



The impact of intimate partner violence on the health and work of gender and sexual minorities in Canada

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Abstract

Objectives Intimate partner violence (IPV) has significant impacts on workers and workplaces. This paper examines the experiences of gender and sexual minority (GSM) people in this context.

Methods People aged 15 and older completed an online survey on the impacts of IPV at work, and brief health and life quality questions. Of 7918 respondents, 8.5% ($n = 672$) indicated GSM status. We examined IPV exposure, health and IPV-related work impacts by overall GSM status, and separately by sexual orientation, and gender.

Results GSM respondents were significantly more likely to report IPV and that the IPV continued at or near their workplace, impeded their ability to get to work, negatively impacted their work performance, and their co-workers; they also reported poorer mental health and life quality. While women were significantly more likely to report IPV and various negative work and health outcomes, being a sexual minority had additional independent negative effects. No differences in willingness to disclose IPV were found.

Conclusions Workplace responses to IPV should account for the additional impacts and barriers faced by GSM people in disclosing abuse and seeking help.

Keywords Intimate partner violence · Gender · Sexual orientation · Work · Health

Introduction

Intimate partner violence (IPV) is a public health issue with significant impacts on workers and workplaces. In a pan-Canadian survey, we documented the prevalence and impacts of IPV on those exposed and their co-workers (Wathen et al. 2015; MacGregor et al. 2016a), including impacts on health and life quality (Wathen et al. 2016) and

supports offered by the workplace (MacGregor et al. 2016b). The present analysis examines the experiences of IPV, and its work and health impacts, among lesbian, gay, bisexual, transgender, queer/questioning and other gender non-conforming (i.e., gender and sexual minority, or GSM) people.

Background

Gender and sexual minorities are at increased risk of IPV and other forms of violence (Edwards et al. 2015a, b), significantly affecting health and well-being (Friedman et al. 2011). Canadian data from the General Social Survey (GSS) suggest that lesbian or bisexual women are more likely than heterosexual women to report violence by a current or previous spouse (20.8 vs. 6.1%); however, since perpetrator gender was not available, the data from women identifying as bisexual likely include opposite-sex partners (i.e., men) (Sinha 2013; see also Barrett and St. Pierre 2013; Goldberg and Meyer 2013; Turell et al. 2017).

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In general, less is known about Canadian men's experiences of IPV; population-based surveys that ask about relationship conflict in general show similar overall rates for men and women, with a number of caveats, reviewed elsewhere (Johnson 2015). There is, however, growing evidence that gay men and men who have sex with men may experience types and patterns of abuse consistent with those experienced by women (perpetrated by male partners) (Nowinski and Bowen 2012; Oliffe et al. 2014).

American studies also support the notion that GSM people experience IPV at similar or higher rates compared to non-minorities (Ard and Makadon 2011; Buller et al. 2014). Walters et al. (2013) found that 44% of lesbian women, 61% of bisexual women, and 35% of heterosexual women reported having been raped, physically abused, and/or stalked by an intimate partner in their lifetime; 26% of gay men, 37% of bisexual men, and 29% of heterosexual men reported at least one of these forms of violence.

Transgender, queer, questioning, intersex, and two-spirited (i.e., trans) people generally experience higher rates of all forms of interpersonal violence (National Coalition of Anti-Violence Programs 2016; Stotzer 2009) than non-trans people of any sexual orientation. For example, Langenderfer-Magruder et al. (2016) found that 51.7% of trans people reported lifetime IPV experiences, compared to 34.2% of cisgender people.

A large body of literature, reviewed by Pizer and colleagues, demonstrates the high prevalence and pervasive impacts of discrimination and harassment faced by GSM people in the workplace (Pizer et al. 2012), with 37% of GSM respondents in a large representative US survey reporting workplace harassment, and 12% reporting losing their job due to discrimination. Multiple data sources support these, and related, findings, including the much higher prevalence of these experiences among trans, compared to lesbian/gay, people.

Barriers to help-seeking

GSM people often face discrimination, violent victimization, and inadequate responses from professionals, causing distrust and fear of seeking help (Edwards et al. 2015b; Potter et al. 2012; Rogers 2016; Stiles-Shields and Carroll 2015). A number of factors have been identified, including the extent to which a person is "out" about their sexual/gender identity. For example, people may be reluctant to out themselves by seeking support from informal or formal sources, and abusive partners may exploit fear of outing to further isolate the victim (Ard and Makadon 2011; Stiles-Shields and Carroll 2015; Walker 2015).

"Outness" has been shown to be more predictive of help-seeking behavior than other factors, including availability and sensitivity of formal services, and past experiences of discrimination (St. Pierre and Senn 2010). In addition, GSM communities may be small and insular. Victims sharing the same social space as their abuser may feel limited in who they can go to for help; they may also wish to avoid bringing further stigma to the GSM community (Edwards et al. 2015b; Potter et al. 2012; Walker 2015). In a review, Calton et al. (2016, p. 585) summarized help-seeking among GSM IPV victims as follows: "three major barriers to help-seeking exist for GSM IPV survivors: a limited understanding of the problem of GSM IPV, stigma, and systemic inequities."

Compounding these barriers is the scarcity of services available to GSM people to address IPV. Most mainstream services view IPV as a male perpetrated, heterosexual experience, function within existing heteronormative biases, and are not equipped to serve members of the GSM community. When services are provided, responses often demonstrate a lack of knowledge, sensitivity, or misunderstanding about GSM issues (Ard and Makadon 2011; Coleman et al. 2017; Edwards et al. 2015b; Kulkin et al. 2007; Rogers 2016; Stiles-Shields and Carroll 2015; St. Pierre and Senn 2010; Walker 2015).

