 20s) attended the victim/survivor group and talked at length in her interview about how hard it was for her to feel that she deserved a place in the program. She said: "I didn't think I was a good fit for the program because my relationship wasn't violent." However, after the pre-group interview and attending the program, Asha said she had better knowledge about what constitutes DFV and her perception about her place in the group program changed. Later in her interview, she said:

> I totally needed to be there … I realise now that her behaviours were not that subtle at all … and it took me a long time to see that I was right to be upset about that! (Asha, client, 20s)

Another client, Jarrah (late 20s), had found the group "helpful" but "tricky". She described the distress she had to manage while undertaking the program and understood this to be a manifestation of the trauma that had resulted from living in an abusive relationship. For her, thinking about what happened in that relationship was "confronting" but she expressed that "in the long run that's not a bad thing". Ultimately, as a result of taking part in the program she felt she was "better equipped with skills to lead a normal life"—that is, a life in which she was not constantly managing strong emotions emanating from her history of abuse. Opportunities to engage in this kind of therapeutic work had been rare for these clients, and each client interviewed described their discovery of the tailored Surviving Abuse program as "lucky".

The clients valued the social cohesion and solidarity with other clients that was fostered through the program, and the caring but direct feedback provided by the program staff. For example, Asha (client, 20s) found that "we all benefitted from finding people who had been through the same thing". Asha's sense of safety within the group setting provided her with opportunities to learn and reflect on her experiences while also extending her support network. When asked how she felt about the Surviving Abuse group since doing the program, she said:

> I'm definitely better than when I started … it's been really interesting to watch us become more comfortable with each other as we went along and everything. … Everyone's very aware of what everyone else is going through and we try really hard to be … compassionate around that.

Another client, Savannah (late 30s) had similar perceptions about the program:

> I thought it was really good. It was challenging, for sure … just like hearing other peoples' experience … that was important. … But also like, yeah, good in terms of being able to highlight and identify particular behaviours and categorising it as abuse. That was important … I felt lighter and like just solidarity is super-super-important for me around this stuff.

Similarly, another client, Summer (early 30s), appreciated the support and understanding she gleaned from the group, despite already having a robust network of supportive friends in place. For her, the fact that the group was made up of people from the LGBTQ community was an important factor:

> The support. Just having other people around you. That's what the biggest thing has been for me, yeah. Just having other people that like get it and that you can talk really like candidly with about your experiences, and not, not feel like you're burdening them. … And even if [the other clients] are like, "Oh shit, that's horrible", you're like, "Oh, but you get it cause you've been there". So for me the biggest strength is just, yeah—community.

Therapeutic relationships with staff and peers were identified by the client participants as particularly beneficial. These relationships supported the clients when working through their distress about living in a minority, as well as their shared experiences of victimisation.

The supportive and therapeutic aspects of the group experience seemed to be particularly valuable to the client participants given the timing of the program during the 2017 Australian Marriage Law Postal Survey and the subsequent announcement of the survey results. For example, Jarrah (client, late 20s) appreciated the support she gained from the group. She understood this to be related to the flexible facilitation style, which was responsive to the broader context of the debate about same-sex marriage, thus enabling members to access the group's support during the postal survey:

> I think that the relaxed structure of it worked because we would often go into a session with a clear outline of what we wanted to get done but if somebody had come up with something else they wanted to talk about we could veer off into that and, and focus on something that was more important at the time. And also because during the past 8 weeks like the whole, the same-sex marriage debate was happening and all of that happened, so on those days we were able to talk about that sort of stuff as well, which was useful, so …

Client participants learnt from the program and also gained support from the group, not only for their distress related to being in an abusive relationship, but also for the challenges associated with being in a minority group during a very politically challenging time. Savannah (client, late 30s) described the group process in the following way: "Just creating a safe space in which to talk about hard stuff. And then also I really enjoyed that they took into account like when people were triggered." In another example, Jarrah (client, late 20s) highlighted how the soothing effect of the group combined with the educational aspects of the program to enable positive client outcomes:

> I guess becoming more sure of what happened and actually giving it a name. Being okay to talk about it a little bit more with people. Not being quite so emotional. I don't know. The timing of this course was probably perfect for me so it coincided with a lot of other things.

The combination of manualised material on domestic violence and spontaneous intervention by staff through compassionate and non-judgemental facilitation enabled the clients to learn about what constitutes DFV/IPV and apply this knowledge to their own experiences while gaining the soothing and validating benefits of a safe and empathetic forum. As such, the clients indicated how the program helped them increase their knowledge of DFV/IPV, and the importance of safe and inclusive space for this work, where there is appreciation of the broader social context of their lived experience.

These factors align well with the values and experiences outlined by participants in the wider LGBTQ community interviews, in particular the importance of "community" and the need to heal after experiencing hostility and discrimination for long periods of time.

Clinician and program designer perspectives

The clinicians interviewed for this study also perceived the effects of minority stress and family ostracism to be affecting clients. For example, they described the intake and pre-group procedures as requiring more than the time allocated (60 minutes) and felt they could have spent longer with clients to engage and prepare them for the program. According to the clinicians, the longer period of time was needed to gain trust with prospective clients, but also due to the high levels of trauma that the clients were reporting and manifesting:

> We did an hour and it still probably wasn't enough. And mainly because the community has been neglected and haven't had support, and quite a lot of trauma. … I guess the strength was spending a lot of time to make sure that the participants felt it was gonna be safe. I remember we had, you know, two or three participants who were highly, highly anxious about coming to Relationships Australia and just mainly because of experiences they've had with, with other organisations. So we spent a lot of time making sure that they felt comfortable. (Group worker)

Similarly, the external professional stakeholders interviewed for this study saw a need for additional support for LGBTQ clients when entering services: "I think anyone going into either group [as a victim or perpetrator] needs one-on-one [intervention] first." (Gillian, counsellor) Services wishing

to undertake similar programs may need to allocate greater resourcing at the outset, especially if the program is being provided within a "mainstream" service. Services may also need to explore opportunities for concurrent complementary counselling to support affected LGBTQ clients. The clinicians thought this was especially the case for mainstream services working with LGBTQ communities for the first time, and that additional work might be needed to engage clients who have previously had negative experiences with such services.

A recurring theme in the interviews with clinicians and program designers was their intention to retain material and interventions which address coercion and control in relationships from the original programs, but also to weave in gender-neutral language and therapeutic approaches which acknowledge the unique experiences of LGBTQ people. Consistent with research conducted by Barnes and Donovan (2016), the clinicians and program designers tended to view certain aspects of DFV/IPV as universal human experiences, and approached their work by facilitating better understandings of universal forms of control and coercion. For example, Terrence (professional stakeholder) said:

> I guess with a queer group we use similar ideas around their entitlement to use violence against their partner but also we look at how heterosexism and homophobia sets up a context for the understanding or minimisation of that violence. For the perpetrator and their partner.

For the clinician and program designer interviewees, program and practice adaptation was informed by their awareness of the lived experience of LGBTQ communities, LGBTQ experiences of being affected by discrimination and marginalisation, and the ways in which these factors affect practice, particularly when developing a working alliance by building rapport and trust: "We needed to do something that can immediately make someone feel safer, and [we're] hopeful that this may be a positive experience." (Group worker) As such, it seemed to be important to the professionals to highlight the additional resourcing needed to attract and engage an LGBTQ client cohort, which was reiterated by another clinician:

> I'd spend up to an hour with people, everyone, on the phone. So my message to them was, "We get you. We will understand you. It's okay for you to come here." (Group worker)

Improving client awareness to strengthen their help-seeking, and educating professionals so they are more likely to make robust referrals, are important tasks for sector development. Participants suggested it was important to establish trust once a client is at a service, and engage that client with the therapeutic work. Additional work with LGBTQ clients was thought to be fundamental to any group work process, but particularly here given the prevalence of minority stress, with professional participants recommending that extra time is taken to do this.

Considerations for program design

In this section, we report on the perspectives of professionals and LGBTQ community members that are relevant to the development of future interventions and victim/survivor programs in LGBTQ communities.

Impact of trauma and high levels of distress

Both professional and community participants tended to raise trauma and minority stress as significant challenges facing members of LGBTQ communities, and reflected on how this impacted relationship function, help-seeking and optimal service provision. For example, Tucker (bisexual man, community member, 30s) felt that "really low self-esteem" was common among his peers, and Azra (queer woman, community member, 20s) said,

> I've definitely seen things, like in queer relationships behaviour is often because someone has also had quite a shit time of being queer. They've got various mental health-like issues and they're just like doing it a bit tough, in general. … Like often friends will excuse behaviour, abusive behaviour because that is going on. … I'm sure that happens in hetero relationships as well but I've definitely seen that where sort of mental health, like within the queer community, where mental health problems kind of end up excusing bad abusive behaviour.

Hoda (queer woman, community member, 30s) perceived DFV/IPV within LGBTQ communities as harder to see, or admit, due to the traumatising impact of living within a marginalised identity:

> There's a lot of minimising … there's also a lot of concern for the person who is using violence from the person who is experiencing it because that person's also been like a victim of different things. So, like whether they've had to leave their home countries because of the like intense homophobia they were experiencing, and they've had sort of trauma around that. … It's hard for [their friends] to process the idea of somebody who has been a victim of a whole bunch of violence, then goes on to use it. And there's a lot of excusing of the behaviour that's violent.

Study participants who identified as being part of LGBTQ communities also described challenges in defining their experience as DFV/IPV due to the empathy and understanding they have for fellow community members who they struggle to view as perpetrators. Community participants often discussed experiencing all forms of intimate violence, including family violence in their childhood, homophobic harassment and discrimination, and DFV/IPV.

When reflecting upon preferred terms for domestic violence, Axel (queer, non-binary, community member, 30s) liked both of the terms "domestic and family violence" and "intimate partner violence" because

> I have experienced both. I've experienced domestic violence like from a stepfather when I was younger. So, for me, like that was violence that happened in the home and that … had huge impacts on me, and like personal violence now is like, you know, that can happen not in the home place.

Axel (queer, non-binary, community member, 30s) talked about needing to manage the distress caused by experiences of homophobic discrimination and family violence, while also managing strong emotions and abusive dynamics within their current relationships. The strategies Axel used to manage this distress were related to the ways in which they cherished community:

> We try to create spaces where we're less violent to each other in our little communities and bubbles. And sometimes we're good at that, and sometimes not so good at it. And sometimes we're harder on each other than what we might be to other people … I was using forms of violence in a recent relationship, like I was getting angry because they were triggering past traumas for me … and I had to go to counselling to understand what the fuck was going on.

Axel (queer, non-binary, community member, 30s), said they undertook a long "process of reflection" about their behaviour and felt that "something was a bit off but I couldn't point to what". Axel's account also indicates the ways in which potential clients of perpetrator interventions might excuse their own abusive behaviours due to perceptions that such behaviours emanate from a place of victimhood and pain. Similarly, Lucinda (queer woman, community member, 20s) craved a safe space where she could talk about her relationships given the stress she experiences as a member of a marginalised community:

> I think the community desperately needs a forum to talk about good relationships. And, and so that we can all be saying to each other, "We have massive amounts of stress. We're all, like we're all triggerable most of the time. We've all got heightened awareness and anxiety." This is, like we need to be able to talk about this and have a language where we can say to each other, "I was doing these things. I don't think they're okay." And I need to unpack why I was doing them without worrying that I'm sitting there opposite some straight counsellor who's gonna be going, "Oh my God, it's a lesbian!" I don't wanna be judged for it. And I don't, I don't wanna be, like I just don't wanna be … like we need a forum that's ours. We need a forum where it's not gonna be judgemental.

For participants of this study, the LGBTQ "community" also represented a "queer collective" which was deliberately "trying not to have heteronormative relationships" (Scout, queer, transgender woman, community member, 30s) due to the sexism and/or abuse they had witnessed within cisgender, heterosexual relationships. From this perspective, it might be disappointing for members of LGBTQ communities to view queer relationships exhibiting abuses of power. For example, Nefeli (queer woman, community member, 20s) said,

> I think that, because we're trying to break down patriarchal gender roles in queer communities, maybe there are ideas that we don't want to perpetuate the same patriarchal violence that you see in like cis, heterosexual relationships. But I also think that it is still really common in queer communities for those power structures to still exist

> even if it's not a man holding power over a woman. It can be other manifestations of that. You still get those power dynamics that end up with one person having power over another.

As outlined in the previous section, participants often felt that they and their peers were affected by trauma experiences, and believed that this interfered with their understanding of relationships and DFV/IPV. Participants also reflected on the need for professionals to adopt a trauma-informed approach. A potential client for the perpetrator program, Jackie (lesbian woman, late 50s) expressed some trepidation about the upcoming therapeutic episode because it "is never what you call a pleasant experience". But she perceived it important for her to gain "self-awareness" and to "grow".

For Asha (client, 20s), on the other hand, the safety and inclusivity of the Surviving Abuse group that she attended meant that, despite having a different identity to other clients, she was able to learn and teach others about experiences that were unique to her sexual identity. Having been a "target within my relationship" due to her sexual orientation, Asha talked about the ways in which she used the Surviving Abuse program to explore her experiences. She also spoke about how she capitalised on the group experience in order to better understand how her sexual identity related to her experiences of abuse, rather than feeling unsafe or misunderstood within the group. In this way, she highlighted that the group culture was an important factor in managing diverse experiences, and that having groups with diverse participants was likely to be a more viable option than simply creating separate groups for each identity within the community. Moreover, some clinicians indicated that in an ideal world, DFV/IPV interventions would be offered alongside relationship skills education programs, as this would provide opportunities to clarify what constitutes an abusive relationship and, through this elucidation, prevent harm and increase safety. One professional stakeholder (Terrence), however, suggested that a relationship education program would not be an appropriate first intervention for perpetrators of DFV/IPV or their victims/survivors:

> Living in an [abusive] relationship like that and being invited to come in to do respectful-relationship strategies is counterproductive. It doesn't fit and it can actually put the victim at greater risk.

Scout (queer, transgender woman, community member, 30s), also talked about her sense of belonging within a queer community and how important this was. For Scout, weighing dilemmas of protecting other community members and seeking help was particularly intense:

> I think where I've seen or experienced violence in an intimate partner relationship because if you're both queer or you're both trans, you're both trying to survive in a world that wants to kill you, basically. And by exposing your partner, even if they're being abusive or violent towards you, by exposing them to interactions with police or the criminal legal system, or prison, it could, could basically … be the death of them. And it's far worse than the sort of abuse or violence that is being done within that relationship.

Clearly, Scout's experiences highlight the help-seeking dilemmas she faces, and we shall explore this in more detail in an upcoming section. For now, it is important to note these beliefs about the violence of mainstream society representing an even greater threat than violence within an intimate relationship. They also highlight the many additional and multilayered traumas associated with being part of a marginalised community, and how this complicates reaching out. Trauma was described as prevalent among LGBTQ communities, both in relation to members' experiences of childhood family violence, and of homophobia and ostracism related to their gender identity and/or sexuality. This affects how participants understand their relationships and complicates assigning accountability to people who use violence in ways that seem to be unique to LGBTQ people. Ultimately, these accounts highlight the role that tailored interventions might play in facilitating better outcomes for clients in addressing these additional factors, and in providing a safe and inclusive space within which to access programs and positive community support.

Diversity within LGBTQ communities

There were recurring discussions through the interviews as to how clients should be grouped and whether the group programs should be mixed gender. While a single-gendered group—that is, a group that was divided into female or male (albeit inclusive of transgender men and women)—would have been the preference for one client of the victim/survivor group, the group that was implemented was mixed gender, open to all sexuality and gender diverse people experiencing DFV/IPV. This was seen as a more appropriate space for non-binary and genderqueer people. Clinicians believed that having a cisgender man in the otherwise all cisgender female victim/survivor group did not seem to reduce client outcomes or interfere with the group climate. Indeed, clients reported that providing the programs in a timely fashion was more important than delaying the group until sufficient clients of a single gender could be reached. For example, Savannah (client, late 30s) was not entirely comfortable sharing the group with a cisgender man but felt that it did not impact on the quality of the program or the outcomes she experienced, saying, "It was fine."

Issues regarding the potential organisation of group programs around gender and sexual identities were discussed at length during the focus groups at the Pride of Place conference. Focus group participants stated that groups separated by gender would be ideal so that women would not be put at risk of facing sexism and misogyny from male clients. While it was rarely described as a feasible option, focus group participants also stated a preference for completely separate groups, where lesbian, gay, bisexual, transgender and queer people would each have their own group. However, through the focus group discussion this option was also appraised as unlikely given the relative size of the community. Others felt that separate groups would ignore the reality that multiple and fluid combinations of different identity positions are possible, and requiring people to select a fixed, singular position could be exclusionary. Discussion ensued as to the multiple groups required in order to meet all possible needs, such as transgender/gay/man, cis/lesbian/woman, and so on. Indeed, interviews with clients and community members highlighted the many ways in which clients might be or feel excluded, or experience prejudice from other group members, based on aspects of their identity in addition to gender or sexual orientation.

Providing a client's perspective on the composition of group programs, Asha (client, 20s) felt that previous experiences relating to her sexual identity at both targeted and mainstream services were unsatisfactory:

> I've had issues in the past going to like queer-specific counselling services and them like not really getting what I was saying 'cause like I [have had relationships with cisgender men], and so like sometimes there's specific stuff around that that, you know, gay-focused services looked and go like, "Oh, but that doesn't make sense." Or, you know, they say sometimes things that are a little bit discriminatory or just aren't great, or whatever.

For Asha (client, 20s), partnered service provision (in this case by ACON and RANSW) was an ideal scenario. She found the program via social media and also noted the utter lack of alternative programs:

> And so, yeah, the fact that it was hosted by ACON, you know, in partnership with Relationships Australia obviously was really important because I don't think I would have gone to a more mainstream service. So, yeah, that was a big factor in it, definitely. But they just, yeah, no-one else is doing this at all.