The emerging evidence strongly suggests that IPV is more common among GSM people than among sexual and gender majorities, but their ability to seek and find help and services is more limited. We could find no GSM-specific IPV research in the context of the workplace, thus the present paper provides data on two important gaps: the prevalence of IPV in GSM people, and its impact on their work and health.

Methods

Overview

We analyzed a subset of data from a survey on IPV and the workplace conducted by researchers at Western University partnering with the Canadian Labour Congress (CLC). The survey was available online across Canada in French and English from December 2013 to June 2014. Those 15 years and older were eligible. Recruitment was primarily through the CLC and its affiliates, including emails distributed through member lists. The survey launch also received national media attention. Further methodological details are reported in Wathen et al. (2015). The project was approved by Western University's Non-Medical Research Ethics Board (#104156).

Measures

Respondents were asked questions regarding demographic and work-related characteristics. GSM status was determined using one question about gender, “What is your gender?” (response options: “female,” “male,” “transgender,” and “other, please specify”), and one question about sexual orientation, “Are you...” (response options: “heterosexual,” “lesbian,” “bisexual,” “gay,” “queer,” “two-spirited,” and “other, please specify”; the terms “queer” and “two-spirited” can also describe gender identity. Some respondents did choose these labels and were therefore coded as “LGBTQ.”). Respondents could indicate multiple sexual orientations. Those who identified as transgender/other and/or anything other than heterosexual were coded as “GSM”; those who identified as male or female and heterosexual were coded as “non-GSM.” Respondents indicating they were “transgender” or “other,” regardless of their sexual orientation, were coded as “trans” and all others were coded as “non-trans.” The European Health Interview Survey-Quality of Life (EUROHIS-QOL) (da Rocha et al. 2012; Schmidt et al. 2006) was used to assess quality of life. For general health and mental health, two questions shown to have good reliability and validity (Ahmad et al. 2014; DeSalvo et al. 2006) were drawn from the Canadian Community Health Survey (Statistics Canada 2011). Measures are summarized in Table 1.

Data analysis

Analyses were conducted using SPSS 23 and SAS. Descriptive statistics/frequencies for demographic and work characteristics were computed. Chi-square tests for binary outcomes (IPV exposure and work outcomes) and one-way analysis of variance (ANOVA) for continuous variables (general health, mental health, and quality of life) were used to examine differences between GSM and non-GSM respondents. Logistic regression was used to examine the effects of gender (women/female vs. men/male) and sexual orientation (heterosexual vs. non-heterosexual) and their interaction on binary outcomes; because there were no significant interactions, we present results from the simpler models. Three separate two-way ANOVAs were used to examine the effects of gender, sexual orientation and their interaction on continuous outcomes. Respondents who did not specifically identify as men or women, or who did not answer this question, were excluded from all analyses examining effects of gender. Frequencies on key variables for trans versus non-trans respondents are presented, but due to the small sample, test statistics were not computed.

Results

Sample characteristics

Of the 8429 people who responded to the survey, 7918 provided answers regarding their gender identity and/or their sexual orientation so their GSM status could be determined; these comprised the primary sample for analysis. In total, 8.5% ($n = 672$) of respondents were GSM. The vast majority completed the survey in English, were born in Canada, and were of British, European, or North American descent. Among those whose GSM status was known, 4.5% ($n = 360$) identified as an Indigenous person of Canada; among those with lifetime IPV exposure, 7.2% ($n = 194$) were Indigenous. As with the full sample (Wathen et al. 2015), the two most commonly represented work sectors were Education, and Healthcare/Social Services. Additional sample characteristics are presented in Table 2.

IPV exposure

Compared to non-GSM respondents, those identifying as GSM were significantly more likely to report IPV exposure at all time points (Table 3). Logistic regression analyses revealed that both female gender and non-heterosexual status were significantly associated with lifetime IPV exposure and exposure at 12 + months. Female gender alone was associated with current IPV exposure, and only non-heterosexual status was associated with IPV exposure in the past 12 months. No significant interaction effect between gender and sexual orientation was found on these outcomes (results of the main effect model are shown in Table 4). Overall, 33.8% ($n = 2678$) of respondents had experienced IPV in their lifetime; the following analyses, detailed in Tables 3, 4 and 5, are limited to these people. Trans respondents were significantly more likely to report current (29.7%) and lifetime IPV (64.9%) than either males or females (see Wathen et al. 2015).

Impact of IPV at or near work

Among those with lifetime IPV exposure, a Chi-square test showed that GSM respondents were significantly more likely to report that IPV continued at or near their workplace (Table 3). For both groups, the most common way this occurred was by abusive phone calls or text messages (46.3%, $n = 138$ and 40.0%, $n = 952$, respectively).

Logistic regression revealed that both female gender and non-heterosexual status were independently and significantly associated with experiencing IPV at or near the workplace (Table 4). For all work-related outcomes, there

Table 1 Outcome measures, intimate partner violence (IPV), health and work among gender and sexual minority people in Canada, 2015

Variable	Question(s)	Response options and coding
IPV status ^a	<ol style="list-style-type: none"> 1. Are you currently experiencing violence from a current or past intimate partner? 2. [if no] Have you experienced IPV in the past 12 months? 3. Did you experience IPV more than 12 months ago? 	<ol style="list-style-type: none"> 1. “yes” or “no” 2. “yes” or “no” 3. “yes” or “no” <p>Respondents experiencing IPV at least one-time point were coded as experiencing lifetime IPV</p>
Impact of IPV at or near work	Did you experience IPV in the workplace in any of the following ways?	Respondents checking off at least one of the following options were coded as experiencing IPV at/near their workplace: (1) abusive phone calls or text messages, (2) abusive e-mail messages, (3) abuser physically came to the workplace, (4) abuser stalked or harassed near the workplace, (5) abuser contacted co-workers/employer (about victim), or (6) other
Impact of IPV on ability to get to work	1. Did/does the IPV affect your ability to get to work?	1. “yes” or “no”
Impact of IPV on work performance	Is/was your work performance negatively affected by IPV due to being:	Respondents checking off at least one of the following options were coded as having IPV negatively affect their work performance: (1) distracted (e.g., by stress, abusive phone calls, emails), (2) tired (e.g., due to sleep deprivations from the IPV), (3) unwell (e.g., anxiety, depression, headache from the IPV), (4) injured (from the IPV) or (5) other
Job loss and time off due to IPV	<ol style="list-style-type: none"> 1. Did you ever lose your job due to IPV? 2. Did you have to take time off work because of the IPV? 	<ol style="list-style-type: none"> 1. “yes” or “no” 2. “yes” or “no”
Impact of IPV on co-workers	Has the IPV affected your co-workers in any of the following ways?	Respondents checking off at least one of the following were coded as having co-workers who were affected by their IPV: (1) they were harmed or threatened, (2) they had to deal with frequent phone calls, messages, or emails from the abuser, (3) they were stressed or concerned about the situation, (4) their work was affected (e.g., increased workload, changed schedule), (5) IPV caused conflict and tension between you and your co-workers (e.g., due to changes in workloads, deadlines, and shared projects), or (6) other
IPV disclosure at work	Did you discuss the IPV with anybody at work?	“yes” or “no”
Quality of life	<p>8-item EUROHIS</p> <ol style="list-style-type: none"> 1. How would you rate your quality of life? 2. How satisfied are you with your health? 3. Do you have enough energy for everyday life? 4. How satisfied are you with your ability to perform your daily activities? 5. How satisfied are you with yourself? 6. How satisfied are you with your personal relationships? 7. Have you enough money to meet your needs? 8. How satisfied are you with the conditions of your living place? 	5-point response scale (e.g., “very dissatisfied” to “very satisfied,” “not at all” to “completely”)
Health status	<ol style="list-style-type: none"> 1. “In general, would you say your health is:” 2. “In general, would you say your mental health is:” 	5-point response scale ranging from 5, “excellent,” to 1, “poor.” Higher scores indicate better health

^aThose responding “yes” to at least one IPV status question were routed in the survey to respond to questions about how the IPV impacted their (and others’) work. In the survey, the term “domestic violence” (DV) was used to differentiate from workplace violence. Questions are reworded here for consistency. DV was explicitly defined in the survey as “any form of physical, sexual, emotional or psychological abuse, including financial control, stalking and harassment. It occurs between opposite- or same-sex intimate partners, who may or may not be married, common law, or living together. It can also continue to happen after a relationship has ended.”

Table 2 Demographic and work characteristics, intimate partner violence (IPV), health and work among gender and sexual minority (GSM) People in Canada, 2015

	Known GSM status (<i>n</i> = 7918) % (<i>n</i>)	Lifetime IPV (<i>n</i> = 2678) % (<i>n</i>)
Gender		
Female	78.7 (6231)	88.1 (2359)
Male	20.8 (1648)	11.0 (294)
Transgender/other	.4 (35)	.9 (23)
No response	.1 (4)	.1 (2)
Sexual orientation		
Heterosexual	91.6 (7255)	89.1 (2387)
Lesbian	1.7 (138)	2.1 (55)
Bisexual	2.9 (227)	3.9 (105)
Gay	1.2 (95)	1.1 (30)
Queer	.7 (55)	.8 (22)
Two-spirited	.2 (19)	.4 (10)
Other (e.g., multiple orientations)	1.6 (129)	2.6 (69)
Age		
15–24	2.7 (216)	2.0 (54)
25–34	17.6 (1394)	16.2 (435)
35–44	23.8 (1881)	24.8 (663)
45–54	31.7 (2507)	33.0 (884)
55–64	21.2 (1675)	20.9 (559)
65–74	2.5 (197)	2.7 (71)
75+	.3 (21)	.2 (5)
No response	.3 (27)	.3 (7)
Employment status		
Permanent	81.1 (6421)	81.1 (2173)
Temporary/fixed term contract	8.4 (668)	7.9 (211)
Casual/seasonal	4.2 (335)	4.1 (109)
Unemployed	1.4 (114)	1.8 (48)
Other, working (e.g., multiple types of work)	1.8 (142)	1.5 (41)
Other (e.g., retired, on leave, student)	2.3 (185)	2.8 (74)
No response/unclear	.7 (53)	.8 (22)
Union status		
Unionized	81.3 (6435)	79.7 (2134)
Non-unionized	17.8 (1406)	19.2 (514)
No response	1.0 (77)	1.1 (30)
Work Week		
Full-time (30 h or more per week)	85.4 (6759)	86.1 (2306)
Part-time (less than 30 h per week)	13.5 (1070)	12.7 (339)
No response	1.1 (89)	1.2 (33)
Size of workplace		
Under 20 workers	18.8 (1485)	17.9 (479)
20–99 workers	31.8 (2530)	31.8 (851)
100–500 workers	23.2 (1838)	24.7 (661)
More than 500 workers	25.2 (1993)	24.7 (662)
No response	1.0 (82)	.9 (25)