Lucinda (queer woman, community member, 20s) was in a polyamorous relationship and felt that even if and when she was victimised by a heterosexual cisgender man, she could not approach a "mainstream" domestic violence support service as her sexual orientation and practices would likely be "pathologised". She said, "So, like I would never walk into a domestic violence service and say, 'Hi. My third partner, who's a cis man, you know, has been doing these things.'" Tucker (bisexual man, community member, 30s) came forward when he saw promotional material about the study, as he was interested in attending a program but also wanted to contribute to knowledge-building for the benefit of others. He discussed the additional challenges faced by those who do not fit the current image of cisgendered female victims/survivors and cisgendered male perpetrators of intimate partner violence:

> Everyone assumes that a woman in a relationship is the abused [party] and the man in a relationship is the abuser. And that's because in the majority of instances that is true; the majority of people are heterosexual. It's a reasonably safe assumption to make but in our community, specifically, a particular program shouldn't be focused on like male or female, bi, gay, lesbian, trans, intersex, anything like that. It should just be this is a support group for abusers to stop their behaviour and this is a support group for the abused, to deal with the trauma, and coming out, and as a survivor. … And anybody who identifies as anything is welcome in either group because it should be an experience of healing and improvement rather than assumptions of your experience. (Tucker, bisexual man, community member, 30s)

In this excerpt, Tucker highlights the importance of providing a safe and welcoming forum through which to heal, which supports themes noted in previous sections. Similarly, Scout (queer, transgender woman, community member, 30s) suggests that programs be underpinned by "broader notions of power" that retain "a critique of sexism and misogyny" while including "other forms of control and coercion". This approach has the potential for group programs to explore abuses of power beyond patriarchal theories, and incorporate a more intersectional form of analysis that considers the use of power from different, dominant social positions. The clinicians we interviewed mirrored client accounts by discussing the perceived value of a safe and welcoming group process and a sense of solidarity between members for enabling positive client outcomes. It appeared that having facilitators who fostered a compassionate and empathetic group climate enabled Surviving Abuse clients to describe their experiences, often for the first time. Clients were also able to share their knowledge and experiences to the benefit of others in the group. Enabling this kind of knowledge exchange is in line with the aims of good group work practice in general, but was particularly important to the clients in our LGBTQ-inclusive Surviving Abuse group due to the impact of historical and current discrimination and marginalisation.

Professional participants also discussed intersectional and diversity considerations in facilitating programs for people within LGBTQ communities; this was particularly the case during the focus groups. While the data are largely treated as a professional sample within this study, the focus group participants also reflected on their personal experiences as community members. Some LGBTQ-identified professional participants reported feeling their identities were being erased from LGBTQ community development initiatives. This was particularly the case for those who identified as bisexual. Others remarked on the "white face of gay culture in Australia" and stated that there seems to be nowhere to refer LGBTQ people who were "Arab" or "Aboriginal". Others said they might be reluctant to attend a program at ACON given that it was still seen as a service for "gay men" and expressed concerns that the service might not be relevant to them as women. Luke (gay man, community member, early 20s), an Aboriginal man, said he was more likely to turn to friends and family for support as he felt safe and accepted within his cultural community. To him, an Aboriginal-cultural framing of DFV/IPV programs was more valuable than one based within an LGBTQ community context. Indeed, he stated that he would rather go to an Aboriginal program, alongside heterosexual, cisgender clients, than a program tailored for LGBTQ people who were not Aboriginal and/or Torres Strait Islanders.

In addition to talking about how the group programs could be composed around gender, sexual and cultural identities, professional participants also discussed the appropriateness of having couples attending the same program versus splitting them up. Professionals who had not worked on perpetrator programs tended to prefer programs to include both members of a couple relationship within one group:

> I think with our community it would be better to work with both members of the couple within the one group. I don't think there'd be the same issues with patriarchy. (Jerri, professional stakeholder)

This was a preference that clinical professionals tended to strongly refute:

> I think that there's the risk of doing family-violence work with victim and perpetrators in the same room … because family violence is not a relationship issue, it's a position that the perpetrator takes on to deliberately dominate and oppress their partner. (Terrence, professional stakeholder)

Participants appeared to value a theoretical framework that was guided by notions of power and control, rather than gender identities and sexualities.

Role of identity in the clinical encounter

Community members discussed the implicit heteronormative assumptions made about families by services and the unique experiences of queer families. Interventions which aim to reduce perpetration of DFV/IPV in LGBTQ communities would be wise to include relationships existing within chosen families and among housemates. For example, when working with transgender people affected by DFV/IPV, Scout (queer, transgender woman, community member, 30s) felt it was important for clinicians to gain an understanding of the affected person's living arrangements and not be limited to conceptualisations engendered by current terminology or imagery. Scout described why she liked the term "intimate partner violence": "queer families do not necessarily look like a traditional family" and this term is gender neutral and could encompass multiple partners and intimacies. She also described her experience of living in a transgender-friendly share house, which she said was "a necessity for trans people" as they needed a safe place to live. These living arrangements mean that relational and domestic forms of abuse can occur beyond sexual or intimate partnerships or traditional "families".

Moreover, it is important to note different experiences of risk and discrimination between members of the LGBTQ communities, and not to assume that identifying as lesbian, gay, bisexual, transgender and/or queer means that individuals are inherently inclusive in their attitudes or behaviours. For example, for Scout (queer, transgender woman, community member, 30s) and other transgender people, there are risks of cisgenderism and exclusion due to transphobia. Other clients expressed concerns about biphobia. Indeed, one bisexual client explained that she had been victimised due to her sexuality within her relationship. She took time in the group process to explain the ways in which her sexual identity had been used by her partner to undermine and shame her, despite understanding herself as "gay and being in a same-sex relationship". Tucker (bisexual man, community member, 30s) had had similar experiences: "I identified as bi when I went into the relationship. He bullied me into telling people I was gay." These excerpts are important reminders that there are differences within LGBTQ communities, and that clients are affected by varying forms of exclusion and discrimination. Such considerations are important when developing bespoke group programs based on gender and/or sexual identity.

Professional participants also reflected on their identities and lived experiences, and the ways in which they might be perceived as facilitators within tailored programs for people within LGBTQ communities. For example, Felix (clinician) was aware that, as a cisgender male, he should be careful not to dominate discussion when working in groups with women (both transgender and cisgender). Similarly, one group worker said that she had worked hard to manage what she viewed as transphobic discourse in the tailored group when one client had stated that "trans women are not real women as they have not been socialised as women". While there were no transgender clients present, this professional felt it was important to foster inclusivity within the group between members of LGBTQ communities, as well as among the broader Australian community.

Professional participants were, at times, ambivalent about the extent to which a mainstream service could meet the needs of LGBTQ communities, particularly when it came to the legal implications of DFV/IPV matters. For example, Adrienne (legal professional) said, "I feel strongly that many LGBTQ people have special needs about access to justice that would not be met by a mainstream legal service." These perceptions were not isolated, and often led to discussions about the pros and cons of working within community-identified forums, and how these should be taken into account by clinicians and program developers:

> I think that there is something about a peer-led program that helps. I think as long as … one of the facilitators is queer, I think that helps. And I can't really tell you why in any scientific way. Just in there's just something around … 'Cause, because our programs here have historically been largely peer-led and, and I think it could be things like, you know, I guess not just having a lived experience as a queer male but being connected to the community in a particular way that perpetrators can't use or misuse

> information about community to avoid responsibility for their abuse. (Terrence, professional stakeholder)

This participant also highlighted the potential risks of inadvertently missing issues, or colluding with perpetrators, should a professional not have sufficient knowledge of aspects of the lived experience of LGBTQ people.

Experiences of clinical encounters between professionals and clients who do not share a sexual identity were discussed at length. Questions were raised by community participants as to whether a heterosexual, cisgender professional can understand or create a safe space for LGBTQ clients. Having had long relationships with multiple mental health practitioners and generalist counsellors, client participants described what they looked for in an optimal and safe professional, and the process with which their trust and commitment was earned. It was important for community participants to gain peer recommendations and word-of-mouth referrals to counsellors, due to the perceived risks of accessing someone who held heteronormative ideals (whether explicit or implicit) or "did not understand" their lifestyle. For example, both Daniel (gay man, community member, 20s) and Parker (gay man, community member, 30s) had tried counsellors who were not identified as gay, and disliked "having to explain everything". A professional we spoke to reiterated this and said, "One thing that I hear is, you know, they're sick of having to explain about the relationship and how the relationship works." (Siobhan, clinician) Daniel was particularly challenged in finding a practitioner:

> It took me 5 years to find my counsellor, but he's a community therapist … like I don't have to explain the nuances of gay sex, such as chemsex or gay relationships, or like I don't have to discuss any of that with them. Like it's just … I've received the most benefit from therapy when I've been the most unguarded. And when I don't have to educate them, on the language, on that sort of stuff. (Daniel, gay man, community member, 20s)

Community participants also had reservations about discussing polyamorous relationships with non-identified professionals. Deeksha (queer woman, community member, 20s) said that positive attitudes towards polyamorous relationships, within the helping professions, were needed to increase the opportunities for DFV/IPV to be appropriately managed:

> I don't know how you would frame this but I think something to do with negotiating alternative relationship styles or non-monogamy in a kind of healthy way would really help to kind of separate some of the positive aspects of that practice from some of the more manipulative ones that in my experience were really part of trying to do polyamory without any, without very much support.

For Daniel (gay man, community member, 20s), it was not only important that he did not have to explain the nuances of his relationship, he also wanted to be able to talk about sexual practices, such as group sex, without the fear that his relationship would be read as inherently dysfunctional. Despite his dilemma about disliking having to explain his life to a non-gay counsellor, Parker (gay man, community member, 30s) felt he needed support and, in reflecting upon the quality of the mainstream support he received, simply stated that "they were good because they were there, and they were responsive". Again, while an inclusive and tailored service was the preference, participants felt their need for support was high and they were motivated to try mainstream services rather than wait for a tailored program.

Experiences with mainstream services among community members included the following examples. Azra (queer woman, community member, 20s) was nervous at first but "found it helpful" when she accessed support from a mainstream service. Similarly, Hoda (queer woman, community member, 30s) said:

> When I walked in, I saw she was wearing a cross and I thought, "Oh no! This is not gonna work!" but she totally won me over and it was really good.

Rusty (queer woman, community member, 20s) had been referred by her GP to a mainstream psychologist and, despite her reservations, said, "It was a really positive experience. I suspected there would be judgements, but no it was fine." Scout (queer, transgender woman, community member, 30s) was more reserved about her experiences with a non-transgender professional. She said,

> the person I went to was recommended by another trans person, as a psychologist who wouldn't be shit and kind of understands these sorts of things. And so she was fine to

> the extent that she didn't say or do anything horrible. But whenever I wanted to talk about my gender, or the way in which my gender and violence intersects, she would be somewhat dismissive and say, "Oh well, your gender identity doesn't have anything to do with those things. Like, it's totally fine however you identify."

In this account, Scout was mostly relieved that the counsellor had not said anything harmful or judgemental. However, she was also frustrated in hearing these platitudes and seemed to think it was a wasted opportunity to process the distress that accompanied her experience of violence. While this example could simply point to poor practice, it also showed the inherent risks that sexuality and gender minority populations take in accessing services and the challenges they face when talking about their experiences of violence. Ultimately, Scout ceased attending as she felt the process to be ineffective, albeit non-harmful.

Arrow (queer, non-binary, community member, 40s) was frustrated by their past experiences, and made some impassioned and direct requests:

> I want mainstream workers to be better at their work because I want to be able to go to a counsellor and say, "There was a woman who did this to me", and for the counsellor to say, "I hear you and that's real." And I think it has to come at all the same interfaces that we want for women who are not in the LGBTIQ space.

Accounts from community members suggest that while an overtly LGBTQ-inclusive site was the preference, participants engaged in efforts to overcome their reservations about accessing support at mainstream services and develop a positive working alliance with these professionals. Participants also described their experiences using community services, such as ACON, to gain support and described their sense of safety and relief when viewing inclusive messaging in promotional and on-site communications. It is important to remember, then, that potential clients for DFV/IPV group programs prefer overtly inclusive spaces that are secular and include visual representations of themselves and their communities, and with services that are provided by knowledgeable staff, including those who identify as LGBTQ. However, workforce-wide inclusivity training was viewed as more important than the gender or sexuality of the professional, by both professionals and clients, who were both cisgender heterosexual or identified as lesbian, gay, bisexual, transgender and/or queer. As one group worker (Sharon) said, "I think [clients] would be more than okay with some heterosexual workers if they were trained and aware of their blind spots."

Community and client participants also shared their perspectives on how services could demonstrate and perform inclusivity, and the implications this would have for the success of DFV/IPV interventions. Summer (client, early 30s) had tried another form of domestic violence support—namely, individual counselling—before her time in this program, but said it was "very heterosexual in nature and it didn't gel with me". It seems that the clients of our Surviving Abuse program were reassured by the stated partnership between RANSW and ACON, as they felt the expertise of both organisations would increase the likelihood that their particular challenges and risk factors would be understood. Providing a service through this type of partnership also seemed to indicate inclusivity and positive interest in doing this work.

Conceptualisations of domestic and family violence/intimate partner violence within LGBTQ communities

In this section we build on the findings presented about the group programs and other experiences of services to explore the ways in which DFV/IPV is perceived and experienced by the range of study participants who identify as members of LGBTQ communities. This includes the ways in which the heterosexual face of domestic violence interacts with gendered images of perpetrators and victims/survivors to compound the challenges of being in an abusive relationship. We start by describing how clients and community members felt hindered by the heterosexual face of domestic violence and observe that the term "domestic violence" is not seen as relevant due to its association with only physical manifestations of abuse. Finally, we outline the ways in which understandings of DFV/IPV can interact with lived experience of identifying as LGBTQ to make understanding DFV/IPV in LGBTQ relationships more difficult.

Clients and community members described a wide and multilayered range of reasons for the challenges they faced in viewing their relationship as abusive. It took time for some participants to see a "domestic violence" program as appropriate, as they could not easily reconcile the term with their relationship. Moreover, they did not see the abusive dynamics within their relationships as severe enough to ascribe the term "domestic violence" to, due to the more insidious forms of abuse they had experienced, such as psychological or emotional abuse, and/or the lack of physical abuse.

The heterosexual face of domestic violence

Clients and potential clients did not have a full understanding of what constitutes domestic violence and felt this term related only to physical forms of abuse. For example, Daniel (gay man, community member, 20s) did not "think to engage with the term 'domestic violence' because you wouldn't perceive yourself as being battered". Deeksha (queer woman, community member, 20s) said she needed to work with a therapist to overcome her confusion about what had occurred in a long-term relationship, saying it had been "very confronting coming to terms with that but also it's a very common story among my friends who I think would be reluctant to use the language of abuse". Like other participants, she perceived the term "domestic violence" to mean "physical violence and control, and [occurring in] long-term relationships within a cohabitating dynamic, and gendered". Having difficulty applying the term "domestic violence" to her experiences of abuse was particularly notable for Deeksha (queer woman, community member, 20s) when in a relationship with a person who did not identify with a particular gender.

Consistent with findings from the Coral Project (Barnes & Donovan, 2016; Donovan et al., 2006; Donovan et al., 2014), community participants expressed confusion and doubt about their experiences of abuse because they did not fit with the cisgender, heterosexual image of domestic violence represented in the media. For example, Daniel (gay man, community member, 20s) did not "self-identify as a victim" of domestic violence, given that he believed that "victims tend to be women". He felt that his difficulty identifying abuse was compounded by the gaslighting and dishonesty he experienced within his relationship: "[My] perception was muddied … because men who have sex with men, well the power dynamic is different … I did not identify [one incident], until like years later." His former partner "completely discredits the abuse I suffered at his hands". It took Daniel years before he could define his boundaries and state to his partner, "No, you don't get to do that."

Other interviews with community members highlighted the ways in which gendered notions of DFV/IPV victimisation might hinder help-seeking and access to support services, where these were available. For example, Hoda (queer woman, community member, 30s) stated,

> There's like just different things that I could have accessed if somebody, you know, saw my situation, put it in the box of DV immediately and then were like, "Here are the things you can access."

Hoda goes on to express a view that it could be even harder for gay men to find support, since they must first overcome the difficulty in identifying DFV/IPV as part of their experience, and then they have even fewer options for support than women: "I'm lucky because I am a woman, because there are really not very many services for gay men who are experiencing intimate partner violence."

Understanding experiences of abuse and violence as DFV/IPV may be made more complex for sexuality and gender minorities due to the heterosexual and cisgender face of domestic violence, and due to the term "domestic violence" being synonymous with physical forms of abuse. These factors appear to combine with dynamics used to undermine partners within coercive relationships to create significant barriers to perceiving an experience as abusive. Even those participants with more knowledge and experience of domestic violence needed time to process DFV/IPV concepts and apply them to their experiences.

Participants described challenges in understanding their experiences as DFV/IPV due to the intense periods of identity formation they had undergone when embarking on a first same-sex relationship and/or identifying as lesbian, gay, bisexual, transgender and/or queer. Participants suggested

it could be more difficult for LGBTQ people to understand DFV/IPV while it was happening, given the changes to self-perception typical of those who were transitioning into a non-normative sexual orientation or gender identity. For example, Arrow (queer, non-binary, community member, 40s) suggested it took longer to understand the dynamics of their first same-sex relationship, compared with their relationships with the opposite sex, and they would pause before reacting to abusive "signals" in order to reflect on what was happening:

> I didn't know how to stand up for myself. When you are still defining yourself and figuring out who you love, and why you love them, it's a vulnerable time. And that's why I think it's harder.

Internalised gender norms also appeared to complicate the appraisal made by participants of their partner's abusive behaviours. For example, Tammy (queer woman, community member, 20s) talked about how she had internalised social messages about women that delayed the perception of her partner's behaviour as abuse:

> I guess I felt a lot more doubtful, like, "Is this really happening?" or, "Maybe I'm just making too much of a big deal about it. Like I'm sure she actually has my best interests at heart", you know? And this comes from this idea of like women being nurturing and caring and loving and often represented as like maternal figures. It makes it a lot more difficult … for me to identify and label it and kind of call it what it is … whether they are violent or not. … It is really hard to identify because of the messages that we're always told.

DFV/IPV in LGBTQ communities appears to be obscured by the language and visual representations of abuse, the social messages regarding what it means to be a man or a woman, and social expectations about how men and women should act when in a relationship. These social conditions are particularly complicated for non-binary or genderqueer people due to the lack of social representations of relationships that include people who do not relate to a particular gender identity.