Table 3 Exposure to and impacts of intimate partner violence (IPV) by gender and sexual minority (GSM) status, Canada, 2015

	GSM % Yes (n)	Non-GSM % Yes (n)	Test statistic χ^2
IPV exposure			
Lifetime IPV	44.3 (298)	32.8 (2380)	36.33**
Current IPV	8.8 (59)	6.3 (456)	6.18 [†]
Last 12 months IPV	5.5 (34)	3.4 (229)	7.70*
12+ months IPV	41.9 (281)	30.8 (2234)	34.80**
Work outcomes ^a			
IPV continued at/near work	62.4 (186)	52.6 (1253)	10.17**
Ability to get to work impeded	49.3 (141)	38.3 (880)	12.81**
IPV impacted work performance	87.9 (262)	81.5 (1940)	7.44*
Lost a job due to IPV	10.5 (30)	8.5 (194)	1.33 ^{ns}
Took time off due to IPV	43.2 (123)	40.7 (930)	0.65 ^{ns}
IPV impacted co-workers	44.6 (133)	36.3 (863)	7.94*
Discussed IPV at work	42.9 (121)	45.3 (1034)	0.58 ^{ns}
Health and quality of life ^a			
	M (SD)	M (SD)	F
General health	3.27 (.95)	3.37 (.94)	3.01 ^{ns}
Mental health	2.96 (1.04)	3.26 (0.99)	21.76**
Quality of life	27.98 (6.42)	29.21 (6.31)	9.19*

[†] $p < 0.05$; * $p < 0.01$; ** $p < 0.001$, *ns* nonsignificant

^aAnalyses limited to respondents with lifetime IPV exposure

Table 4 Exposure to and work impacts of intimate partner violence (IPV) by gender and sexual orientation^a, Canada, 2015

	Sexual orientation				Gender (women)	Sexual orientation (non-heterosexual)
	Heterosexual		Not heterosexual			
	Women (n = 2133) ^b % Yes (n)	Men (n = 247)	Women (n = 226)	Men (n = 47)		
					OR (95% CI)	
IPV exposure						
Lifetime IPV	37.0 (2133)	16.6 (247)	52.2 (226)	29.4 (47)	2.83 (2.47–3.23)**	1.62 (1.37–1.91)**
Current IPV	6.9 (398)	3.9 (58)	7.4 (35)	7.5 (12)	1.87 (1.45–2.41)**	1.30 (0.97–1.75)
Last 12 months IPV	3.5 (189)	2.8 (40)	6.2 (27)	4.0 (6)	1.28 (0.93–1.74)	1.64 (1.13–2.39)*
+ 12 months IPV	35.0 (2012)	14.9 (222)	45.9 (217)	26.4 (42)	2.90 (2.53–3.33)**	1.61 (1.36–1.91)**
Work outcomes ^c						
IPV continued at/near work	53.3 (1137)	47.0 (116)	62.8 (142)	57.4 (27)	1.30 (1.03–1.64) [†]	1.51 (1.18–1.95)*
Ability to get to work impeded	39.3 (812)	29.7 (68)	48.9 (107)	45.5 (20)	1.55 (1.20–1.99)**	1.61 (1.26–2.07)**
IPV impacted work performance	82.4 (1758)	73.7 (182)	88.1 (199)	83.0 (39)	1.69 (1.28–2.24)**	1.62 (1.12–2.33) [†]
Lost a job due to IPV	8.9 (184)	4.4 (10)	11.0 (24)	7.0 (3)	1.79 (1.10–2.91) [†]	1.27 (0.84–1.92)
Took time off due to IPV	42.3 (87)	25.8 (59)	44.2 (96)	40.9 (18)	1.76 (1.36–2.27)**	1.13 (0.88–1.46)
IPV impacted co-workers	36.8 (786)	31.2 (77)	43.8 (99)	44.7 (21)	1.25 (0.98–1.60)	1.40 (1.09–1.79)*
Discussed IPV at work	45.8 (942)	40.4 (92)	45.9 (100)	36.6 (15)	1.22 (0.96–1.55)	0.95 (0.74–1.23)

[†] $p < 0.05$; * $p < 0.01$; $p < 0.001$

^aAnalyses limited to women and men

^b*n* for actual analyses may differ slightly for each outcome depending on missing data

^cAnalyses limited to respondents with lifetime IPV exposure

Table 5 Health and life quality among intimate partner violence (IPV)-exposed respondents by gender and sexual orientation^a, Canada

Health and quality of life	Sexual orientation				Main effect gender	Main effect sexual orientation	Interaction
	Heterosexual		Non-heterosexual				
	Women (<i>n</i> = 2133) ^b <i>M</i> (<i>SD</i>)	Men (<i>n</i> = 247)	Women (<i>n</i> = 226)	Men (<i>n</i> = 47)			
					<i>F</i> (<i>df</i>)		
General health	3.39 (.94)	3.23 (.92)	3.26 (.92)	3.37 (1.09)	.09 (1,2448)	.00 (1,2448)	2.35 (1,2448)
Mental health	3.26 (.99)	3.26 (1.02)	2.97 (.99)	2.95 (1.18)	.01 (1,2452)	10.44** (1,2452)	.02 (1,2452)
Quality of life	29.30 (6.29)	28.48 (6.36)	28.15 (6.43)	27.23 (6.29)	2.24 (1,2456)	424* (1,2456)	.01 (1,2456)

* $p < 0.05$; ** $p < 0.01$

^aAnalyses limited to women and men with lifetime IPV exposure

^b*n* for actual analyses may differ slightly for each outcome depending on missing data

was no significant interaction effect between gender and sexual orientation.

Impact of IPV on ability to get to work

GSM respondents were significantly more likely than non-GSM respondents to have their ability to get to work impeded by IPV (Table 3). Logistic regression showed that this outcome was independently and significantly associated with female gender and non-heterosexual status (Table 4).

Impact of IPV on work performance

GSM respondents were significantly more likely to report that their work performance was impacted by IPV than non-GSM respondents (Table 3). Among both groups, the most common ways in which this happened was by being distracted (e.g., by stress, abusive phone calls; 82.8 and 80.6%, respectively), tired (e.g., due to lack of sleep, from IPV; 77.5 and 75.3%, respectively), and feeling unwell (e.g., depression, headache related to IPV; 79.8 and 75.6%, respectively). Logistic regression showed that both female gender and non-heterosexual status were independently and significantly associated with reports of work performance being impacted by IPV (Table 4).

Job loss and time off due to IPV

No difference was found between GSM and non-GSM respondents in the likelihood of losing a job due to IPV. Similarly, GSM and non-GSM respondents were equally likely to have taken time off from work due to IPV (Table 3).

Logistic regression analyses revealed that female gender, but not sexual orientation, was significantly associated with losing a job, and taking time off work due to IPV (Table 4).

Impact of IPV on co-workers

GSM respondents were significantly more likely than non-GSM respondents to report that their co-workers were impacted by their IPV (Table 3). For both GSM (34.9%, $n = 104$) and non-GSM respondents (28.4%, $n = 675$), the most common way this happened was that they were stressed or concerned about the situation. Logistic regression analyses showed that non-heterosexual status, but not gender, was significantly associated with reports of co-workers being impacted by the IPV (Table 4).

Discussed IPV at work

There was no difference in the likelihood that GSM and non-GSM respondents had discussed the IPV with someone at work (Table 3). Among those who did discuss it, there were no differences between groups in whether any negative actions were experienced at work as a result of disclosure (GSM: yes, 17.1%, $n = 20$, no, 82.9%, $n = 97$; and non-GSM: yes, 15.8%, $n = 160$, no, 84.2%, $n = 850$, $\chi^2 = .12$, $p = .73$). Logistic regression analysis revealed that neither gender nor sexual orientation was associated with respondent reports of discussing the IPV at work (Table 4).

General health, mental health and quality of life

GSM respondents reported significantly poorer mental health and quality of life than did non-GSM respondents; there was a nonsignificant trend in the same direction for general health (Table 3). The gender by sexual orientation interaction predicting general health was not significant and there were no effects of gender or sexual orientation for this outcome (Table 5). However, non-heterosexual respondents had poorer mental health and quality of life compared to heterosexual respondents. There were no effects of gender or gender by sexual orientation interactions predicting these outcomes (Table 5).

Impacts of IPV at work for transgender/“other” respondents

Descriptive data for GSM respondents who identified as trans compared to those who identified as male or female are presented in Table 6. Although the trans subsample is small and statistics were not computed, it appears that some trends exist, with trans respondents reporting more impacts at work than non-trans respondents. They also appear to be particularly unlikely to discuss the IPV at their workplace. Among those with lifetime IPV, trans respondents seem to have equivalent health and well-being outcomes to cisgender respondents in the GSM sample.

Discussion

This study provides important data that begin to fill two key research gaps, namely the prevalence of IPV among GSM people in Canada, and, importantly, how experiences of IPV impact their work, health and well-being. Drawing on a very large data set, we found that, in general, those identifying as GSM were more likely to experience IPV, and more likely to feel its impacts on their work, health and quality of life. Specifically, GSM respondents are more likely than non-GSM respondents to report current, past year, and lifetime IPV, and non-heterosexual respondents and women were more likely to report IPV exposure at multiple time points. Women and sexual minority respondents reported significantly greater impacts of IPV on their work, including their ability to get to work, the IPV “following” them to work, work performance, and impact on co-workers. There were no differences between GSM and non-GSM respondents regarding job loss or time off work due to IPV.

Analyses of gender and sexual orientation indicate that women and non-heterosexual respondents reported greater impact of IPV on their ability to get to work, their work performance, and they were more likely to report IPV occurred at/near their work compared to men, and to heterosexual respondents. Women were more likely to report job loss and time off due to IPV; sexual orientation was not related to these outcomes. Non-heterosexual respondents reported significantly more impact of IPV on their co-workers; no gender difference was found.

There were no differences in GSM status, gender, or sexual orientation regarding willingness to discuss IPV at work, and when respondents reported disclosing, no differences in the rates of negative outcomes related to disclosure.

Those identifying as GSM reported significantly worse mental health and life quality, with a trend to poorer general health. Non-heterosexual respondents reported poorer mental health and quality of life; no gender differences were found.

Respondents identifying as trans were significantly more likely to report IPV than those identifying as men or women (Wathen et al. 2015). Although test statistics were not run due to small sample size, trans respondents may be more likely than non-trans respondents (in the GSM subsample) to report negative impacts of IPV on their work and workplace. While trans respondents reported poorer health than cis respondents overall (Wathen et al. 2016), trans status and health do not seem to be related in this small trans, IPV-exposed sample.