Participants tended to make comparisons with relationships between cisgender, heterosexual people in order to define their experiences given the lack of both social representation of relationships between people who identify within sexuality and gender minorities and opportunities to talk about and reflect on their relationships and DFV/IPV. Observations were drawn from their family of origin, including witnessing dysfunctional relationships between their parents and among extended family. Azra (queer woman, community member, 20s) thought that DFV/IPV in heterosexual relationships was more severe and that "queer" relationships were more likely to manifest non-physical forms of abuse, such as "withholding affection, stalking or harassment". Another participant, Arrow (queer, non-binary, community member, 40s), was told by their abusive partner that it could not "possibly be [domestic violence] because I'm not a man", highlighting some of the direct ways in which a heterosexual and gendered framing of domestic violence can be used to undermine a victim's/survivor's appraisal of their situation. Participants such as Scout (queer, transgender woman, community member, 30s) thought that abuse within "trans households" was more emotional, subtle and indirect, albeit still harmful over time as it was "crazy-making". One professional (Terrence, professional stakeholder) who had experience working on perpetrator programs with gay men said:

> We've had men in our group say that they felt that straight men's violence was worse than the violence that was happening in their relationship. So, you know, I guess we do try and challenge some of those ideas and myths in our group. I guess that, that would be one of the main differences that we look at, yeah …

A group program could provide a forum through which to interrogate myths about DFV/IPV in LGBTQ relationships, which would be a valuable opportunity for the clients of such groups. This is especially important in instances where gaps in knowledge regarding DFV/IPV are used to minimise violence or victimise a partner.

Consistent with our findings in the State of knowledge review for this study (Badenes-Ribera et al., 2015; Davis et al., 2015; George et al., 2016; Riggs et al., 2016; Walters & Lippy, 2016), participants perceived identity-based abuse to be an important factor within LGBTQ relationships compared

with heterosexual, cisgender couples. For example, Parker (gay man, community member, 30s) described witnessing a transgender friend being objectified and humiliated by his gay male partner at a party, and shared his distress at how hard it had been to say something at the time. Similarly, Arrow (queer, non-binary, community member, 40s) had had doubts about their capacity to appraise situations, due to their own experiences around identity formation. They said:

> I grew up thinking I was probably crazy because I was queer. So I grew up thinking there was already something in me that's broken. So it doesn't take much for a partner to play on that and go, "Yeah, you are totally broken. And here's the ten ways that you are broken." So it plays out because we have these other vulnerabilities and, but we have other triggers, I think. So it means that like just that stuff around you, your partner saying, you know, "I could out you to broader parts of the community as crazy or I could out you as being gay." … Homophobia and transphobia are oppressive systems of power that tell us who we are, who they want us to be and who they want us to love.

Participants like Arrow (queer, non-binary, community member, 40s) felt that vulnerabilities relating to the harrowing effects of homophobia, biphobia or transphobia could be exploited by a violent partner to increase the gaslighting and isolating dynamics of DFV/IPV.

Importance of community and belonging

Community participants described their impressions of the types of abuse that LGBTQ people can experience within their significant relationships, and suggested that the particular ways in which these experiences interact with their notions of the "community" or "queer collectives" could make it harder to understand or acknowledge such behaviours as abusive. Given the importance of community membership and belonging, many of the participants described their fear of losing community connections by calling out abusive behaviours. Participants were often reticent or scared to speak up about their experiences of DFV/IPV due to the fear they would be excluded from their network of friends and "chosen family". For example, they might be seen at a DFV/IPV group by a fellow member of their community, which was thought to be likely given that LGBTQ communities can be relatively small and well connected. This could also be exacerbated by living in a small town or a remote geographic location. Arrow (queer, non-binary, community member, 40s) lived in a rural setting and said:

> I mean I wanted to go to a group and I rang a women's health centre, and said, "I wanna come to a group." And, in the end, I did not go because I thought, if I know, if there's another lesbian in that group, I'm toast. Like everybody's gonna find out. They're gonna ring [name removed for confidentiality] and say, "This woman's talking shit about you." It's gonna be it for me. I'm gonna have to move towns.

Being a member of a "small community" was also thought to form the basis of a tool of coercion used by perpetrators. For example, Mustafa (queer, transgender man, community member, 40s) reflected on the danger that regional community members could face, including social isolation should someone be excluded from a tightknit group in a remote town. He had known people "unwilling to leave" abusive relationships as doing so would lead to a "worse fate", that is, being excluded from the "queer community" in their hometown. Tammy (queer woman, community member, 20s) also expressed that the need for being connected to community led to dilemmas when acknowledging and naming DFV/IPV within relationships:

> When we've found our community it's become a real core part of our identity and where we feel safe. And we don't wanna give that up. And oftentimes it is, talking about violence can be a threat to that and it can fractionalise our communities, and further marginalise us. So, it is a bit more of a thing, I think, for us to weigh up than it is for say a heterosexual person to weigh up who might be able to find other safe environments to move to if they, if they need to move out of their community.

Community participants described a space of protection and safety fostered by a sense of community and belonging; at the same time, protecting the community was a disincentive to talking openly about DFV/IPV. For example, Tammy (queer woman, community member, 20s) said:

> I really love my community of queer friends and I feel a really strong bond. And there's like a sense of like a

> protection and safety, and an identity that kind of forges us together, that's kind of useful. If I didn't have that community, I would feel a lot more ostracised and isolated in the general, non-queer public. So, in the context of already feeling quite unsafe in the broader context there's kind of an internalised drive where you don't wanna call out someone else from your community and you don't wanna talk about, you know, perpetrators of violence.

Given the negative representation of what Tammy (queer woman, community member, 20s) described as "queer relationships" among the "general, non-queer public", the resulting stigma and discrimination directed at LGBTQ communities was thought to hinder potential clients coming forward and seeking help with DFV/IPV. In some instances, this compelled community members to support each other informally. Hoda (queer woman, community member, 30s) said, "I've seen beautiful examples of friends taking care of friends in our community." These accounts speak to the lack of engagement with and trust in formal, mainstream services, rather than a lack of motivation to access support. They also suggest that community members could provide expertise to relevant organisations about what it takes to support peers experiencing DFV/IPV. For example, Scout (queer, transgender woman, community member, 30s) had some recommendations related to the philosophical underpinnings of potential DFV/IPV programs for LGBTQ communities:

> Just as one really obvious example, because it's operating from the framework that is largely like a cisfeminist framework, an analysis of patriarchy, whereas some of the community-based things that I've been to have sort of more thinking beyond that about the western, colonial gender system and have critiques of, you know, like punitive, criminal, legal responses or the prison system and that kind of thing.

In the absence of tailored programs and inclusive services, some participants described their involvement in community-led, grassroots interventions. Mainstream and targeted services could learn from these informal, community-led interventions and enhance their domestic violence work by integrating approaches that have emerged from grassroots initiatives by the LGBTQ community. We also note, however, that these innovations focus on victims/survivors and, with the exception of "accountability workshops" (mentioned by focus group participants) that have been run by community members for people concerned about their use of violence, they do not address perpetrators' needs.

Even when community members judged they had good general knowledge about DFV/IPV, they reflected on difficulties relating it to their own experiences. Arrow (queer, non-binary, community member, 40s), for example, was struck by their level of confusion about their relationships: "I have good literacy in domestic violence but I could not somehow apply it to my own story." Having said this, Arrow was generally "able to see red flags in [friends'] relationships" and, due to the lack of appropriate services available, provided informal support to many friends. Providing support in this way was seen by Arrow as a core part of community membership, as "It's just part of being a good person in a queer family. … It's my unpaid case work."

Other participants described their perceived need to find a safe and inclusive forum through which to discuss their changing gender identity, and how this intersected with their relational behaviours. For example, Mustafa (queer, transgender man, community member, 40s) felt that he needed safe spaces and supportive friendships through which to develop as a good man, but instead he had to learn this in isolation from others, solely within his existing relationship:

> I think that there needs to be more done to support trans men to be good men in the world. There's not a lot of role models in this world that we can model ourselves on in a relationship … something that I was quite shocked at, and so I tried to adjust to make it, yeah … So I was received much more aggressively, if that makes sense. So, as my voice deepened, my partner, even if I said the same thing as I'd said like months before, with a, with a higher voice, it was received as much more aggressive. And so we went through a bit of a process. … So I remember … they said, "I'm just feeling, I'm just experiencing you as much more like aggressive but I think it's just the tone, like the deeper tone of your voice like an angry man who's much more intense than an angry woman for me", I was like, "Okay. This is good to know."

Such excerpts highlight the particular challenges facing LGBTQ people in navigating intimate relationships within a society that lacks positive representations of LGBTQ relationships. Moreover, Mustafa (queer, transgender man, community member, 40s) highlights the need people have to understand their sexuality and gender outside the overwhelmingly negative portrayal of relationships within LGBTQ communities. Mustafa's suggestion for greater support for transgender men also indicates that standard men's behaviour change programs that do not acknowledge these complexities would not be appropriate.

Professionals' conceptualisations of domestic and family violence/ intimate partner violence in LGBTQ communities

As in the client and community interviews, professional stakeholders were invited to share their perceptions and experiences of DFV/IPV within LGBTQ communities. While professionals offered more sophisticated definitions of DFV/IPV, they had less confidence in discussing sexuality and gender diversity. At times, this meant there were contradictions in their descriptions of DFV/IPV within LGBTQ communities and in their recommendations. Many of the professionals remarked that they had not previously considered many of the issues raised, due to not being asked or not having had opportunities to discuss the topic.

Professionals also tended to view "domestic violence" as heterosexual and believed that the LGBTQ clients they worked with were reluctant to admit that they were abusive in the same way as cisgender men in heterosexual relationships. Indeed, professional participants in this study described their trouble when identifying the perpetrator and the victim in an abusive relationship between LGBTQ people, which related to how they understood domestic violence. Finally, professional participants talked about emotional distress and relationship intensity, which could be caused by living as an LGBTQ person within a homo/bi/transphobic and heteronormative society, as factors heightening risks associated with domestic violence. While these descriptions were less often connected to concepts of marginalisation or trauma by professionals compared to client and community accounts, these views highlight similarities between personal and professional understandings of DFV/IPV within LGBTQ relationships.

Knowledge gaps about gender and sexuality

The professionals in this study tended to have quite sophisticated understandings of both domestic violence and LGBTQ relationships, yet there were participants who admitted to "feeling out of their depth" when asked about the interactions between the two. For example, one police professional (Kurt) was open about their knowledge gaps and reflected upon the lack of opportunity they had had to discuss these issues. When asked about what they understand gender and sexuality to mean, Kurt (police professional) said, "It's a hard question … I don't know how to answer that … no one's ever asked me that so I don't really know." It is interesting to note that this feeling was not aligned with their work, as some professionals were in targeted roles or regions with a high proportion of LGBTQ clients and service users and this may have suggested they would be familiar with discussing these concepts, but like Kurt, many were not.

In addition to knowledge gaps about gender and sexuality, a lack of understanding about LGBTQ relationships affected how the professionals understood DFV/IPV within LGBTQ communities. At times the appraisals that professionals made regarding LGBTQ community members indicated a conflation between sexual practices and DFV/IPV dynamics:

> To speak honest and open, promiscuity and jealousy. Jealousy, a lot, and like a lot of promiscuity. … I can't go into details but that's, like more recently those are the ones I've seen where there's been a fight over Grindr, you know. Trying to get somebody's account or there's a fight because somebody's come home with somebody else and the other person wants them to go. (Kurt, police professional)

Given stereotypes towards people within LGBTQ communities and the lack of comprehensive inclusivity training provided across the DFV/IPV sector, professionals who identified as members of the LGBTQ community felt it is better for LGBTQ perpetrators and victims/survivors to be treated by a fellow community member. These participants had the perception

that professionals who were community members would have greater awareness and empathy:

> Because we inherently understand that level of violence that we live with on a daily basis. You know, whether that's just the elbow out the car, yelling out, "Oh yeah, fucking dyke!" or too scared to hold your partner's hand down certain streets, constantly assessing threat. It's, I think coming, coming to somebody who can … an LGBTIQ organisation is so important. To have a member of community acknowledge, "I think too that what you're going through is not okay." (Gillian, counsellor)

More often, however, the interviews with professionals were imbued with confusion and contradictions about concepts of gender and sexuality, non-binary identities, different family structures and polyamorous relationships, and seeing DFV/IPV as "the same" for everyone—while describing unique behaviours within LGBTQ communities. This indicated a significant need for training and intervention. For example, one professional said,

> It's all the same. But a domestic violence offence is a domestic violence offence … no matter what the makeup of the relationship is. I wouldn't say it's the same. There's always different things … speaking very generally, you know, as I said before, drugs and alcohol, third party involved, just promiscuous relationships or open relationships and more or less those ones just that additional factors that have come into it. So, in a sense, I've forgotten the question, 'cause I've confused myself. (Graham, professional stakeholder)

Mustafa (queer, transgender man, community member, 40s), who had both professional and personal experience with DFV/IPV, talked about how a lack of understanding of LGBTQ relationships and practices could lead to pejorative judgements about clients that obscure risk assessment and inappropriately apportion blame. He said:

> Society positions gay men as being promiscuous sluts and driven by a primal need. And then for themselves, but it's not okay for their partner. And recognising that DVLOs [domestic violence liaison officers] in particular see a very pointy end of peoples' experience but I think it's unfair and homophobic to suggest that the thing that drives the use of power and control against a partner is jealousy and being promiscuous. I think, really, research suggests that, you know, gay men are certainly not as promiscuous as some populations but also have really established communities of care, and have lived through, you know, a tsunami of death with like the AIDS epidemic. And managed to survive. So I think, yeah, I don't buy that. I think that's garbage. (Mustafa, queer, transgender man, community member, 40s)

A number of professionals who were interviewed admitted to using similar judgements towards LGBTQ clients in their work and also talked about their awareness of other professionals doing so. However, there was also an absence of awareness in the professionals' accounts of the range of practices developed over many decades in some gay communities that support and sustain practices like non-monogamy and recreational drug use. Furthermore, moralising judgements about gay men's relationships fail to recognise alternative intimate cultures and the community of care which often forms the backdrop to the so-called "promiscuity" witnessed by professionals. These judgements also inappropriately impose assumptions on clients about the greater safety and moral superiority associated with monogamy. The extent to which professionals' knowledge gaps affected their work is unclear; however, it appears their understandings of gender and sexuality affected how they viewed DFV/IPV within LGBTQ relationships, and their beliefs about whether or not they should intervene.

Misunderstandings of sexuality and gender identities

Professional understandings of DFV/IPV within LGBTQ relationships were also affected by their understandings of gender and sexual orientation. For example, one professional said:

> If a lesbian couple fight, they throw punches. Whereas, a gay male, they'll come and report that they've been slapped, or they have been punched or something like that. Or, you know, they feel intimidated for these reasons … I won't stereotype 'cause I don't wanna call them "princesses" but like [if] they were to get slapped, like it might be a slap of violence and that's where they'll come

> and report to us. So, I guess more they take the more minor assaults as minor assaults are more … affect them more than a minor assault to a lesbian couple. (Graham, professional stakeholder)

In this example, we observe how stereotypical ideas of gender and sexual orientation intersect to influence the professional's judgement of risk. When men who are gay report a "slap", Graham (professional stakeholder) seems to view this as not appropriately masculine, trying (unsuccessfully) not to apply the pejorative label "princesses". He thus minimises the violence, and in comparing gay men's reporting to police with the presumably tougher, (more masculine) non-reporting by lesbians, he is denigrating those men and effectively dismissing the need for a comprehensive appraisal of risk.

As with the client and community interviews, professional participants reflected upon the gendered nature of DFV/IPV and programs for heterosexual clients, and indicated concerns about the appropriateness of such interventions for LGBTQ clients:

> Some people, I don't wanna say many people because it's probably not fair, have a gendered and dominance-based view of domestic violence so, if they were to come across a relationship between two women where there has been violence, they may have some difficulty in matching that up with what they know about DV generally. (Adrienne, legal professional)

This quote highlights the understanding and knowledge gaps that professionals may have, when working with LGBTQ people experiencing DFV/IPV, that may affect their decision-making about how and when to intervene. We will explore this in more detail in upcoming sections, but for now we note that professionals' understanding of gender and sexuality seemed to affect the ways in which they understood DFV/IPV, and in doing so highlighted the workforce development needs within this sector in Australia.

Professionals tended to see the lack of knowledge and understanding as a resourcing issue. For example, rather than blaming police, Adrienne (legal professional) reflected upon her work across agencies and spoke of her sympathy for police given their onerous workloads:

> Police—I found to be generally good. I think like it's hard to get, it's hard to get a hold of police just generally not just the DVLOs [domestic violence liaison officers]. I think the DVLOs are generally well trained when it comes to LGBTQ DV. I think it would be helpful if there were a clear protocol for, say, services like ours to communicate with police 'cause it kind of seems to be luck of the draw. So sometimes we get an email address, sometimes we don't. Sometimes we have to phone 17 times before getting through to someone.

This participant also outlined the compounding barriers to making informed and considered appraisals of the cases they worked with, such as a lack of detail within procedures or time poverty. Other issues raised by professionals that interrupted good risk assessment were related to the heterosexual face of domestic violence: "I think that there is a perception that basically that DV is a straight thing and we [members of LGBTQ communities] wouldn't behave like that." (Chris, clinician)

Focus groups with conference delegates discussed the ways in which DFV/IPV was portrayed in the public domain and how it is generally understood. "Family violence" was thought to be a somewhat useful term given many LGBTQ people have experienced violence in their family of origin. However, for most delegates the preferred term was intimate partner violence, allowing for recognition of intimate relationships that were not necessarily "domestic". Domestic violence was a term thought to infer cohabitation and living together, which obfuscated the diverse power disparities that could be exploited in non-traditional living arrangements. The use of the word "violence" in either DV or IPV was also considered unhelpful by these participants, who thought it to be misleading due to its suggestion of physical abuse, rather than a broader range of coercive behaviours.

Ultimately, one of the bigger barriers to overcome in conceptualising DFV/IPV for LGBTQ people was the faith that these relationships were "utopian", and participants expressed discomfort acknowledging that abuse and violence

occurred, let alone that it could be promoted outside of a safe, LGBTQ space.