It is not surprising that gender and sexual minorities report more IPV, and greater impacts on their work, health and life quality than cisgender and heterosexual respondents; this is consistent with the prevalence data reported above, and with what is well known about stigma faced by

Table 6 Work and health impacts of intimate partner violence (IPV) within gender and sexual minority (GSM) respondents by trans status, Canada, 2015

Impact of IPV at work	Trans (<i>n</i> = 23) Yes <i>n</i> (%)	Not trans (<i>n</i> = 273) Yes <i>n</i> (%)
IPV continued at/near work	16 (69.6)	169 (61.9)
Ability to get to work impeded	14 (60.9)	127 (46.5)
Lost a job due to IPV	2 (8.7)	27 (9.9)
Took time off due to IPV	8 (34.8)	114 (41.8)
IPV impacted co-workers	12 (52.2)	120 (44.0)
IPV impacted work performance	22 (95.7)	238 (87.2)
Discussed IPV at work	6 (26.1)	115 (42.1)
Health and life quality	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)
General health	3.26 (1.05)	3.28 (.94)
Mental health	3.00 (1.19)	2.97 (1.02)
Quality of life	28.93 (5.78)	28.00 (6.40)

Due to the small number of trans/other participants, test statistics were not conducted. The actual *n* for each statistic varies due to missing data

GSM people (Pizer et al. 2012). What is interesting is that GSM people experiencing IPV, with the possible exception of those identifying as trans, are as willing as their non-GSM counterparts to discuss the IPV at work. This can be interpreted two ways. First, it could be argued that, given the higher prevalence and impacts of IPV, we might expect more GSM people to come forward. However, we know from related analyses that many people in general are not aware of the full range of supports and remedies (if any) available through their employer and/or union (MacGregor et al. 2017). We also know that disclosure, especially under circumstances where the person is not “out,” can pose risks. As one of our respondents indicated (as a negative experience): “My ex told my boss I was gay and my brother-in-law did the same with co-workers.” Said another: “Well my ex ... made threats to call the media and tell them I’m gay [and] also threatened to come take me down at my work; my HR did nothing to protect me other than make me look stupid...”

A second way to interpret this finding is that, even despite the additional stigma of being a gender/sexual minority (on top of the already considerable stigma associated with being a victim of IPV), the lack of difference in “willingness to discuss at work” presents a unique opportunity, where workers of all genders and sexual orientations see the workplace as a potential site of support and safe intervention. The fact that there were no differences in reported negative outcomes of disclosures is a positive indicator (though, at between 15 and 20%, these negative outcomes are still unacceptably high). As one respondent indicated “I became a groundbreaker in making workers comfortable with gays in the workplace. As a result I am active in both the union and community promoting equality.” Several other GSM respondents commented on the importance of taking an intersectional approach to IPV awareness and education in the workplace (Dinno 2017). As one bisexual female respondent notes: “I think education, much like what the workplace engages with around racism and LGTBQ issues, are important to end the stigma and raise awareness [about IPV].” We would also argue strongly for intersectional approaches to researching experiences of violence among gender and sexual minorities—an area where robust, and nuanced, data are urgently needed.

While most of the gender analyses revealed predictable outcomes, with women and trans people more likely to experience IPV and its impacts, and, within the IPV-positive sample, GSM respondents more likely than cis/hetero respondents to report work and health impacts, it is worth highlighting that a relatively small minority of men did report IPV exposure. In addition to the stigma of being a man exposed to IPV (Hines and Douglas 2015), some of these men faced the added challenge of being a

sexual minority. Further research is needed to explore the patterns of abuse experienced by men, and the role of partner sex and gender in these patterns (Hines and Douglas 2010; Tilbrook et al. 2010; Oliffe et al. 2014).

Several limitations should be noted. First, while the largest of its kind, this is not a randomly sampled survey. However, the alignment between population IPV prevalence rates, and overall demographics, with representative surveys of these issues lends validity (see Wathen et al. 2015). Second, the questions used to assess health and life quality are brief, providing only the most general sense of these concepts; additional research with more robust tools is required to fully explore these relationships. Third, the workplace impact questions are self-report, developed for this survey; further testing and/or validation with employer-reported measures would add valuable information. Finally, these cross-sectional data provide only a snapshot in time, and additional studies are needed to determine the nature and direction of some of the observed relationships. For example, is poorer mental health among the GSM subsample driven primarily by workplace harassment/discrimination due to minority status, or by IPV? Are these effects cumulative, or distinct? These data can begin to point in specific directions, but further research is required.

Implications

While workplace-specific strategies for GSM workers experiencing IPV are difficult to find, learnings from the broader literature may be useful. First, employers and unions should strive toward inclusivity, with strategies such as engaging in active outreach and education, including advertising to promote IPV awareness among GSM workers. Second, collaboration between mainstream and GSM service providers—and links to workplace supports, including through unions—may help to stimulate dialogue on IPV, support informed practice and ultimately improve available resources. Third, there is a need for education about gender and sexual minorities and IPV, including in the workplace. All personnel, but especially leaders, require training that includes the use of inclusive language and specific knowledge of GSM issues and resources, particularly pertaining to IPV (Badenes-Ribera et al. 2015; Buller et al. 2014; Kulkin et al. 2007; Rogers 2016; St. Pierre and Senn 2010; Walker 2015). Finally, workplace responses to IPV should take into account the unique additional workplace impacts, and barriers, faced by trans people in disclosing abuse and seeking help.

At a policy level, the original Canadian survey report was used by our partner, the Canadian Labour Congress, and its affiliates, in collective bargaining to advocate for remedies such as paid leave for IPV—this has been

successfully implemented by a number of unions in Canada. Similarly, several Canadian provinces have used these results to support legislation in provincial parliaments for paid domestic violence leave. There is also significant interest among employers to address the issue, through site-specific training, and also through more robust data collection (Boyer and Chénier 2015). This work is also being replicated internationally (International Trade Union Confederation 2014).

In a concurrent analysis (Saxton et al. 2018), we found that among those experiencing IPV, just over a third—and twice as many women—reported a violent incident to the police, with mixed perceived helpfulness; small subsamples precluded analysis by GSM status. Fewer were involved with the criminal and family law systems, and their satisfaction also varied. Analysis of open-ended responses provided insight into possible reasons for this variability, and a key finding was the perception that getting help depends on “being lucky” in terms of specific officials encountered. Taken together, these analyses point to the need for better coordination and integration of services, from the workplace to other sectors, including health, mental health- and criminal justice, and a specific focus on those especially marginalized, including gender and sexual minorities.

Conclusions

This research has empirically demonstrated what many have likely intuited—IPV is a widespread and impactful problem that affects many people, and especially those who identify as gender and/or sexual minorities. Despite the additional burden of stigma associated with both GSM status and IPV victimization, many are willing to disclose abuse at work, and seek support. The workplace is well-situated—for its own benefit, and those of its workers—to design strategies to safely respond to and support people of all genders and sexual orientations who experience IPV and its impacts. As one of our GSM respondents noted: “[It is] important to remember that this is not a gender issue—both men and women, gay or straight can be victims of domestic violence, or abusers themselves.”

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Compliance with ethical standards

Conflicts of interest The authors declare that they have no conflict of interest.

Human and animal rights All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. The project was approved by Western University’s Non-Medical Research Ethics Board (#104156).

References

- Ahmad F, Jhaji AK, Stewart D, Burghardt M, Bierman AS (2014) Single item measures of self-rated mental health: a scoping review. *BMC Health Serv Res* 14:398. <https://doi.org/10.1186/1472-6963-14-398>
- Ard KL, Makadon HJ (2011) Addressing intimate partner violence in lesbian, gay, bisexual, and transgender patients. *J Gen Intern Med* 26(8):930–933
- Badenes-Ribera L, Frias-Navarro D, Bonilla-Campos A, Pons-Salvador G, Monerde-i-Bort H (2015) Intimate partner violence in self-identified lesbians: a meta-analysis of its prevalence. *Sex Res Soc Policy* 12(1):47–59
- Barrett BJ, St. Pierre M (2013) Intimate partner violence reported by lesbian-, gay-, and bisexual-identified individuals living in Canada: an exploration of within-group variations. *J Gay Lesbian Soc Serv* 25(1):1–23
- Boyer C, Chénier L (2015) Domestic violence and the role of the employer. The Conference Board of Canada, Ottawa. <http://www.conferenceboard.ca/e-library/abstract.aspx?did=7576>. Accessed 5 Aug 2017
- Buller AM, Devries KM, Howard LM, Bacchus LJ (2014) Associations between intimate partner violence and health among men who have sex with men: a systematic review and meta-analysis. *PLoS Med* 11(3):e1001609
- Calton JM, Cattaneo LB, Gebhard KT (2016) Barriers to help seeking for lesbian, gay, bisexual, transgender, and queer survivors of intimate partner violence. *Trauma Violence Abuse* 17(5):585–600
- Coleman TA, Bauer GR, Pug D, Aykroyd G, Powell L, Newman R (2017) Sexual orientation disclosure in primary care settings by gay, bisexual, and other men who have sex with men in a Canadian city. *LGBT Health* 4(1):42–54
- da Rocha NS, Power MJ, Bushnell DM, Fleck MP (2012) The EUROHIS-QOL 8-item index: comparative psychometric properties to its parent WHOQOL-BREF. *Value Health* 15:449–457
- DeSalvo KB, Fisher WP, Tran K, Bloser N, Merrill W, Peabody J (2006) Assessing measurement properties of two single-item general health measures. *Qual Life Res* 15:191–201
- Dinno A (2017) Homicide rates of transgender individuals in the United States: 2010–2014. *Am J Public Health*. <https://doi.org/10.2105/ajph.2017.303878>