Professional and stakeholder interviews echoed client and community interviews by providing insights into the communal investment made by community members in viewing LGBTQ relationships as inherently equitable:

> … because of the gendered nature [of heterosexual DV positioning women as the victim with less power] and the pressure on [gay] women to present amazing-looking relationships … to friends and to family. And because they have gendered it all so much, gay women, where do we fit into that gendered model when it's happening in our personal spaces? (Gillian, counsellor)

Given the prevalence of abuse within heterosexual dyads, most professional and stakeholder participants sympathised with the need to address the gendered nature of abuse. However, they were also concerned that this emphasis had created conceptual and structural gaps for LGBTQ women, related firstly to whether the concepts of DFV/IPV could even be applied to LGBTQ relationships, and secondly to barriers to accessing support because the service system is not structured to respond to non-heterosexual or non-cisgender needs. Another issue raised by professionals was how to ascertain who is the victim and who is the perpetrator outside of heterosexual dyads. As per the process required when working with cisgender, heterosexual couples, participants were keen to clarify that they did not allow assumptions to permeate this process, and emphasised the importance of understanding the history of the relationship dynamics. For example, one professional said,

> I've never gone into a DV [situation] and gone, "Oh well, the man must have hit the woman." It's not the case at all. It'd, as I said, it comes into, injuries play a little bit of a part but, of course, there's defensive injuries as well which might appear on a perpetrator, which the victim has done to defend themselves. There's history. (Shay, police professional)

Those working in referral services for domestic violence presentations noted the complete lack of referral pathways for women who were labelled perpetrators, and understood this to be an issue. Professionals who described their work as "process-driven"—following the same set procedures for all circumstances—also seemed to perceive their service provision as equitable. However, these perceptions of equity appeared to be due to a lack of knowledge about the lived experience of people within LGBTQ communities. As Arrow (queer, non-binary, community member, 40s) pointed out in their interview:

> So, when police are saying, "Yeah, we treat everybody the same", what they're really saying is, "We don't understand equity", because they don't understand, well, nobody's the same at all. And I just think what that looks like in my lived experience. I think there's just so much variety in the different ways that a person can torture you when you're queer. There's just so much interesting variety for that person.

Similarly, Siobhan (clinician) said:

> There used to be discussions at work, "Everyone's the same, we treat everyone the same", which is actually not what is wanted in some ways. Like, it's more like, "No. I want you to understand what it means for me to be part of the community" and the highs and lows of that.

These findings demonstrate that the ways in which professionals understand DFV/IPV for LGBTQ communities have implications for how potential clients are directed to and treated within programs. Moreover, their views are not hidden but seen by potential clients and this in turn compounds barriers to seeking help.

Barriers to accessing services

So far, we have presented findings from interviews and focus groups to describe the ways in which clients and clinicians perceived and experienced the Surviving Abuse program, and explored the ways in which community members and professional stakeholders perceive and experience DFV/IPV in LGBTQ relationships. These accounts have highlighted the potential role that tailored programs might have for potential clients, but also the extensive barriers these clients face to accessing support. In this section, we discuss further

findings from all participant groups to elucidate the service access barriers and facilitators across client help-seeking and referral pathways, as well as the dynamics of client engagement with services.

Help-seeking

Throughout our reporting of the interview and focus group findings, we have noted that there are challenges at each stage of the client journey to accessing DFV/IPV interventions. The victim/survivor group client interviews demonstrated how victims/survivors may be hindered from appraising their situation as abuse, which makes it harder to seek an appropriate intervention. If this problem of perceiving abuse is overcome, there is a second barrier related to understanding services to be inclusive and safe to attend.

Arrow (queer, non-binary, community member, 40s) did not feel that the organisations they had previously had contact with were appropriate for their experiences and needs. Arrow explained their selection of a counsellor when younger and discussed what signalled an inclusive service:

> I was about 17 [years old] and I went … I didn't know how to find a service that would work for me. And I knew that I was probably like bisexual or gay, or something, so I went to a service that was run by a Baptist church. And I got as far as the waiting room, and then all the walls were covered in like really important Christian messages and everybody was really heterosexual. And I realised probably I wasn't gonna be a safe person in that service. So, even though I'd made the appointment, which was a big deal, I'd got there, which was massive, I was sitting there and I was ready to go but, before even anybody came out to say, you know, "Come in now", I just bailed because I just suddenly thought, "Probably I can't be vulnerable in this space."

For Arrow (queer, non-binary, community member, 40s), overt symbols of Christianity were synonymous with heteronormative ideals, and as such, they felt unsafe in any space associated with a Christian denomination. Given the association that some Christian denominations have with heteronormative and homophobic philosophies, and the lack of LGBTQ-inclusive imagery in the reception in which Arrow waited, it is probable that some other potential LGBTQ clients would also feel unsafe in comparable services.

Community-identified participants tended to view the wide range of relationship styles within LGBTQ communities as preventing an optimal therapeutic outcome. Deeksha (queer woman, community member, 20s) said that positive attitudes towards polyamorous relationships were needed within the helping professions to increase the opportunities for DFV/IPV to be appropriately managed:

> I don't know how you would frame this but I think something to do with negotiating alternative relationship styles or non-monogamy in a kind of healthy way would really help to kind of separate some of the, some of the really kind of positive aspects of that practice from some of the more manipulative ones that in my experience were really part of trying to do polyamory without any, without very much support.

Tammy (queer woman, community member, 20s) described her sense that potential clients avoided seeking help due to the fear that they inadvertently confirmed pejorative and discriminatory stereotypes directed at relationships within LGBTQ communities. She said:

> You don't wanna paint that picture because it might be used in inappropriate ways by media or by the broader society, or by you know, conservatives. And it can kind of fuel a fire that's already being used against us. So, I think that that's kind of an added layer that, that our community faces in speaking about violence, that we experience, is that we, that these people are our friends and our community, and in a context where we often feel isolated and socially ostracised.

Study participants across all cohorts described a series of additional challenges related to their gender and sexuality, and a lack of appropriate services to meet their particular needs. As highlighted above, for these participants it seems that understanding DFV/IPV behaviours within LGBTQ relationships was harder due to the heterosexual and cisgender face of domestic violence. Other hindrances include the perception of the relatively small size of the LGBTQ community. For example, Arrow (queer, non-binary, community member, 40s) wanted to talk about their

relationship with a counsellor, but their partner worked in the sector: "She said, 'You're poisoning all those workers against me' … so I was stuck." Other participants noted issues within their relationships and wanted to go to ACON or phone a helpline, such as QLife.[4] However, they knew professionals who worked for those services and they did not want to discuss their relationship with their peers. These accounts highlight some of the dilemmas facing LGBTQ people experiencing DFV/IPV when seeking support—specifically, weighing up accessing support from a targeted service but knowing the employees, or accessing support from a mainstream service and risking an unsatisfactory or harmful clinical encounter from service staff.

Client engagement

Focus group participants at the Pride of Place conference tended to see DFV/IPV within LGBTQ communities as a relevant issue. The lack of interventions and support for DFV/IPV for people within LGBTQ communities was identified to be a prominent service gap. These participants perceived the challenges in engaging clients to perpetrator programs to be manifold. First, work was needed to enable community members to be aware of abusive behaviours in their relationships. LGBTQ community members then also needed service responses that were safe and inclusive. Only one focus group participant described the work of mainstream organisations as "helpful", while most focus group participants tended to prefer the idea that DFV/IPV programs would be provided through a "self-determination" approach—that is, "by us, for us". While there were concerns about the viability of this strategy given that the "community is tiny", a lack of trust in mainstream services by LGBTQ community members also reinforced the prospect of "community-led groups" to be a more feasible option. For example, one focus group participant said:

> I'm really interested in whether we do it for ourselves or whether mainstream services do it. And I think there's lots of problems about us doing it for ourselves, in terms of being a small community and all that. But I think that trust with mainstream services is a real problem.

Professional participants suggested community awareness of the existence of DFV/IPV within LGBTQ communities is also needed. For Arrow (queer, non-binary, community member, 40s), the need to broaden representations of gender and sexual identities in DFV/IPV in public education campaigns was important. This was needed to presumably change the "face of domestic violence" but also increase the likelihood that LGBTQ community members would see the issue of DFV/IPV as their own, and the need for tertiary intervention as relevant. Arrow said:

> I wish in a way I'd had some kind of public messaging around, "Domestic violence can be like this for lesbian women." Just campaigning that had pictures of us in it so I knew, "Oh yeah, this is about us as well."

Community participants also doubted they would approach a service for a perpetrator intervention because these programs were seen as male and heteronormative. For example, Tucker (bisexual man, community member, 30s) said he was not able to access support as a male victim of DFV/IPV: "I was specifically looking for somewhere I could physically go and talk to someone about this. And it just did not exist." In addition, Hoda (queer woman, community member, 30s) said the way domestic violence was presented was "so heteronormative" that LGBTQ people would not even approach services for help. Finally, Tammy (queer woman, community member, 20s) said:

> I'd find it so much easier to engage in help-seeking if the domestic violence is to do with a man or in the context of a heterosexual relationship. Because, even off the top of my head, I can think of a bunch of services that I can go to just from government awareness campaigns, from friends, from like there being discourse and rhetoric around domestic violence. But, when we're talking about it in a same-sex relationship, it's like really difficult for me to even have an idea in my mind of what services there might be that would create the environment, the safety that I need in order to disclose.

Public awareness campaigns and media representations that focus solely on cisgender heterosexual experience were seen by LGBTQ community participants to not only obscure the identification of abusive behaviours within their relationships,

4 QLife is a national LGBTI peer support and referral service in Australia, funded by the Australian Government.

but also reduce their confidence that services would be able to effectively respond to their needs.

The disjuncture between LGBTQ identities and the way most services are presented (as heterosexual and cisgender) invites community members to assume they do not "fit" into those services. Negative prior experiences of mainstream systems can compound this sense that available support is not meant for them and will not be safe to attend. For example, Scout (queer, transgender woman, community member, 30s) said,

> As someone who doesn't identify with the gender I was assigned at birth and identifies as genderqueer and trans fem, like a men's behaviour change-type formal sort of program is just going to be completely like not useful at all or may, in fact, cause harm … which is not, not so much about like ideology or, or politics or anything but more about like reality of like policing and the criminal legal system have been sites of violence for me personally and many people. And they're not at all places that would, that I could necessarily go to in order to prevent or respond to harm or violence in my community.

Participants also talked at length about their reluctance to identify themselves as a victim of domestic violence. For example, when Asha (client, 20s) signed up for the victim/survivor program, she said,

> It was marketed as a domestic violence group and I remember going to the initial meeting with the facilitator [as part of the intake process] and I said, "I don't think this is a good fit for me", because there was no violence.

Indeed, clients of the Surviving Abuse program reported feeling that they were not an "appropriate client" as their "experience wasn't severe enough". Given the hostility that LGBTQ communities often face, it is not surprising that participants perceived disclosing DFV/IPV, in order to activate support, as risky, precisely because it involved being out to services. Professionals also reported feeling that LGBTQ people were not accessing support as they were worried that they would be "outed". Indeed, one counsellor suggested that presenting as an LGBTQ person experiencing DFV/IPV to a service involved a "double stigma" of identifying as a non-conforming gender or sexuality and the shame of DFV, both of which bring fear of being outed as well as fear of not being believed.

Referral pathways

In this section, we explore the role of professionals in directing potential clients to DFV/IPV perpetrator groups, and the ways in which the perceptions and experiences of professionals interact with this need. The representation, or public face, of services is important for clients who self-direct for support related to DFV/IPV. However, clinicians and professional stakeholder participants at RANSW noted that the majority of clients for the current mainstream perpetrator program, Taking Responsibility, came through formal referrals and mandates from child protection and family law courts. Professional participants in this study endorsed engaging perpetrators via the criminal justice system, but also had concerns that these pathways would create gaps for people who were affected by DFV/IPV but not seen by the courts. This is reflected in the account provided by one professional who had worked on perpetrator programs for people within LGBTQ communities. Before the program was formally accredited it received internal referrals:

> So it was an unfunded program from 2003 to about 2015 and I guess most of the referrals came from [a targeted service that provided counselling] and from within our pre-existing services. … That involved a little bit of informing the practitioners here that the group was gonna be running. We were really encouraging workers to ask their clients if they felt that this program was something that they were interested in. (Terrence, professional stakeholder)

Once the perpetrator program was accredited, a formalised referral process was put in place which helped the service populate the groups:

> Since I guess 2015 the majority of the referrals now come from external sources, so [partner contact is now] required, that's involved an unfunded and informal sort of campaign to go out and promote the program. … So we've had other community services, various courts sort of respondent workers at Magistrates Courts who are aware of our program, who sort of refer directly to us …

> meetings with police, corrections, you know, I guess doing presentations [about] how people can make referrals, and why it's important that queer men do come to our group, and the risks that are involved in queer men doing sort of family violence work in mainstream services. (Terrence, professional stakeholder)

It takes a significant period of time to establish a referral pathway for perpetrator programs—longer than was allowed for the planning of this study. Having applied this effort, which was thought to have taken 10 years, the LGBTQ perpetrator group worker interviewed as part of the professional stakeholder cohort asserted that his clients were a mixture of mandated and voluntary clients. In his opinion, they were working with a wide range of motivational levels which he thought to mirror the work he conducted in the "mainstream" groups. In reflecting on referral pathways which had worked, a group worker currently working on perpetrator programs said "advertising on Grindr and Facebook has been useful for us" (Terrence, professional stakeholder). Echoing earlier statements, Sian (police professional) spoke of accessing potential clients through a domestic violence liaison officer (DVLO):

> If you're attending a domestic violence situation, there's predominantly a perpetrator and a victim. So that's frontline policing. Nothing at all changes. From a behind-the-scenes perspective, [it's] a domestic violence liaison officer role, which is the supportive role.

However, the institutions that would implement any potential formal referral pathways also have workforce development needs that could affect the success of this process. Procedures and knowledge about referral pathways will not be effective unless implemented through skilled and sensitive professional practice. Moreover, the LGBTQ community and criminal and legal systems have a fraught relationship that should be factored into any future DFV/IPV initiatives. This was exemplified in accounts regarding the lack of trust between members of the LGBTQ community and the police. As Hoda (queer woman, community member, 30s) said:

> I think it's tricky especially for the LGBTQ community whose relationship with police is not necessarily, you know, there's not a lot of trust in the police because of, you know, the police have not always been on our side. And I think people really feel that. … I had friends who were like, "You should go to the police with this because, you know, get it, you can get an AVO [apprehended violence order]", or whatever, at the time. But not feeling like I wanted to go to the police because of not feeling like the police were gonna necessarily be on my side, not only because I'm queer but also because I'm black. So I would say that kind of those systems of oppression definitely impacted my ability to seek help.

Some study participants had doubts that issues of trust towards the police could be overcome in the short term. For example, Mustafa (queer, transgender man, community member, 40s) said:

> I think it's unlikely that community members will report anything to police, to begin with. Yeah. I don't, my experience has been that the police aren't the first port of call for people … also a lack of trust that the service will be appropriately trans-inclusive for trans women in particular but, you know, any variety of trans people. I mean I've supported a few people to go to the police and that's just always been a waste of time. I don't know if police take as seriously those experiences of DV that aren't physical assault. And I … also think it can be difficult for them to prosecute things that are very specific for our community, like intimidation and fear related to coming out or affirming gender, or friendship circles and things like that.

Indeed, one participant, Sian (police professional), felt that discrimination could be prevented through referral to a NSW Police gay and lesbian liaison officer. However, the clients on the waitlist for the perpetrator program as well as the DVLO interviewed perceived the allocation of NSW Police gay and lesbian liaison officers to be uneven and not available in many areas. These perceptions were reflected by other professionals, some of whom also shared their own experiences of stigma and discrimination from police officers and other services due to their sexual orientation. Echoing interviews with clients and community, professional participants perceived that services need to be overtly inclusive and diverse workforces need to be built to address the challenges of living in a society that is hostile to gender and sexual minorities. In thinking about why LGBTQ clients might prefer community-identified

professionals, one clinician said "they will feel understood" (Siobhan, clinician). For group workers, however, group work skills and the ability to manage therapeutic relationships with LGBTQ clients were a key factor:

> We had a conversation among the coordinators about whether the leaders need to be a part of the LGBTQ community. So that was a big conversation. And, if that's the case, how do we identify who is part of the community? … There were some strong views that it shouldn't matter … and whether we elevate that above group work skills. (Shona, clinician)

For another professional participant, the clinician's identity and group work practice needed to be considered alongside the risk of colluding with clients within perpetrator programs. In particular, having insider knowledge could potentially be a hindrance as well as a benefit:

> The nuts and bolts of the work is really the same as it is in mainstream groups, so the risk of colluding with men can be increased if you're a peer. (Terrence, professional stakeholder)

Terrence ultimately suggested that issues of possible collusion needed to be managed within the co-facilitator relationship, and in behaviours among group workers:

> There's also the risk that they will exclude the other facilitator, particularly if she is a woman [working in a men's group]. So you sort of have to behave in ways to invite them [the co-facilitator] into the group. But that happens in mainstream groups anyway, there's maybe just an additional layer of collusion here.

The community participants also reflected on the ways in which their understanding of DFV/IPV within LGBTQ communities affected their help-seeking behaviours. As highlighted in the previous section, interviewees described a wide range of barriers to viewing abusive behaviours as a form of domestic violence, including a lack of understanding about what constitutes DFV/IPV, not perceiving it to be relevant in LGBTQ relationships and being fearful of bringing negative attention to their community. These barriers seem to hinder help-seeking for these participants. As an example of the lack of help-seeking, one of the police professionals felt that LGBTQ people were not reporting DFV/IPV at the same rates as cisgender, heterosexual people:

> Compared to any heterosexual relationship or any other domestic violence relationship it's, I feel, it's not high. It's not higher than a heterosexual relationship. I personally feel it's under-reported. (Kurt, police professional)

When asked by the interviewer why they think DFV/IPV is under-reported by members of the LGBTQ community, Kurt said:

> There's obviously there's a stereotype that police won't understand the relationship. Police won't understand the situation. … There's usually a controlling factor or the controlling factor of threatening to out the other person. I've seen that a couple of times and that's the reason they haven't reported it. Or that they don't feel that they'll be treated right due to past stigmas or past interactions, or something like that.

This interview highlights the need for inclusivity training for professionals within formal services, which has the potential to reduce the risk of judgemental and punitive responses to members of the LGBTQ community who approach such services for support. They also highlight the need for services to promote themselves as inclusive, overtly welcome LGBTQ clients, and demonstrate an accepting, non-discriminatory approach. As one clinician noted:

> I think that people come into services and they are really hypervigilant around the intake process, the waiting room, you know, "Is this person gonna be okay with my sexuality?" A whole range of thoughts and feelings that people generally from the heterosexual communities don't even process, you know? And it can be something as simple as a rainbow sticker or a brochure, something that can immediately make someone feel safer; not necessarily safe but safer and hopeful that this may be a positive experience. (Tracey, group worker)

Professional participants in this study perceived DFV/IPV programs for LGBTQ communities to be missing. Furthermore, some professionals reported being frustrated by the lack of support services: "It's a gap and it's not okay." (Sharon, group worker) Later in her interview, Sharon

admitted to being overwhelmed at what it would take to get the programs off the ground, but also said she was committed to continue this process, stating, "I think step one is having the program. Step two is putting these programs on. Step three is patiently waiting for the uptake." She was also keen for RANSW and ACON to advocate for ongoing funding so that tailored programs for LGBTQ community members are offered as part of a standard portfolio of services, rather than as a time-limited trial.