- Edwards KM, Sylaska KM, Barry JE, Moynihan MM, Banyard VL, Cohn ES et al (2015a) Physical dating violence, sexual violence, and unwanted pursuit victimization: a comparison of incidence rates among sexual-minority and heterosexual college students. *J Interpers Violence* 30(4):580–600
- Edwards KM, Sylaska KM, Neal AM (2015b) Intimate partner violence among sexual minority populations: a critical review of the literature and agenda for future research. *Psychol Viol* 5(2):112–121
- Friedman MS, Marshal MP, Guadamuz TE, Wei C, Wong CF, Saewyc E et al (2011) A meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals. *Am J Public Health* 101(8):1481–1494
- Goldberg NG, Meyer IH (2013) Sexual orientation disparities in history of intimate partner violence: results from the California health interview survey. *J Interpers Violence* 28(5):1109–1118
- Hines DA, Douglas EM (2010) A closer look at men who sustain intimate terrorism by women. *Partner Abuse* 1(3):286–313
- Hines DA, Douglas EM (2015) Health problems of partner violence victims: comparing help-seeking men to a population-based sample. *Am J Prev Med* 48(2):136–144
- International Trade Union Confederation (ITCU) (2014) Stop gender based violence at work! Support an I.L.O. Convention. Retrieved from International Trade Union Confederation. <http://www2.worksafebc.com/Topics/Violence/Resources-DomesticViolence.asp#Readmore>. Accessed 5 Aug 2017
- Johnson H (2015) Degendering violence. *Soc Polit* 22(3):390–410
- Kulkin HS, Williams J, Borne HF, de la Bretonne D, Laurendine J (2007) A review of research on violence in same-gender couples: a resource for clinicians. *J Homosexuality* 53(4):71–87
- Langenderfer-Magruder L, Whitfield DL, Walls NE, Kattari SK, Ramos D (2016) Experiences of intimate partner violence and subsequent police reporting among lesbian, gay, bisexual, transgender, and queer adults in Colorado: comparing rates of cisgender and transgender victimization. *J Interpers Violence* 31(5):855–871
- MacGregor JCD, Wathen CN, MacQuarrie BJ (2016a) Domestic violence in the Canadian workplace: are co-workers aware? *Saf Health Work* 7(3):244–250
- MacGregor JCD, Wathen CN, Olszowy L, Saxton M, MacQuarrie BJ (2016b) Gender differences in workplace disclosure and supports for domestic violence: results of a pan-Canadian survey. *Viol Vict* 31(6):1135–1154
- MacGregor JCD, Wathen CN, MacQuarrie BJ (2017) Resources for domestic violence in the Canadian workplace: results of a pan-Canadian survey. *J Workplace Behav Health* 32(3):190–205
- National Coalition of Anti-Violence Programs (NCAVP) (2016) Lesbian, gay, bisexual, transgender, queer, and HIV-affected intimate partner violence in 2015. New York, NY: Emily Waters. http://avp.org/wp-content/uploads/2017/04/2015_ncavp_lgbtqipvreport.pdf. Accessed 5 Aug 2017
- Nowinski S, Bowen E (2012) Partner violence against heterosexual and gay men: prevalence and correlates. *Aggress Violent Behav* 17(1):36–52
- Oliffe JL, Han C, Maria ES, Lohan M, Howard T, Stewart DE et al (2014) Gay man and intimate partner violence: a gender analysis. *Sociol Health Illn* 36(4):564–579
- Pizer JC, Sears B, Mallory C, Hunter ND (2012) Evidence of persistent and pervasive workplace discrimination against lgbt people: the need for federal legislation prohibiting discrimination and providing for equal employment benefits. *Loy LA Law Rev* 45(3):715–780
- Potter SJ, Fountain K, Stapleton JG (2012) Addressing sexual and relationship violence in the LGBT community using a bystander framework. *Harvard Rev Psychiat* 20(4):201–208
- Rogers M (2016) Breaking down barriers: exploring the potential for social care practice with trans survivors of domestic abuse. *Health Social Care Commun* 24(1):68–76
- Saxton MD, Olszowy L, MacGregor JCD, MacQuarrie BJ, Wathen CN (2018) Domestic violence victims' experiences with police and the justice system in Canada. *J Interpers Violence*. <https://doi.org/10.1177/0886260518758330>
- Schmidt S, Muhlan H, Power M (2006) The EUROHIS-QOL 8-item index: psychometric results of a cross-cultural field study. *Eur J Public Health* 16:420–428
- Sinha M (2013) Measuring violence against women: statistical trends. Ottawa, ON: Canadian Centre for Justice Statistics. Statistics Canada. Catalogue no. 85-002-X. <http://www.statcan.gc.ca/pub/85-002-x/2013001/article/11766-eng.htm>. Accessed 5 Aug 2017
- St. Pierre M, Senn CY (2010) External barriers to help-seeking encountered by Canadian gay and lesbian victims of intimate partner abuse: an application of the barriers model. *Viol Vict* 25(4):536–552
- Statistics Canada. Canadian Community Health Survey (CCHS) (2012) 2011 Questionnaire and reporting guide. http://www23.statcan.gc.ca/imdb-bmdi/instrument/3226_Q1_V8-eng.htm. Accessed 5 Aug 2017
- Stiles-Shields C, Carroll RA (2015) Same-sex domestic violence: prevalence, unique aspects, and clinical implications. *J Sex Marital Therapy* 41(6):636–648
- Stotzer RL (2009) Violence against transgender people: a review of United States data. *Aggress Violent Behav* 14(3):170–179
- Tilbrook E, Allan A, Dear G (2010) Intimate partner abuse of men. Edith Cowan University, Perth
- Turell SC, Brown M, Herrmann M (2017) Disproportionately high: an exploration of intimate partner violence prevalence rates for bisexual people. *Sex Relat Therapy*. <https://doi.org/10.1080/14681994.2017.1347614>
- Walker JK (2015) Investigating trans people's vulnerabilities to intimate partner violence/abuse. *Partner Abuse* 6(1):107–125
- Walters ML, Chen J, Bredig MJ (2013) The national intimate partner and sexual violence survey: 2010 findings on victimization by sexual orientation. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/nisvs_sofindings.pdf. Accessed 5 Aug 2017
- Wathen CN, MacGregor JCD, MacQuarrie BJ (2015) The impact of domestic violence in the workplace: results from a pan-Canadian survey. *J Occupat Environ Med* 57(7):e65–e71
- Wathen CN, MacGregor JCD, MacQuarrie BJ (2016) The relationship between intimate partner violence, work, and health. *J Interpers Violence*. <https://doi.org/10.1177/0886260515624236>
- World Health Organization (1996) WHA 49.25 Prevention of violence: a public health priority. http://www.who.int/violence_injury_prevention/resources/publications/en/WHA4925_eng.pdf. Accessed 5 Aug 2017