The accounts from professionals and community members provide insider knowledge about the challenges faced in developing referral pathways to DFV/IPV programs for people within LGBTQ communities. These challenges can occur due to professionals' attitudes and behaviours and client mistrust of mainstream services. While previous sections provided examples of some benefits an LGBTQ client can experience at a mainstream service, there are also potential risks, which highlight the need for workforce development within allied services. Professional and community participants described a lack of referral pathways, compounded by the relatively small and close-knit nature of the LGBTQ community. Ultimately, the importance of providing safe, inclusive groups was a consistent message from participants, with questions of whether staff should be community-identified being secondary.

Discussion and conclusions

In this section we reflect on the process of locating and engaging clients in the program. We then proceed to compare our findings with previous research and assess the contribution our work has made to an understanding of providing DFV/IPV behaviour change programs for members of LGBTQ communities. The limitations of the study are discussed, and recommendations made for future policy and practice.

Locating and engaging clients

We found promoting the tailored programs, including locating and engaging clients, took longer than the 12–18 months allocated within this study. Indeed, the interviews with professional stakeholders who were group workers from successful programs revealed that a tailored perpetrator program with a new community can take up to 10 years to establish. At the 12-month stage, we had a small cohort of four potential clients for the perpetrator program. Three of these potential clients were interviewed as part of the study. However, establishing a victim/survivor program was achievable within the 18-month timeframe, and we were able to populate one group in the Sydney CBD within 6 months. This fell far short of the number of tailored programs initially proposed and extended time frames must be considered for the development and delivery of programs in the future.

Our experience indicates that establishing a tailored perpetrator program for LGBTQ communities requires extensive promotional activity over a long timeframe. While the victim/survivor program had slightly more success in recruiting participants, we only filled one group; similar barriers of trust and engagement affect both programs. Moreover, the success of promotional activities may be subject to broader political and social dynamics which have the potential to hinder and disrupt dissemination of information, as well as how the materials are perceived. We suggest that future programs factor in a longer timeframe for the establishment phase of tailored programs for LGBTQ communities. Moreover, it is advisable that more work is undertaken across agencies and sectors to raise the profile and awareness of DFV/IPV in LGBTQ relationships, and to determine how better to meet the needs of LGBTQ communities in accessing services and understanding DFV.

Comparisons with previous research

Consistent with findings from the Coral Project (Barnes & Donovan, 2016; Donovan et al., 2006; Donovan et al., 2014), the findings in this study highlight that DFV/IPV is perceived by both LGBTQ communities and broader stakeholders to be a heterosexual issue and members of LGBTQ communities experiencing DFV/IPV face additional difficulties in identifying abuse. Our findings support earlier findings that reported that lack of trust in mainstream services is a barrier to help-seeking (McNair & Bush, 2016; McNair et al., 2017; Turell, Herrmann, Hollan, & Galletly, 2012). We highlight the need to increase trust to support help-seeking among LGBTQ people, as well as improve community readiness to address DFV/IPV. Our study provides new information about how DFV/IPV may be minimised or excused due to the high levels of investment LGBTQ people have in protecting their communities. This dynamic of minimising DFV/IPV in order not to bring negative attention to the community appears to be underwritten by the experiences of LGBTQ individuals who experience distress associated with being in a minority group. In this case, protectiveness towards community reputation is heightened by the lived experience of stigma and discrimination, and fear of inviting increased hostility from the wider community. These findings add further substance to reports by Cruz (2003) about how minority stress provides a context for tensions faced by LGBTQ individuals in leaving an abusive relationship, between concern for being disloyal to the community on one hand and the need to speak out to stop the abuse on the other. Our findings are also consistent with previous research that found homophobia, transphobia and heterosexism isolate LGBTQ couples and prevent help-seeking in relation to DFV/IPV (Campo & Tayton, 2015). Moreover, this isolation as a minority group seems to interact with the heterosexual face of domestic violence to further hinder LGBTQ victims and perpetrators being "seen" (Guadalupe-Diaz & Jasinski, 2016). Indeed, the narratives presented here provide rich detail about participants' experiences and how isolation and lack of help-seeking occur through confusions around whether DFV/IPV is relevant to LGBTQ experience, protectiveness over community reputations and mistrust of non-LGBTQ services.

This study provides new information about the challenges of establishing tailored programs for people within LGBTQ communities—namely, that program promoters require significant timeframes to locate and engage clients. These challenges seem to be compounded by the "heterosexual face" of DFV/IPV, and media campaigns would be advised to include LGBTQ people in their representations of DFV/IPV. Work is also needed to establish referral pathways via professionals who come into contact with potential clients for perpetrator programs. These factors are worthy of consideration for future efforts to promote tailored programs. Our reflections on the use of survey instruments to measure change within tailored programs contribute new information for services wanting to develop and test their own programs for LGBTQ clients.

The findings from this study also support those from the Coral Project (Barnes & Donovan, 2016; Donovan et al., 2006; Donovan et al., 2014) that found professionals and clinicians have low levels of confidence in working with clients who identify as lesbian, gay, bisexual, transgender and/or queer. Professionals reported wanting more training to increase their knowledge and awareness of, and competence relating to, issues that affect LGBTQ people.

The differences and intersections of experience within LGBTQ communities warrant consideration in tailoring DFV/IPV programs. Understanding diversity of LGBTQ experiences and acknowledging discrimination and structural disadvantage within LGBTQ groups is critical in order to prevent a homogenous view of LGBTQ lives, and to sensitively navigate group dynamics. This includes but is not limited to taking account of transphobia, biphobia, and tensions between differing genders and ethnicities. Such issues of diversity triggered lengthy discussion among participants about how to collate group clients. This study provides new information about the preferences and fears of potential clients. Ultimately, members of LGBTQ communities interviewed for this study perceive the need for these programs as pressing and believe they should not be delayed for the sake of developing bespoke, separate cohort groups. Furthermore, given the value that clients and community members placed on community relationships and the emphasis from clients and clinicians on intervening within a safe space, promoting a sense of community could be a useful vehicle for managing differences between LGBTQ community members within tailored DFV/IPV programs.

Despite the challenges in accessing clients, our findings indicate that police and courts are potential referral pathways for people from LGBTQ communities to engage in tailored programs. The criminal justice system may in this sense provide an incentive or non-negotiable pathway for help-seeking. However, extensive workforce development is required to ensure that clinical and institutional encounters for LGBTQ people are helpful and not a cause of additional harm. Skilled and well-informed responses to LGBTQ people in all parts of the DFV and mainstream sectors would support trust-building to encourage word-of-mouth and self-referral. In interviews with professional stakeholders we heard the perpetrator programs underway in Victoria required nearly 10 years of promotion and interagency networking to establish a group for gay and bisexual men. Grindr and other apps and websites where community members seek out sexual encounters were mentioned as viable promotional forums. For the victims/survivors in our study, social media promotion and referrals by counsellors and psychologists proved to be robust pathways to services. As the literature review indicated, there are multiple barriers to LGBTQ people self-identifying as in need of DFV/IPV services either as perpetrators or victims/survivors, and further barriers to then feeling able to access services. This suggests that significant tailored promotion of DFV as a relevant and important concern for LGBTQ people, plus assisted pathways to services, are needed.

Previous literature has indicated that understanding DFV/IPV as predominantly an expression of rigid gender stereotypes, patriarchy and male privilege excludes LGBTQ experience (Wendt & Zannettino, 2015). From this perspective, cisgender men use violence to control and dominate cisgender women as part of socially and culturally sanctioned norms for masculine and feminine behaviours. This renders all but cisgender, heterosexual relationships invisible, making it difficult for people in LGBTQ relationships to understand their experience as DFV/IPV, or identify themselves as victims/survivors or perpetrators. For example, men found it hard to see themselves as victims, since this contradicts common representations of DFV/IPV in which women are the only victims/survivors of violence. In addition, women in same-sex

relationships found it hard to view their partner as abusive, given stereotypes of women as nurturing. The participants in this study who identified as transgender yearned for positive transgender male role models and described their challenges in adopting positive aspects of male identity and avoiding toxic masculinity. For non-binary and genderqueer participants, current domestic violence interventions seem inappropriate due to the cisgender paradigm commonly adopted. Future programs should integrate knowledge and interventions which allow clients to navigate their experiences of gender, including how these experiences relate to DFV/IPV and relationships. Failure to include such an approach has the potential to hinder client engagement and miss valuable opportunities to develop positive ways of relating that are connected to gender identities and roles.

Interviews with professionals and external stakeholders echoed many of the themes from the client/community cohort—in particular, that members of the LGBTQ community indicate high levels of stress due to historical and current experiences of discrimination and ostracism. Some clients and community members had experienced violence in their family of origin, including violence from relatives upon coming out, in addition to DFV/IPV in their adult relationships.

In contrast to a range of client and community accounts, professionals in some cases were less enthusiastic about the treatment LGBTQ communities had received from mainstream services. Interviews with police professionals provided some particularly sobering accounts of poor practice and lack of knowledge. Given potential clients who were directed to the tailored perpetrator program in this project had been referred by police or through the courts, it seems this referral pathway is not completely disrupted. We argue, however, that it is likely that effective and well-trained police would provide a safer, more robust pathway between DFV/IPV callouts and access to behaviour change responses, and reduce the likelihood that potential clients feel structurally abused by the process. Allied professionals perceived this lack of knowledge and training as leading to unhelpful reactions by police, and this may mean people at risk will not come forward for fear of an inappropriate and harmful institutional response. These data provide details about the ways in which professionals and clients perceive and experience encounters with mainstream service systems and how responses might be improved.

The LGBTQ community members we spoke to seemed to desire and urgently require safe and inclusive forums in which to consider their relationships, as well as desiring to build their skills for communication and conflict management and to develop ways of reducing abusive behaviours in affected relationships. Indeed, community-led, informal collectives have already embarked on this work, and mainstream services have the opportunity to learn from these initiatives in order to develop effective perpetrator interventions for LGBTQ communities.

Limitations

As noted earlier, the provision of the intended six tailored group programs did not occur, so the resulting clinical data set was much smaller than expected and related only to a single victim/survivor group. As such, the initial two research questions—1) Does a tailored DFV/IPV perpetrator program for LGBTQ clients achieve positive outcomes? and 2) How do clients perceive these interventions?—could not be answered. We see the low level of client referral and engagement in the groups as a finding in itself and share our experiences to guide others wishing to develop and implement tailored programs in the future. Since ACON and RANSW were not able to locate and engage sufficient clients for these groups during the research, we recommend that future projects allocate a longer timeframe for this task. The client survey results from the victim/survivor program are not generalisable and should be replicated in order to achieve findings. We therefore did not include these results in our findings but provided them in the appendices in order to describe our methods and the performance of the survey itself.

Promotion of the programs coincided with a significant event in Australia throughout the second half of 2017. The Australian Marriage Law Postal Survey led to a series of negative social media campaigns that denigrated same-sex couples and their families. ACON decided to withdraw promotion of the tailored programs to avoid the risk of messages about LGBTQ DFV/IPV being misconstrued or used to support

anti-marriage equality campaigns. It was thought that further associations between LGBTQ communities and DFV/IPV should be treated as sensitive and timed accordingly. This reinforced the notion that perpetrator and victim/survivor programs occur within social settings and that events like the Marriage Law Postal Survey have an impact on finding and engaging clients. Rather than cease promotional activities, we changed our strategies and conducted further in-service presentations rather than advertising through social media platforms. In this way, we tried to reach potential clients through service referrals rather than self-direction, with some, if minimal results.

This research was not resourced or designed to investigate separate experiences of diverse populations within LGBTQ communities. As such, we have only been able to draw limited conclusions about tensions or differences that should be addressed in delivering DFV/IPV programs to mixed LGBTQ groups. In particular we did not recruit any intersex-identified people to the study and cannot infer any findings for intersex people.

There is also a limit on the extent to which the overall findings of this research are transferable to other countries, and between regions within Australia. Future research would be wise to explore regional differences and how these impact on program provision and client preferences.

Despite these limitations, the qualitative findings make a substantive contribution to knowledge in this field and provide valuable insights to inform the development of future programs for LGBTQ communities. This study helps to fill the gap that exists within the scant Australian literature on LGBTQ peoples' perceptions and experiences of DFV/IPV, and the preferred modes of practice within perpetrator and victim/survivor groups. Indeed, through this project we have gathered the largest qualitative data set about these issues to date, and we expect many of the findings will resonate with the broader LGBTQ communities within NSW, throughout Australia and internationally.

Recommendations for policy and practice

Based on the findings from this research, there are significant challenges to locating LGBTQ clients and engaging them in tailored perpetrator programs. These challenges occur due to issues of low awareness of DFV/IPV in LGBTQ communities and predominantly cisgender, heterosexual media representations of DFV/IPV. There are also structural barriers to engaging LGBTQ clients, such as low levels of inclusivity training for service providers, a lack of knowledge and/or confidence about gender and sexuality, and a lack of referral pathways within the DFV/IPV workforce. As such, we make the following recommendations:

- Make LGBTQ inclusivity training required learning for all DFV/IPV sector staff, particularly those employed in specialised DFV/IPV roles.
- Advocate that inclusivity training be made mandatory within clinical organisations, and among police and legal professionals.
- Develop referral pathways into LGBTQ-friendly DFV/IPV programs for key professionals, such as court support workers and magistrates.
- Increase the representation of LGBTQ people in promotional material about DFV/IPV.
- Use social media platforms to increase DFV/IPV awareness in LGBTQ communities and use these channels to engage clients for future programs.
- Provide ongoing funding to develop, trial and implement tailored programs. Short funding cycles do not provide adequate time to populate groups within an under-developed community area.
- Ensure programs respond to diverse needs within mixed LGBTQ groups and manage transphobia and biphobia.

While the initial aims of this study were not entirely met, due to the limitations of the sample size as a result of challenges in recruiting clients to the tailored programs, this report provides findings based on the largest body of qualitative data internationally and within Australia to date about these issues. The insights emerging from our analysis could be used by practitioners, policymakers and funding bodies to improve services for LGBTQ people experiencing DFV/IPV and increase safety within communities.

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APPENDIX A

Program tailoring

In the section below, we outline the specific revisions made to each of the existing mainstream programs and describe the aims underlying the changes made. It should be noted that the perpetrator program for LGBTQ communities, which was based on RANSW's Taking Responsibility program, required more substantive changes than the program for victims/survivors. This is because the original program devotes significant content to unpacking cisgendered male privilege. However, many of the core concepts and activities from the Taking Responsibility manual remained unchanged as they were considered by RANSW's clinical team and ACON's staff to be relevant for both LGBTQ and non-LGBTQ communities. The exercises, including psychoeducational interventions and prompts for group discussion, aim to enhance perpetrators' sense of accountability, enable them to become aware of the effect of their behaviours on others and learn to practice more ethical and equitable relationship styles. The core content from the mainstream program that was retained in the tailored LGBTQ manual includes tactics of oppression, relationship ethics, communication skills, managing emotions, stages of change (see Prochaska & DiClemente, 1983), understanding cognitive behavioural approaches to change and developing relationship skills.

Modification was prioritised in two key ways:

1. incorporating theories and models applicable to LGBTQ experiences
2. changing language or exercises to reflect diversity relating to gender and/or sexuality.

Theories and models

The LGBTQ behaviour change program manual includes specific theories applicable to LGBTQ communities' experiences of minority status and oppression. These include the Minority Stress Model (Meyer, 1995, 2003), and revised theories of sex, gender, sexuality and intersectionality, such as Rosenblum's (1994) queer intersectionality, Sedgwick's (1990) works on queer theory and Foucault's (2001) writings on subjectivity and the self. These theorists look in different ways at how power operates through social roles and structures to oppress non-dominant identities, as well as at layers of compound disadvantage and the relationship of structural oppression to individual behaviour choices.

Language and exercise adjustments

The group work practice specialist at RANSW began the adaptation of the mainstream programs by changing pronouns throughout the program manuals. This involved removing pronouns that assumed the gender of participants and their partner/s, as well as other obvious gender indicators. For example, one session in the Taking Responsibility program was titled "What it means to be a man". In this case, the session title was changed to "What it means to be a good partner". In a second example, an activity in the Taking Responsibility program that was originally called "In her shoes" involved a worksheet with images typical of women's footwear, including high heels. The activity title was changed to "In their shoes" and included images of a variety of unisex shoe styles, such as sneakers.

After this initial process, the ACON DFV coordinator went through the manual and removed or changed all heteronormative and gendered assumptions whose removal/change could be made without changing the integrity of the program content. An example of this change in the Taking Responsibility program is a role-play activity where a participant (assumed male) acts out driving a car, while their partner (assumed female and played by another group participant) sits in the front seat, and a child (played by a third group participant) acts as a witness to the violence between the male and female characters from the back seat. This role-play was considered to be heteronormative with stereotypical gender roles being used, including the assumption that participants would have a child in their care. It was noted participants' children were brought into discussions as motivators for change in the original Taking Responsibility program. In the LGBTQ program, we extended the range of characters who acted as witnesses and external motivators for change to include children, family, friends and community to account for the many LGBTQ people who do not have children. As a result, the role-play was changed to a dinner party that the participants hosted with their partner. Additional program participants acted as their friends who were guests that witnessed violence in place of a child.

As a third step, another significant edit was undertaken with the creation of a set of LGBTQ strengths cards, as the original Taking Responsibility cards predominantly depicted images

of heterosexual men and fathers. The new LGBTQ-specific strengths cards depicted culturally relevant images such as the Sydney Gay and Lesbian Mardi Gras parade, rainbows, drag queens and same-sex couples holding hands. We also added strengths such as "pride", "diversity" and "resilience" with accompanying images that relate to the LGBTQ community and its experiences.

Taking Responsibility (for sexuality and gender diverse minorities) program manual

Group work program manuals at RANSW begin with an introductory section for facilitators. This provides theoretical and clinical information to explain the overall purpose of the intervention, the target population for the program and potential clinical presentations. Manuals also define a program logic and outline each session with estimated activity times, handouts and other resources. Alternative exercises are suggested for the facilitator to respond flexibly to clients' particular needs.

The introduction highlights the importance of establishing trust from participants, guiding the facilitator to:

- create a safe, respectful and honest environment
- allow participants to move at their own pace
- ask permission to explore certain avenues before doing so
- be sensitive to participants' feelings of shame and guilt
- be open and non-judgemental about participants' gender identity and sexuality
- establish pronouns in the first meeting
- work to get acknowledgement of the violence once communication is established.

The perpetrator program intake procedures are:

1. a telephone assessment as initial screening and intake
2. several face-to-face assessments with group leaders prior to commencement of the program
3. 18 sessions of the group program
4. a series of meetings before, during and after the group program with an individual counsellor, to independently assess the usefulness and application of learning from the program.

Revising the perpetrator program

There was a lack of consensus between professionals from RANSW and ACON about the best approach to titling the program, so "Taking Responsibility" has been used as a draft title for the purposes of the report. Initially, the two organisations generated the title "Pride in Change" as this was thought to resonate with the community and to foster a strengths-based approach to behaviour change without shame or stigma (while also not excusing or minimising the harms caused by DFV/IPV). However, after checking with ACON staff this was thought to be too close to another initiative (Pride in Diversity), and the title was abandoned. With the support of communications professionals at RANSW, a new set of titles were drafted. A final suggestion was "Riding Waves". When focus-tested with ACON staff, however, the feedback was that it conjured images of "beach and surfer dude" culture, which is indicative of heterosexuality and not inclusive of potential participants who were transgender, gender diverse or queer. The title was then put on hold and a plan was made to source a title using narratives from the first cohort of clients of the tailored program, which was not completed in the current project.

Session 1: What and why?

The first session focuses on setting the foundations for the group over the course of the program. This commences with the facilitation of a group agreement which aims to establish respectful communication within sessions and confidentiality, and requests that clients refrain from sexual/romantic relationships with other group participants until program completion. The session outline was modified to acknowledge LGBTQ identities and discrimination, with the aim of establishing a safe space and fostering group cohesion. This was done by inviting participants to reflect on their identities, while looking at the impact of discrimination on their relationships, communities and sense of self. For example, the activity "Who are we?" was inserted to invite

participants to consider the differences and similarities in identities, values and attitudes that are found within LGBTQ communities. Participants are then encouraged to reflect on their own identity and the messages they received both when they were growing up and in their current lives, including those from the media, government and their communities. It is anticipated that both these activities will act as a reference point throughout the program to support participants to become more aware of their own sense of self and identity, and those of others. These activities were designed with the intention that LGBTQ participants who may feel invisible in predominant heteronormative paradigms would be empowered, setting the scene for positive change.

Session 2: LGBTQ relationships, domestic violence and the experience of change

The focus in session 2 is on the exploration of DFV/IPV within LGBTQ communities, community-specific tactics of oppression, and inviting group members to think about their readiness to make changes in behaviour, using the "Stages of change" model (Prochaska & DiClemente, 1983). This model outlines five stages along the path to achieving new, more desired behaviours. First developed in the context of substance use, it explains behaviour change as a process that requires sustained effort, managing "triggers" and relapse, and having a tailored approach at each stage. It is now considered applicable to many different types of behaviour (for further information see Prochaska, Redding, & Evers, 2002).

The tailoring of this second session involved incorporating myths commonly held about LGBTQ relationships into general understandings of healthy relationships and experiences of abuse. For example, the session deconstructed myths surrounding LGBTQ relationships, such as:

- women are inherently non-violent, or are unlikely to cause injury
- men are naturally aggressive
- men want sex all the time
- the more butch or masculine-presenting partner is likely to be the abuser
- hormones make transgender men aggressive and transgender women irrational and volatile
- domestic violence does not exist in LGBTQ communities.

The myth cards included in the course pack are to be laid out on the floor one at a time with conversations focused on whether participants could relate to the myths described and the potential impacts of such myths. The negative outcomes of each myth are stated on the underside of each myth card.

The myth-busting exercises aim to raise awareness about DFV/IPV within the clients' relationships while alleviating the shame or stigma associated with having an identity that is under-represented. The content was informed by research evidence and practice experience which shows that myths about LGBTQ relations can prevent LGBTQ people from fully recognising or accepting DFV, and often act as a barrier to seeking help (Wendt & Zannettino, 2015). This session also explores tactics of violence which are unique to LGBTQ relationships, that include but are not limited to:

- withholding medication from a transgender partner
- publicly "outing" your partner
- using your partner's sexuality and gender against them.

This content is included with the aim of supporting clients to recognise covert and overt forms of power and control that can be used in LGBTQ relationships. Finally, the session draws on the Stages of change model (Prochaska & DiClemente, 1983) to mobilise previous experiences of change, such as "coming out", to help to motivate clients to maintain change processes particularly when this is challenging and distressing. The exercises in this session were selected to motivate client engagement and foster group cohesion and energy as part of preventing group attrition.

Sessions 3–5: The "build-up" process and using communication skills

Many of the activities in sessions 3–5 from Taking Responsibility were considered applicable to LGBTQ participants with only minor modifications, for example exercises on mindfulness, understanding the human brain and taking time out. However,

Table 2 "How could I have reacted?" activity

I was upset because	What was I thinking?	How did I respond?	What I expected from my partner?	How I could have reacted instead?
E.g. someone passed me on the street and called me a faggot.	E.g. it's unfair that I get called faggot in the street, I'm not safe.	I told them to "fuck off". Then told no one and later that night I had a fight with my partner.	I don't know what I expected but everything my partner did that night annoyed me.	I could have sat with my partner or a good friend and talked about how it made me feel. I could have taken time out to think about why I was in a bad mood.

one of the activities in Session 3 which was tailored for LGBTQ participants involved mapping the physical experience of anger in the body. In the Taking Responsibility program, participants are asked to draw their body on a large piece of paper and to hang it up. In the tailored version for LGBTQ participants we decided to focus on mapping internal parts of the body, such as the heartbeat, tightness of stomach and ability to swallow. This took into account practice-based knowledge of the sensitivities that can exist for some transgender and gender diverse people in the relationships they might have to their bodies. These sensitivities may mean that drawing and focusing on particular parts of the body could potentially be an uncomfortable or triggering experience.

In the original Taking Responsibility program, sessions 4–7 were all named "communication skills". Through the tailoring process we renamed the sessions to reflect a more specific focus on LGBTQ relationships. This left session 4 as "communication skills" followed by three sessions of "relationship skills" addressing LGBTQ issues, such as effects of minority stress or non-binary gender relationships. This allowed us to include LGBTQ content based on our knowledge of the target communities: ACON has more than 30 years of clinical service provision, group work and community engagement experience in the LGBTQ community. Over these decades, ACON has developed, trialled, tailored and evaluated many programs, using community feedback. Therefore, greater emphasis was placed on discussions about sex, consent and boundaries; the effects of minority stress on relationships; and relationship dynamics outside of traditional gender roles.

Session 6: Relationship skills (managing strong emotions)

This session explores the contributing factors of minority stress and trauma that are experienced by LGBTQ communities and impact a client's behaviours and relationships. The content in this session is designed to build upon the foundation knowledge included in the earlier sessions regarding DFV/IPV behaviours, awareness about identities, group cohesion and mobilisation of change factors. While minority stress and trauma are not thought to cause DFV/IPV, such experiences are positively associated with increased risk of both victimisation and perpetration (Balsam & Szymanski, 2005; Gehring & Vaske, 2017). Moreover, addressing experiences of minority stress can increase safety and help clients to manage strong emotions (Carvalho, Lewis, Derlega, Winstead, & Viggiano, 2011). Session 6 therefore explores the experience of minority stress and its associated impacts, including internalised homophobia, an inability to assert oneself, depression and anxiety.

As part of learning to manage strong emotions, the activity in the Taking Responsibility program called "Trigger points" gives clients the opportunity to reflect on what causes anger, how their thinking patterns have caused this emotional manifestation, their resultant behaviours and alternative ways of being. In the tailored program, this activity was repurposed using LGBTQ community-specific examples of causes of upset and anger, common thinking patterns that may follow and possible responses that could prevent their use of violence, as depicted in Table 2.

Session 7: Relationship skills (role-playing relational behaviours)

This session had minor amendments only and was renamed "relationship skills" (rather than "communication skills"). In the session, group participants enact interviews with an externalised entity called "argument"—the defensive and often aggressive voice in their head—to learn ways to calm the voice and interrupt its effects on behaviour. This is a

technique from narrative therapy (White & Epston, 1990) which supports individuals to separate themselves from the "problem" to work on their responses and increase their agency in changing their response. Jenkins (1990, 2009) has written on the use of this technique with men who use violence.

Session 8: Relationship skills (trust and respect)

This session invites clients to explore the qualities of trust and respect with the aim of assisting them to build positive relationships with their partners, family, friends and community. Such relationships may be currently constrained as a result of being socially constructed through expectations of gender roles and rules to regulate sexuality. Discussion and activities focus on the ability of people to make choices about who they are, how they present themselves and what they want from relationships.

It is recognised that sexual practices can be affected by dynamics and practices of power and control, and that sexual violence is a common tactic for gaining and maintaining power and control in an abusive relationship (Australia's National Research Organisation for Women's Safety, 2019; Stark, 2013). For this reason, it was important that the perpetrator program manual explore sex in abusive relationships.

We noted a lack of sexual content in the original Taking Responsibility manual and did not want to omit this topic here. Furthermore, mainstream services operate under the assumption that clients are cisgender, heterosexual, mono-sexual and monogamous, which can lead to LGBTQ people feeling uncomfortable or misunderstood (Australasian Sexual Health Association, 2015; Australian Human Rights Commission, 2015). With this in mind, the LGBTQ behaviour change manual aimed to create a safe space where sexual practices and boundaries could be explored and understood. An activity is included in this session, titled "Breaking away from gender rules", that aims to deconstruct myths that surround sex in LGBTQ relationships, including:

- all gay men should have anal sex
- the masculine person is the top (penetrative sexual partner)
- women want to take it slow.

This activity was also designed to enable discussion about how gender impacts DFV/IPV in LGBTQ relationships outside the gendered understanding of domestic violence between a man and a woman. In doing so, the activity aims to increase awareness of patriarchal and misogynistic attitudes that might be at play within LGBTQ dyads and provide opportunities to escape negative forms of masculinity and femininity that may inform aspects of the clients' relationships.

Session 9: What it means to be a good partner

In session 9, the section titled "What it means to be a man" was replaced with "What it means to be a good partner". The session invites clients to explore jealousy, any expectations they may have of their partners and relational behaviours through the concepts of sexual ethics (Carmody, 2003) and entitlement (Flood, 2013). This was thought to be particularly relevant for clients who may engage in casual sex, both overtly and covertly, and those in polyamorous or non-monogamous relationships, which are thought to occur at higher rates within LGBTQ relationships (Mooney-Somers, Deacon, Klinner, Richters, & Parkhill, 2017).

Sessions 10 and 11: Family of origin—Naming violence and breaking from its limiting effects

Sessions 10 and 11 invite clients to examine messages they received from their family of origin. In the program tailoring, we expanded these sessions to include a focus on rejection, family violence, ostracism, homophobia, biphobia, transphobia or intersex invisibility. For example, rejection by families resulting from homophobia and transphobia is thought to exacerbate the feeling of not belonging for many LGBT people (Robinson, Bansel, Denson, Ovenden, & Davies, 2014; Takács, 2006). Additionally, rejection from families of origin is thought to contribute to high rates of youth homelessness in Australia, with estimates suggesting that a quarter of the 20,000 homeless young people in NSW identify as gay or lesbian (Australian Human Rights Commission, 2014). Moreover, family rejection is thought to contribute to lower rates of health and wellbeing among LGBTQ people (Buller, Devries, Howard, & Bacchus, 2014; Gillum & DiFulvio, 2014; Li, Baker, Korostyshevskiy, Slack, &

Plankey, 2012; Roberts, Rosario, Corliss, Koenen, & Austin, 2012). As such, it was imperative to include sections in the LGBTQ behaviour change manual that addressed the impact of dynamics within families of origin. This includes the impact of participants' own experiences of family violence and/or homophobia and transphobia while growing up, with the aim of raising awareness of the exacerbating effect that such trauma can have on their use of violent behaviours in adulthood. Explicitly discussing families of origin also enables recognition of clients' chosen family, and an exploration of violence-supporting attitudes or messages that may be present in these relationships.

Session 12: Maintaining change

The aim of this session is to shift the focus to the future and learn from previous behavioural patterns. As the program continues, clients will explore ways they can maintain changes and build on positive relationship skills development. In this session, clients are invited to explore notions of reputation within small communities, including the potential that they face repercussions from the community for their use of violence, managing to live in small communities with their current or ex-partner/s, and feelings of guilt and shame once they have recognised and acknowledged their use of violence.

The audio-visual materials for this session were drawn from the ACON library, including a documentary series produced by ACON that provides positive representations of the diverse range of relationships that exist within LGBTQ communities. The series presents eight NSW-based, LGBTQ-identifying people who describe their relationships, including what works for them, the challenges they face and how they overcome these challenges. Such audio-visual materials are used with the aim of inspiring discussion and broadening the visualisations that clients hold about what constitutes a positive relationship and how to avoid the barriers to respectful relationships.

Session 13: Changing unhelpful thinking habits

Session 13 required little adaptation from the original Taking Responsibility program manual besides adjusting the content to incorporate inclusive language. This is because this session primarily involves universal cognitive behaviour therapy and empathy-building exercises where the participants role-play what their current or former partner/s would say about them and their use of violence. Participants are prompted to:

- distinguish between fact and interpretation
- identify their habitual ways of viewing their partners
- identify how our behaviour is seen by others, including blind spots.

The main adaptation for this session involved the development of a set of LGBTQ strength cards that are used in the closing sessions of the program. The generic cards used in the Taking Responsibility program showed images of men with their children or men and women as couples, and were not inclusive of LGBTQ people. As noted earlier, the LGBTQ cards that were developed for this program included images of pride parades and positive depictions of gender diverse people, same-sex couples, and gay icons such as drag queens.

Session 14: Developing a different story about who you want to be

Session 14 retained the core message of "developing a different story about you and who you want to be". However, the resources to be used in this session were changed. For example, the Taking Responsibility program uses a DVD that depicts heterosexual men and domestic violence. In the revised LGBTQ version, video clips were inserted from two well-known television series: *Queer As Folk* and *The L Word*. These video clips were included as a visual representation of same-sex relationships where unhealthy patterns of control were evident. Beyond it being validating to see same-sex relationships in mainstream media, the facilitators could also point out patterns of control and invite a consideration of how these depictions might reinforce unhealthy relationship behaviours for some participants, based on Gerbner's cultivation theory (Gerbner & Gross, 1976).[1] Additionally, both segments are from popular TV

1 Gerbner and Gross argue that television supports the cultivation of certain social realities in order to "legitimize action along socially functional and conventionally acceptable lines" (1979, p. 176). In other words, "the world of TV" (p. 182) encourages people to adopt particular assumptions about the world and norms of behaviour.

series likely to have already been viewed by participants, allowing the group to share their understanding of how the relationships progress across the seasons of each show. The intention was to support robust discussions around healthy and unhealthy patterns of relating, including:

- which characters and relationships were popular and why
- who participants related to most
- whether the characters were role models and why
- if and how participants may have compared or modelled their behaviours on other media personalities or TV characters
- how certain stereotypes were glorified
- whether or not they perceived any dynamics in the character's relationships as unhealthy when they first watched the series (if they had seen it before)
- any expectations that the characters have of their partners and how realistic or unrealistic these are.

Another activity is also included in this session that builds on the theme of session 13 regarding the difference between fact and personal interpretation. Participants are supported to look at alternative ways to interpret and respond to their partner's behaviour. This is to counter their initial descriptions of what they believe led them to use violence. Facilitators challenge the participants' assumptions by listening for and highlighting aspects of their description that reveal a different story of their partner's behaviour, and how the participant responded. The key messages in this activity are based on narrative therapy frameworks (Jenkins, 1990; White & Epston, 1990) where common life patterns are defined as "dominant stories" that can be reviewed and changed. That is, people's identities and the meanings they make about themselves and other people are produced through stories, stereotypes and myths in our society. When these stories become "taken for granted" and assumed to be reality they can hide underlying assumptions, biases and prejudices, becoming dominant explanations or ways of interpreting experience. For example, dominant stories have been used in our society to create specific ideas about gender identities—that is, that there are particular ways of being a man or a woman. If dominant stories remain unquestioned, they can contribute to DFV/IPV by limiting the options people perceive are available to them for stopping their violence, and perpetuating relationship problems. The challenge, from a narrative therapy perspective, is to develop alternative stories that reflect how you wish your life to be defined (Jenkins, 1990). The activity on dominant stories used in the original Taking Responsibility program showed comparisons between boss/worker and men/women. In the tailored version the examples used reflected gay/straight and cisgender/transgender situations.

Session 15:
Defining and developing trust

This session is focused on defining and developing trust in relationships. There was little modification required other than the use of inclusive language, as the session utilises universal cognitive behaviour therapy and empathy approaches to encourage participants to:

- have an understanding of the importance of trust in relationships
- begin to understand how to develop trust
- take responsibility for past and present thoughts and behaviours.

Session 16:
Acknowledging the past

This session is focused on acknowledging the impact of past behaviours. As with previous sessions that utilise universal cognitive behaviour therapy and empathy approaches, little modification was required other than inclusive language. In this session participants were encouraged to:

- understand their partners' viewpoint of the abuse
- gain insight into their partners' experience of the abuse
- acknowledge that the past will continue to live on in the present.

The program manual notes highlight the importance of facilitators being mindful of the extra burden that shame and negative past experiences can have for LGBTQ people and the impact this might have on exercises designed to assist participants to acknowledge their past. This session is a good example of why it is important to have community-identified facilitators of LGBTQ behaviour change programs with lived experience as opposed to non-community identified facilitators who only perceive LGBTQ experiences.

Session 17:
Making use of new knowledge

This session is focused on reinforcing new knowledge gained in the program, with the aim of encouraging participants to put readiness for change into action. As with sessions 13—16, the session utilises universal cognitive behaviour therapy and empathy approaches and required little modification other than the use of inclusive language.

Session 18:
Wrapping up

This final session is a chance to debrief and reflect on progress made by participants both during the course and in the rest of their lives as a result of the course. It is also a chance to celebrate the participants' commitment to the program and to ongoing growth and change.

Surviving Abuse (LGBTQ victims/ survivors) program manual

The 8-week group program for LGBTQ victims/survivors was based on the RANSW program, Women: Choice and Change, designed for women who have experienced DFV/IPV. As with the perpetrator program, tailoring this program involved ACON and RANSW staff collaborating to remove content that was potentially misgendering and heteronormative. In addition, community-appropriate exercises, resources and language were integrated throughout.

Core program content

The minimum number of clients for this program is six people, with the ideal size being between 8–12 participants. In addition to risk assessment and safety planning as a core part of the intervention, the aim of the program is to provide participants with:

- increased understanding of self and others
- strategies to enhance self-esteem and self-confidence
- increased knowledge about relationship styles and communication skills
- expanded choices for self and future relationships.

Key topics from the original Women: Choice and Change program include:

- understanding the impact of family violence
- grief and loss
- communication and conflict resolution
- stress management
- self-esteem
- equality in relationships (Relationships Australia NSW, 2019).

Much of the core content from the original program was retained for the tailored Surviving Abuse program, including material on:

- setting boundaries
- increasing knowledge about domestic violence and the cycle of violence
- relationship and communication skills
- safety planning, self-esteem and self-efficacy
- social networks and cohesion
- assisting people in finding appropriate referral pathways
- grief and loss associated with relationship breakdown.

The sessions incorporate psychoeducation, group discussion and trust-building exercises. Both the original Women: Choice and Change and the tailored Surviving Abuse program manuals focus on healthy relationships with a view to enabling clients to increase agency and shape future relationships in positive ways.

Revising the victim/survivor program

As part of revising the victim/survivor program, there was a lot of discussion about the proposed program title—Blue Skies: Surviving Abuse. The figurative title was developed by RANSW and tested by ACON staff who identify as members of the LGBTQ community. The feedback from ACON staff was that the proposed title did not have meaning for them and was not likely to gain recognition in their communities. A final decision was made to use the shortened title Surviving Abuse as it reflects a strengths-based approach and supports the vision of a life without violence.

As with the tailoring of the perpetrator program, the RANSW and ACON program designers included information and materials on LGBTQ identities, including how LGBTQ identities might intersect with experiences of DFV/IPV in relationships and how DFV/IPV can be experienced by LGBTQ people. As part of this approach, tailored exercises were largely aimed at promoting discussion about the shared and disparate marginalisation and stigma commonly experienced by people in LGBTQ communities (Meyer, 1995, 2003). These group activities were designed to foster safety and support between clients.

Session 1: Welcome and introductions

Following the establishment of group process, when agreements are set and an overview of the program is provided, we included an introductory discussion where clients were invited to explore the diverse range of LGBTQ identities and relationships that exist both within the group and more broadly in the LGBTQ community. In the discussion, attention is paid to discrimination and internalised homophobia experienced by LGBTQ people. These experiences are then unpacked based on the assumption that they have a role in hindering help-seeking and recovery for LGBTQ people who have experienced DFV/IPV. Survival and resilience are used as concepts to mobilise clients' existing strengths with the aim of re-framing experiences of victimisation to be viewed as resources that clients can draw on to overcome adversity. The session closes by exploring the clients' strengths and other positive coping mechanisms for future experiences.

Session 2: Power, control and growing through separation

This session invites clients to explore the impacts of heterosexism, discrimination and heteronormativity on their identity, sense of self and relationships. To support clients to discuss the effect that homophobia, transphobia and/or biphobia have had on their relationships, Riddle's homophobia scale (1995) is included as an exercise in the session. The scale has 12 items describing attitudes towards LGBTQ communities on a continuum from most homophobic to most positive. Clients are asked to apply this scale to their experiences of high school, family and extended family, community groups (sports club, church, art class), last workplace, current workplace and/or the government. By including resources that speak to LGBTQ experiences this session aims to foster a stronger sense of self and belonging among clients.

As with the original Women: Choice and Change program, clients are invited to explore what makes a positive and respectful relationship. In the tailored program the facilitators utilise their knowledge of the ways in which DFV/IPV can present and be experienced within LGBTQ relationships to support the discussion. This exercise is designed to enable discussion among clients about domestic violence, including the unique tactics of oppression and potential power differences found in LGBTQ relationships. To support this, the session includes an adaptation of the Duluth power and control wheel. The LGBTQ victim/survivor manual maintains the inclusion of the traditional power and control wheel, as this is thought to be applicable and relevant to all communities.

Session 3: Relationships and communication

This session in the Women: Choice and Change program focuses on beliefs about relationships and the historic patterns that sometimes occur within them. Towards the end of the session, participants clarify what is important for them in their relationships, the stages involved in relationships and how their expectations can be achieved. This content was not tailored significantly due to perceived universality of effective communication, styles of healthy relating, boundaries and saying no. The only changes made to this session were the removal of gendered pronouns and addition of visual aids we called "LGBTQ strengths cards" (visual representations of empowerment and strengths designed to trigger group discussion about goals for each client, described previously in this report).

Session 4: Feelings, healing and self-care

In the original Women: Choice and Change program, the focus for this session was on self-awareness, self-talk, self-esteem and self-care. In the tailored version, information about the internal effects of homophobia, biphobia and transphobia were also added.

Research shows that internalised homophobia, biphobia and transphobia are associated with dysfunctional relationship styles (Frost & Meyer, 2009). Specifically, anxiety, shame and self-loathing are associated with the internalisation of phobias and are likely to manifest as negative behaviours in intimate relationships (Coleman, Rosser, & Strapko, 1992). Experiencing these negative emotions is also associated with reduced relationship satisfaction. Based on this evidence, the exercises in this session attempt to address the impact of internalised phobias on clients by raising awareness of negative emotions and their associated behaviours. Key discussion points in the session include:

- internalised attitudes of "homo/trans/biphobic":
  - denial
  - self-hatred
  - self-pity
  - resignation
- internalised attitudes of "dealing with phobia":
  - self-acceptance
  - self-love
  - support
- internalised attitudes of "transcending phobia":
  - pride
  - celebration.

Content on homophobia, biphobia and transphobia was drawn from the training manual developed by Miller and Mahamati (2000). Miller and Mahamati's Scale of Internalised Homophobic Attitudes was manualised in the following way:

> This shows what happens when an LGBTQ individual, brought up in a homophobic world, takes on board all the messages heard over many years. In this model the scale ranges from denial, self-hatred, self-pity and resignation, to self-acceptance and self-love, to supportiveness, pride and celebration. With this, it is possible to place one's self on and think about what might cause a shift up and down the scale, trying to avoid the life-denying stages of denial, self-hatred, self-pity and resignation. It helps you ascertain what you need in order to make the move in a positive direction. For example, perhaps a really positive interaction with an LGBTQ-person support group or individual friendships could foster a feeling of pride and supportiveness, where a hostile homo/trans/biphobic work atmosphere could put one down to the point of resignation.

In the original mainstream program, the session finishes with an exercise where clients reframe a pertinent stereotype to fit their experience. This closing exercise is designed to leave the clients feeling more positive and hopeful, having challenged a negative stereotype. The importance of leaving this exercise in the LGBTQ version of the program was to help combat any shame felt by individuals as a result of their abusive relationship or being the victim of gender and/or sexuality-based discrimination.

Session 5: Self-worth and self-care

In the original mainstream program, this session is focused on the social and emotional costs of violence on women and children within society in general. However, since evidence suggests high rates of mental health and suicidality in LGBTQ communities (Carman, Corboz, & Dowsett, 2012), it was felt to be important to narrow this focus to individual mental health and wellbeing.

Session 6: Rights and responsibilities

The focus for this session is on experiences of grief and loss, as well as rights and safety planning. Minimal changes were made to the original session for LGBTQ participants as these issues were thought to be universal. However, handouts were added for some LGBTQ specialist support options. Safe options for pets were thought to be necessary and appropriate to include for people from LGBTQ communities. Extra information specific to gender transition medications or collecting HIV medication was also added—for example, developing plans for collecting hormones as they are usually picked up from the same pharmacist on a regular cycle.

Session 7: Networking and safety planning

After exploring positive relationships and ethical communication skills earlier in the program, attention is

turned towards safety planning in the final sessions. The focus in the seventh session is on supporting LGBTQ people to connect with services that are known to be inclusive of LGBTQ victims/survivors. Client safety and empowerment is increased by providing information about support available from LGBTQ organisations. A NSW Police gay and lesbian liaison officer can be invited to present at this session and to attend to questions and concerns from participants related to reporting experiences of abuse and violence to police and the justice system. As our State of knowledge review found, LGBTQ people are known to face additional barriers to help-seeking, with very low reporting rates to police for domestic violence in LGBTQ relationships (Gay and Lesbian Health Victoria, 2015, p. 27).

Session 8: Choice and change

As with the original program, this session focuses on revision, review and celebration. Key concepts from the program are summarised and clients are invited to reflect on their own learning and share a review of their progress. There is recognition and celebration of individual achievements, and a final summing up of what people believe they will take forward.

APPENDIX B

Promotional strategies to recruit program participants

These strategies were used to promote both the perpetrator and the victim/survivor programs.

Date	Promotional strategy
2016	
12 May	First flyer emailed to 700 professionals via the ACON DFV coordinator database
26 May	Factsheet for referrals sent to 750 professionals via an updated ACON DFV coordinator database and including additional names provided by staff
13 June	ACON LGBTIQ DFV landing page launched
13 June	Flyer emailed to promote a community information night at ACON via the ACON DFV coordinator database
20 June	Community information event held at ACON (Surry Hills, Sydney) with 40 attendees
28 July	Second version of the perpetrator program flyer emailed to 800 professionals via the ACON DFV coordinator database
11 August	New perpetrator flyer emailed to LGBTIQ-friendly GPs/medical services
22 August	Letters mailed to Chief Magistrate of NSW and to Legal Aid seeking promotional support and input regarding the feasibility of the study
4 October	Information event held at ACON (Hunter), with two local services in attendance
23 November	Flyers for victims/survivors and perpetrators mailed to 17 services, including six local police area commands: Surry Hills, Kings Cross, Parramatta, Wollongong, Newcastle, and Redfern
28 November	Presentation given at the Illawarra Family Law Pathways information night; presentation given at the Men's Behaviour Change Network meeting (Sydney)
2017	
22 August	Presentation given to the NSW Police gay and lesbian liaison officers and domestic violence liaison officers at Parramatta Area Command; six police professionals in attendance
31 August	Presentation given at the Inner City Legal Centre which provides specialist advice and court support to LGBTQ people experiencing DFV/IPV; CEO and frontline staff in attendance
13 September	Presentation given to Justice Advocacy (Sydney); CEO and frontline staff in attendance, who subsequently promoted the groups through their networks
18 September	Individual briefings provided to Family Law Court (Sydney) solicitors, court support workers, referral officers, magistrates and men's support workers

Date	Promotional strategy
25 September	Presentation given at Women's Justice (Sydney), an advocacy organisation that aims to highlight the needs of incarcerated women
11 October	Presentation given at the RANSW clinical meeting (Hunter)
18 October	Presentation given at the RANSW clinical meeting (Illawarra)
25 October	Presentation given at the RANSW clinical meeting (Sydney)
1 November	Presentation given to counsellors and therapists at Uniting (Sydney)
2018	
10 January	Information packs mailed to Director of Public Prosecutions, Aboriginal Legal Service, Legal Aid and individual magistrates in Parramatta
12 February	Presentation given to RANSW clinical staff to boost referrals

APPENDIX C

Tailored victim/ survivor program survey results

The information presented in this section relates to the feasibility and process of conducting pre-and post-intervention surveys using selected scales. As the sample was too small, results are not conclusive or generalisable. However, our analysis of responses is used to illustrate feasibility, alongside other reflections on the process of conducting the surveys. As the tailored perpetrator program originally planned as part of the project was not conducted, the analysis relates to the single victim/survivor client group only. The validated scales are explained in the Data collection section of the body of the report. We invite other service-based researchers to replicate this survey to work towards developing optimal evaluation methods for future tailored programs.

Survey response rates

Pre-intervention

At the pre-intervention stage (time 1), the research team collected nine surveys from 10 clients. The completion of the surveys by clients took longer than both the researchers and group facilitators had allocated at the beginning of the group and we recommend shortening the surveys for future programs by eliminating some of the scales.

Post-intervention

At program completion (time 2), we gathered four complete responses. Using unique identifiers, we were able to match the post-intervention responses with pre-intervention responses. It is important to note that one person provided a first and third survey only, and two participants provided all three responses. At the 3-month stage (time 3), follow-up surveys were mailed to participants, and two participants returned their responses. We did not receive responses at the 6-month time point (time 4).

Pre- and post-intervention survey responses

Gender equity

Overall, survey respondents reported high or very high support for equity between men and women prior to the program and at subsequent time points. However, one participant indicated medium support for gender equity, agreeing that men made better politicians than women, there was no longer discrimination against women within the Australian workforce, and men should take control of relationships and be head of the household. Compared to the baseline responses, the participants' responses indicated high scores in support of equity between genders at the end of the program and at the 3-month follow-up time point. As such, these clients reported high support for gender equity, and this did not change over the 3-month period.

While the majority of this small sample of victims/survivors supported gender equity, the single exception demonstrates an alternative position. We recommend retaining the gender equity scale in future evaluations of DFV/IPV programs, as this suggests there may be differing levels of support for gender equity among LGBTQ clients and these views are likely to affect relationship dynamics and the use of violence.

Self-esteem

At the pre-intervention stage, responses to the self-esteem scale were varied and were categorised between moderate and high. Compared to cisgender, heterosexual clients of the mainstream victim/survivor group, these respondents indicate slightly higher levels of self-esteem (Gray, Broady, & Hamer, 2019). The levels of self-esteem were also higher than we hypothesised for this cohort, as we anticipated self-esteem to be negatively affected by both DFV/IPV victimisation and the lived experience of being part of a sexuality and gender diverse minority. However, it is possible that being part of an identified community, and benefiting from the protective factors that relationships within these communities enable, might counteract some of the negative consequences of marginalisation. The four respondents to

the post-intervention surveys had self-esteem scores that were categorised as moderately high to high at all three time points. These clients seem to have had positive levels of self-esteem and this did not change across the time points.

While these results require replication, given the relatively high levels of self-esteem identified among respondents, we suggest that tracking self-esteem scores for clients from the LGBTQ communities is not a priority. Rather, this scale could be eliminated in favour of other outcome indicators. However, future studies would be advised to test the idea of community as a protective buffer to the detrimental impact of marginalisation on self-esteem, potentially using the Rosenberg self-esteem scale as part of the design.

Social support

Participant responses to the Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet, & Farley, 1988; Zimet, Powell, Farley, Werkman, & Berkoff, 1990) were more varied, with responses ranging from low to high levels of isolation at the first time point. These responses are in contrast to the scores reported in the client responses to the mainstream victim/survivor group at RANSW, which indicated high levels of isolation and low levels of social support (Gray et al., 2019). When exploring these issues in the client interviews it seems that isolation emanating from abandonment or ostracism from their family of origin is common for clients of the tailored programs, but this seems to be counteracted by strong social networks emanating from peers and chosen family. These responses are consistent with qualitative interview accounts from the community participants about the protective factors that arise from the strength of LGBTQ community connections and benefits that emanate from being a community member. However, there did not appear to be differences, based on age, sexuality or gender, in social isolation or social support between clients who responded to the survey.

At the post-intervention stage, scores relating to levels of social support remained high immediately post-intervention and at the 3-month follow-up. As such, clients who completed post-intervention surveys appear to have maintained high levels of social contact, and the single respondent who provided responses at all three time points indicated slight improvements at each time. While these results require replication, we suggest that given the relatively high levels of social support and minimal change identified in these, tracking social support and social isolation for clients from the LGBTQ communities is not a priority and this scale could be eliminated in favour of other outcome indicators.

Psychological distress

Similar to findings from the mainstream victim/survivor groups at RANSW (Gray et al., 2019), the Surviving Abuse clients reported high levels of psychological distress prior to the program. Indeed, all but two respondents reported very high levels of distress. Therefore, respondents attending the tailored victim/survivor group had similar levels of distress to their cisgender, heterosexual counterparts. What is unclear, however, is the extent to which this distress was connected to DFV/IPV victimisation or to being non-heterosexual, non-cisgender or both. Despite having good social support, the Surviving Abuse participants appeared to be manifesting distress at the outset of the group program. These results support recent local, community-wide data which reports on the high levels of distress among women within LBTQ communities (Mooney-Somers et al., 2017).

Compared to baseline scores, the four clients who provided follow-up responses indicated slight improvements in their distress levels at program completion. At the 3-month stage, however, the three clients who provided responses reported that their distress levels were slightly higher again. Compared to our cisgender, heterosexual client cohort, these clients experienced only slight improvements to psychological distress levels, and for some these slightly worsened over time. We had expected to see greater improvements to psychological distress for the clients of the tailored program. However, interview findings also suggested that trauma is a factor that contributes to psychological distress among LGBTQ communities, but our survey did not include a trauma scale. Future research would be advised to track psychological distress over time and examine the relationship between psychological distress scores and trauma manifestations.

"Outness", internalised homonegativity and perceived stigma

As noted above, previous research has highlighted the detrimental impact of minority stress on members of LGBTQ communities (Rollè et al., 2018). Based on this research, we included scales that measured outness and levels of internalised stigma and homonegativity among Surviving Abuse clients. We note, however, that this research is in its infancy, both within this study and more broadly, and we do not have a comparison group. Having said this, the participants reported varied scores relating to minority stress prior to the program. In addition, levels of outness were high and levels of internalised homo/biphobia were low. Respondents provided low scores for the extent to which they had internalised social stigma. In all, respondents' scores relating to minority stress were lower than expected, meaning they were not as negatively affected by minority stress as we originally hypothesised.

At the post-intervention stage, we noted that measures relating to levels of outness indicated the greatest shifts, with almost all the respondents reporting slightly higher levels of outness compared to the baseline. This shift continued to increase at the 3-month time point. The respondents who provided all three survey responses reported the greatest shift (baseline, conclusion of program and 3 months post-program). These clients also reported slightly increasing levels of psychological distress. As such, it is possible that increasing outness can be associated with high distress levels, and future research would be advised to replicate this survey and test the correlation between these two variables.

Most of the respondents reported low levels of the need for privacy. Scores were similar across the survey time points, with the exception of one respondent whose need for privacy slightly lowered and another respondent who indicated a slightly higher need for privacy at each time point. Almost all respondents reported low levels of internalised homonegativity, and these scores remained the same or slightly improved across their follow-up time points. Respondents tended to report low levels of perceived stigma that were consistent across the time points. There is only one exception: the respondents who provided three surveys indicated slight improvements in their perceived stigma levels at the third time point, as their responses were categorised as medium-low at baseline and low at the 3-month time point.

Working Alliance Inventory

Scores on the three domains for this scale were positive and respondents reported that they found the conduct of the professionals was always respectful and non-judgemental. All the scores were very high, except for lower scores for the goal alignment domain, which suggests a slight improvement could be made in collaborative goal-setting with clients.

Client satisfaction

Respondents reported that the program had met their expectations and was very useful. The scores on this survey indicate very high levels of satisfaction with the program. This is similar to responses reported for the cisgender, heterosexual mainstream program (Gray et al., 2019), in which clients reported strong satisfaction with the service and felt it had been helpful to them.

APPENDIX D

Surviving Abuse pre-group survey

These surveys are confidential, but we want to match your initial responses with your follow-up responses to make better comparisons. The following questions will help us match your surveys without being able to personally identify you.

What is the first letter of your mother's name? _____

How many older siblings do you have? _____

In which month were you born? _____

Gender

What is your current gender identity? (Please tick all that apply)	What gender were you assigned at birth:
Male ☐	Male ☐
Female ☐	Female ☐
Non-binary ☐	
Different identity (please state) ☐	

Sexual Orientation

Do you consider yourself to be:

- Lesbian, gay or homosexual ☐
- Straight or heterosexual ☐
- Bisexual ☐
- Queer ☐
- Different identity (please state) ☐

Intersex Status

Are you intersex?

- Yes ☐
- No ☐
- Prefer not to say ☐

Please also indicate the gender and sexuality of your partner/former partner

Gender

What is your current gender identity? (Please tick all that apply)

- Male ☐
- Female ☐
- Non-binary ☐
- Different identity (please state) ☐

What gender were you assigned at birth:

- Male ☐
- Female ☐

Sexual Orientation

Do you consider yourself to be:

- Lesbian, gay or homosexual ☐
- Straight or heterosexual ☐
- Bisexual ☐
- Queer ☐
- Different identity (please state) ☐

Intersex Status

Are you intersex?

- Yes ☐
- No ☐
- Prefer not to say ☐

Demographics

What year were you born? .....

Do you identify as being from a culturally and linguistically diverse background? Yes/no

If yes, please specify: .....

Do you identify as being Aboriginal or Torres Strait Islander? Yes-Aboriginal/yes-Torres Strait Islander/no/both

Have you any dependent children? (Please circle) Yes/no

If yes, how many? .....

What is your personal income? (Please circle)

$0-499 per week $500-999 per week $1000+ per week

Or your annual income? .....

Relationships and sexual practice

What is your relationship status? (Please circle) Single/married or monogamous/de facto/non-monogamous/separated or recently single/divorced/widowed

Are you currently in a sexual relationship with a regular partner? Y / N

What kind of relationship/s do you currently have (tick all that apply)

Single	( )
Casual sex partner/s (male)	( )
Casual sex partner/s (female)	( )
Casual sex partner/s (non-binary)	( )
Regular sex partner (male)	( )
Regular sex partner (female)	( )
Regular sex partner (non-binary)	( )
Regular partner "relationship" (male)	( )
Regular partner "relationship" (female)	( )
Regular partner "relationship" (non-binary)	( )

Is/was this your first relationship? Yes/no

If no, how many relationships have you had? .....

Is/was this your first LGBTQI relationship? Yes/no

If no, how many relationships could be categorised as LGBTQI? .....

Is/was this a monogamous or non-monogamous relationship? Yes/no

How many monogamous relationships have you had? .....

How many non-monogamous relationships have you had? .....

Gender equity scale

How much do you agree with the following statements?	Strongly disagree	Disagree	Undecided	Agree	Strongly agree
On the whole, men make better political leaders than women					
When jobs are scarce, men should have more right to a job than women					
A university education is more important for a boy than a girl					
A woman has to have children to be fulfilled					
It's OK for a woman to have a child as a single parent and not want a stable relationship with a man					
Discrimination against women is no longer a problem in the workforce in Australia					
Men should take control in relationships and be the head of the household					
Women prefer a man to be in charge of the relationship					

Scale for ascertaining social isolation/social support

Please indicate how much you agree with the following statements:	Very strongly disagree	Strongly disagree	Mildly disagree	Neutral	Mildly agree	Strongly agree	Very strongly agree
There is a special person around when I am in need							
There is a special person with whom I can share my joys and sorrows							
My family really tries to help me							
I get the emotional help and support I need from my family							
I have a special person who is a real source of comfort to me							
My friends really try to help me							
I can count on my friends when things go wrong							
I can talk about my problems with my family							

Please indicate how much you agree with the following statements:	Very strongly disagree	Strongly disagree	Mildly disagree	Neutral	Mildly agree	Strongly agree	Very strongly agree
I have friends with whom I can share my joys and sorrows							
There is a special person in my life who cares about my feelings							
My family is willing to help me make decisions							
I can talk about my problems with my friends							

Self-esteem scale

How much do you agree with the following statements?	Strongly disagree	Disagree	Agree	Strongly agree
On the whole, I am satisfied with myself				
At times I think I am no good at all				
I feel that I have a number of good qualities				
I am able to do things as well as most other people				
I feel I do not have much to be proud of				
I certainly feel useless at times				
I feel that I'm a person of worth, at least on an equal plane with others				
I wish I could have more respect for myself				
All in all, I am inclined to think that I am a failure				
I take a positive attitude toward myself				

Psychological distress scale

In the past 4 weeks, about how often did you feel?	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Tired out for no good reason					
Nervous					
So nervous that nothing could calm you down					
Hopeless					

In the past 4 weeks, about how often did you feel?	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Restless or fidgety					
So restless you could not sit still					
Depressed					
That everything was an effort					
So sad that nothing could cheer you up					
Worthless					

"Outness" inventory relating to your sexual orientation

Seven-point rating scale:

1 = person definitely does not know about your sexual orientation

2 = person might know about your sexual orientation status, but it is never talked about

3 = person probably knows about your sexual orientation status, but it is never talked about

4 = person probably knows about your sexual orientation status, but it is rarely talked about

5 = person definitely knows about your sexual orientation status, but it is rarely talked about

6 = person definitely knows about your sexual orientation status; it is sometimes talked about

7 = person definitely knows about your sexual orientation status, and it is openly talked about

Items:	N/A	1	2	3	4	5	6	7
My new straight friends								
My work peers								
My work supervisors								
Strangers								
My old straight friends								
Mother								
Father								
Siblings								
Extended family/relatives								
Members of my religious community (church, temple)								
Leaders of my religious community (minister, rabbi)								

"Outness" inventory relating to your gender identity

If you do not identify as having a diverse gender identity, please skip this section.

1 = person definitely does not know about your gender identity

2 = person might know about your gender identity, but it is never talked about

3 = person probably knows about your gender identity, but it is never talked about

4 = person probably knows about your gender identity, but it is rarely talked about

5 = person definitely knows about your gender identity, but it is rarely talked about

6 = person definitely knows about your gender identity, and it is sometimes talked about

Items:	N/A	1	2	3	4	5	6	7
My new straight friends								
My work peers								
My work supervisors								
Strangers								
My old straight friends								
Mother								
Father								
Siblings								
Extended family/relatives								
Members of my religious community (church, temple)								
Leaders of my religious community (minister, rabbi)								

Need for privacy

(1: strongly disagree – 7: strongly agree)

Items:	N/A	1	2	3	4	5	6	7
I prefer to keep my relationship rather private								
I keep careful control over who knows about my relationship								
My private sexual behaviour/gender identity is nobody's business								
If you are not careful about whom you come out to, you can get very hurt								
I think very carefully before coming out to someone								

Items:	N/A	1	2	3	4	5	6	7
My sexual orientation/gender identity is a very personal and private matter								
I prefer to act like friends rather than lovers with my partner when we're in public								
I generally feel safe being out of the closet these days								
I worry about people findings out I'm a (lesbian/gay man/trans-person)								
In public I try not to look too obviously (lesbian/gay/ trans-person)								
I'm embarrassed to be seen in public with obviously "gay" or "trans" people								
I feel comfortable expressing affection with my partner out in public								

Internalized homonegativity

(1: strongly disagree – 7: strongly agree)

Items:	N/A	1	2	3	4	5	6	7
I am glad to be a <lesbian/gay/LGBTQI identified/ gender diverse>								
Homosexual lifestyles are not as fulfilling as heterosexual lifestyles								
I'm proud to be a part of the LGBTIQ community								
I wish I were heterosexual/cisgender								
Whenever I think a lot about my gender/sexuality I feel critical about myself								
Whenever I think a lot about my gender/sexuality I feel depressed								
Most problems that LGBTIQ people have come from their status as an oppressed minority, not from their gender/sexuality per se								

Stigma scale

(1: strongly disagree – 6: strongly agree)

Items:	N/A	1	2	3	4	5	6
Most people would willingly accept a LGBTQI person as a close friend							
Most people believe that a LGBTQI person is just as intelligent as the average person							
Most people believe that a LGBTQI person is just as trustworthy as the average citizen							
Most people would accept a LGBTQI person as a teacher of young children in a public school							
Most people feel that homosexuality is a sign of personal failure							
Most people would not hire a LGBTQI person to take care of their children							
Most people think less of a person who is LGBTQ or I							
Most employers will hire a LGBTQI person if he or she is qualified for the job							
Most employers will pass over the application of a LGBTQI person in favour of another applicant							
Most people in my community would treat a LGBTQI person just as they would treat anyone							
Once they know a person is gay, most people will take his opinions less seriously							

Thank you for completing this survey!

APPENDIX E

Surviving Abuse post-group survey

This survey replicates the pre-group survey, with the exception of the demographic questions, and addition of the Working Alliance Inventory (to ascertain the extent of the therapeutic relationship between clients and professionals) and client satisfaction survey. It also includes an invitation to take part in a qualitative interview.

These surveys are confidential, but we want to match your initial responses with your follow-up responses to make better comparisons. The following questions will help us match your surveys without being able to personally identify you.

What is the first letter of your mother's name? _____

How many older siblings do you have? _____

In which month were you born? _____

Working Alliance Inventory

Please select the response that applies best to you:	Seldom	Some-times	Fairly Often	Very Often	Always
As a result of these sessions I am clearer as to how I might be able to change					
What I am doing in the group gives me new ways of looking at my problem					
I believe the group facilitators like me					
The group facilitators and I collaborate on setting goals					
The group facilitators and I respect each other					
The group facilitators and I are working towards mutually agreed upon goals					
I feel that the group facilitators appreciate me					
The group facilitators and I agree on what is important for me to work on					
I feel the group facilitators care about me even when I do things that they do not approve of					
I feel that the things I do in the group will help me to accomplish the changes that I want					
The group facilitators and I have established a good understanding of the kind of changes that would be good for me					
I believe the way we are working with my problem is correct					

Client satisfaction survey

Overall, how useful did you find the group program?	Not at all useful	Not very useful	Neither	Slightly useful	Very useful
Overall, how likely is it that you would recommend the group program to a friend?	Not at all	Not very likely	Neither	Likely	Very likely
How satisfied or not satisfied were you with the program?	Not at all satisfied	Not satisfied	Neither	Satisfied	Very satisfied

Do you have any other comments or feedback about the group program?

Invitation for follow-up

We would like to follow up with some clients to get more feedback about their experience of attending the group.

We would like to invite you to complete short follow-up surveys in 3- and 6-months' time, and/or a telephone interview at a time that suits you to discuss your experience in more detail. If you complete an interview, you will be offered a $50 Coles Myer voucher to thank you for your time.

If you are interested, please fill in your contact details, and indicate whether you are interested in being contacted for follow-up surveys, an interview, or both. You can change your mind about this at any time.

I am interested in participating in (please tick all that you would like to participate in):

☐ Follow-up surveys

☐ A telephone interview

Name: _____

Email: _____

Phone: _____

Postal address: _____

Please separate this page from the rest of the survey before placing it in the envelope.

Thank you for completing this survey!

APPENDIX F

Interview guide for client and potential client participants

Consent preamble

As you will have read in the consent form, our interview will be like a conversation where you get to raise issues you see as pertinent. I have a guide here, but you can pass any question, stop the interview at any time and revoke your consent at a later date. Please also let me know if you feel distressed by the interview, and we can take a break or gain support for you, as needed. First, we will talk about the group program and your experiences, your experiences of violence and abuse in your relationships, and there will be an opportunity for you to add information and recommendations before we finish. Due to the confidential nature of these interviews, I will ask you some demographic questions, and these will be handled separately. Again, just pass any questions you don't feel comfortable asking.

Before we start, do you have any questions?

Opening

Have you attended any other group programs?

What were these groups?

What were they like?

Have you ever attended programs at RANSW or another mainstream organisation before?

What was your experience on this group program?

Have you ever attended counselling at ACON?

What was your experience of this counselling?

Referral pathway and motivations

What brought you to this/these groups?

Clients only: How did you feel about coming to this group?

Clients only: Since completing the group program, how do you now feel about groups?

Clients only: What were your goals in attending this group?

Clients only: How was it for you approaching RANSW/ACON for this service?

Who else/what other services did you approach? What was that like for you?

How has it been for you in gaining access to services/support?

What has been helpful/not helpful?

Clients only: How was having the program situated <insert the venue> for you?

What is your experience of the inclusivity of these programs? And these venues?

Were their differences in the help you or your partner/former partner received? How do you understand these differences?

Client satisfaction and perception of group function

Clients only: How might we improve the groups you attended?
Clients only: Would you recommend groups to anyone?
Clients only: Are there other kinds of groups would you like to do? If not, what alternative service might you choose?
Clients only: Has the tailored program met your needs, if so in what ways?
How has it failed to meet your needs?

Perceptions, knowledge and experience of IPV/DFV

What has been your experience of violence and abuse in intimate relationships?
Has there been other experiences of violence and abuse in other relationships? Or situations?
In addition to what you said earlier, how do you understand intimate partner violence?
How do you understand power and control?
Who has/had the power in your relationship? How do you understand this?
How has gender played out in your relationship?
How has this played out in relation to your sexuality?
How has this played out in relation to your gender identity?

Clients only: Outcomes and impact

Have you noticed any changes yourself since you began this group?
Would the significant people in your life notice any changes in you?
What are these changes? If not, why do you think that is?
Did you notice any changes in the other clients in your group? What kinds of changes did you notice?
How do you think it will be for you to maintain any changes you've made?
What might help you sustain these changes?
If not, what prevented you from sustaining changes?

Particular complexities

How do you think being identified as LGBTIQ affected your experiences of violence or abuse, if at all?
What, if any, other challenges or experiences have you had?
How has society (social norms and barriers) facilitated what happened to you?
Shaped your behaviours?
And helped you?

Other factors

In this section, we have more direct questions about your circumstances and experiences that relate to the factors discussed in the published research. Some of these questions are quite sensitive and personal. Please do not hesitate to pass any questions you do not feel comfortable answering.

Have alcohol and other drug use played any role in your experiences of IPV/DFV? If yes, in what ways?

Was this your first relationship? Has this had a role in your experiences?

Closing

Have you ever been involved in an interview study like this before?

What was it like for you?

Is there anything you'd like to add before you finish this interview?

Okay, now I'll ask you some demographic questions, some of these are quite personal and the reason we ask is to compile a profile of the people we spoke to. No individual information about you will be attached to the interview or used in publications.

Gender and sexuality indicators

What is your current gender identity?

Are you intersex?

What gender were you assigned at birth?

What sexuality do you consider yourself to be?

Partner's gender and sexuality indicators

What is your partner's/former partner's current gender identity?

Are they intersex?

What gender was your partner/former partner assigned at birth?

How does your partner or former partner identify?

Demographics

What year were you born?

In what country and city were you born? How do you describe your cultural heritage?

Do you identify as Aboriginal or as a Torres Strait Islander?

What is your education level?
What is your current employment status?
What is your current relationship status?
Where and with whom are you currently living?
Are you a parent or have any dependent children in your care? If so, how many children do you have?

Thank you for your time today. We really appreciate your input.

APPENDIX G

Interview guide for clinicians, program designers and professional stakeholders

Consent preamble

As you will have read in the consent form, our interview will be like a conversation where you get to raise issues you see as pertinent. I have a guide here, but you can pass any question, stop the interview at any time and revoke your consent at a later date. Please also let me know if you feel distressed by the interview, and we can take a break or gain support for you, as needed. First, we will talk about the group program and your experiences, your experiences of violence and abuse in your relationships, and there will be an opportunity for you to add information and recommendations before we finish. And due to the confidential nature of these interviews, I will ask you some demographic questions, and these will be handled separately. Again, just pass any questions you don't feel comfortable asking.

Before we start, do you have any questions?

Opening

In order to capture the workforce profile, we are interested in how you came to work in this area. What is your background and professional pathway?

How long have you worked in this sector? For clinicians: how long have you worked in groups?

Have you worked with LGBTQ clients in any other form?

How did you know you were working with LGBTQ clients?

Have you worked in other DFV groups? Or services?

Working with clients who identify as LGBTQ

How are LGBTQ people recruited to the services in your area?

How do you understand help-seeking or client engagement with LGBTQ clients?

In your experience, what motivates LGBTQ clients to attend the services you've worked in?

Is your work different when working with clients who identify as LGBTQ?

How is it different?

What kinds or work have you undertaken with LGBTQ clients?

Are there differences in your way of working between the different interventions?

How do you understand these differences?

What kind of training have you done for this work?

What kind of training do you need?

Do you think LGBTQ clients prefer working with LGBTQ professionals? Why do you think that is?

Awareness and understanding of gender and sexuality

How do you understand sexuality?
How do you understand gender? And gender identity?
How do you think LGBTQ clients are affected by notions of gender? Heteronormativity? Homophobia?

Preferred interventions

How does counselling or group work fit with the lived experience of LGBTQ people?
What role do you see therapy and group work as having for LGBTQ clients? Or LGBTQ people in general?

Professional sexuality and gender identity

How do you identify? How has this enabled your work? And potentially hindered your work?
What was coming out like for you?
What do you need to feel safe to come out?

Recommendations

Clinicians only: What do you see as the strengths of group work for LGBTQ people?
Clinicians only: What do you understand as the limitations?
How might services for LGBTQ people be improved?

Closing

Have you ever been involved in an interview study like this before?
What were your thoughts?
Is there anything you'd like to add before you finish this interview?
Thank you for your time today. We really appreciate your input.

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AUSTRALIA'S NATIONAL RESEARCH ORGANISATION FOR WOMEN'S SAFETY

to Reduce Violence against Women & their Children