ADAPTING THE ISLANDS OF SAFETY MODEL FOR LGBTQ2S+ COMMUNITIES

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By

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We accept this thesis as conforming to the required standard.

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ABSTRACT

The purpose of this study was to gain initial feedback from lesbian, gay, bisexual, trans, queer, two-spirit and other gender and sexual minority (LGBTQ2S+) counsellors, social workers and anti-violence workers on the Islands of Safety response-based model and whether it could be used in LGBTQ2S+ communities. Online, asynchronous focus groups were conducted over the course of a week in February 2016 with 26 counsellors, social workers, psychiatric nurses, anti-violence workers and outreach workers from across a spectrum of genders, sexualities and ethnicities. Results showed that resistance and dignity were the most embraced response-based ideas. Focusing on both responses and impacts of violence was important. Including family of choice, using the client’s language for their gender and sexuality and not making assumptions about family structure and the gender of the primary parent was important. Participants who stated that they knew about or were connected to Métis and Indigenous cultures and politics supported working to bridge differences in genders and sexualities across cultures without changing the Islands of Safety model. Non-Indigenous, non-Métis LGBTQ+ health care practitioners need more training around Métis and Indigenous views of gender and family structure to contextualize the traditional view of family used in the model.
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DEFINITION OF TERMS

Gender

There are a large number of people in LGBTQ2S+ communities who find labelling and categorization offensive and dangerous to their physical, emotional, mental and spiritual well-being. They are working to live in ways that are not bound quite so much by labels and categories, and they fight to be able to live their genders and sexualities in more safety. Labelling and categorization have been, and continue to be, used by the health care professions in ways that are pathologizing, deeply disrespectful and dangerous to LGBTQ2S+ people. Words describing gender and sexuality are always evolving and have many meanings. It is through this lens that I reluctantly offer some guideposts, from my perspective as a queer person in my forties, on the genders and sexualities included in this study. These signposts in no way cover all possible genders or sexualities, or positions within those genders and sexualities, and, in fact, may not even cover the full meaning of the genders and sexualities of the participants in the study.

Cisgender is a term to describe people whose felt sense of gender matches their doctor-assigned gender at birth. Gender minority is an umbrella term used by some researchers to describe people who do not identify as cisgender. Gender is a multi-dimensional spectrum, rather than a binary norm of male and female, which includes genders like genderqueer, gender non-conforming, gender non-binary, genderfluid and transgender.

Trans is another umbrella term with a wide range of subject positions and beliefs about gender, so it is vital to not make assumptions about trans-ness, a person’s gender or their gender journey. Transgender usually describes people who are transitioning (can be emotionally or mentally, not just physically) into their felt sense of gender. It is possible that the person is
transitioning from one gender to another; when the transition is complete, they might dis-identify as transgender and identify as man or woman. It is also possible that the person will maintain trans-ness as part of their identity. That person may or may not want to be called “trans-man” or “trans-woman”, or “trans-masculine” or “trans-feminine”. Once the person has transitioned into their felt sense of gender, it is also possible that their gender will be any of the huge multitude of genders.

Trans, with or without the word gender on the end, can also mean that the person believes that gender is always in transition and/or performative and transgender or trans might be a person’s permanent gender or aspect of identity. Often the suffix “gender” is left off the word “trans” for many reasons, including to be more inclusive of different ways to be trans, so in the rest of this paper, I will be using trans instead of transgender. To be respectful, it is vital that all people, including service providers, educate themselves on gender and sexuality and use a person’s pronouns and current name in the contexts that person wants those pronouns and names used, as it may not be safe to use those pronouns and names with work, health insurance providers or certain family members. It is also really important that service providers think about whether they actually have a valid reason for asking about the details of a person’s gender or sexuality for assessments and applications and know why service providers are asking for that information (Forge, 2012). I would caution against depending on assumptions or simple definitions of trans, transgender, queer, gender non-conforming, gender non-binary or genderqueer. As none of the participants stated that they were transsexual, I am not defining transsexuality in this thesis.

The distinction is made between sexuality and gender due to the theory of intersectionality: the experiences of being cisgender and trans or genderqueer within a same-sex
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relationship can be different from each other. Many trans or genderqueer people have relationships across genders, which they may describe as heterosexual or queer or both heterosexual and queer, depending on a lot of factors that are not the focus of this paper. Therefore, if we only study lesbian or gay or “same-sex” relationships, we exclude many sexualities and genders, and the research creates an artificial and only partially accurate view of LGBTQ2S+ cultures and relationships. Research on gay men has been generalized to other sexualities and genders, and further research has shown that studies done on one segment of a sexuality and/or genders cannot be generalized to other sexualities and/or genders (Diamond, 2006).

Queer is now a common umbrella term than can describe gender and/or sexuality, as a way to denote relationships and identities that subvert societal norms, and also to “take back” what used to be a homophobic slur. Some people, especially people over 40, still identify the term queer as a pejorative, although it is in wide use in populations under 40. Basically the rule for all gender and sexual communities is to use and respect the person’s own language, in the contexts they are comfortable using that language, and, if necessary, confirm the meaning with them to avoid assumptions about meaning. Confirming where it is safe to use a person’s gender, name and pronouns is vital, as there are situations where using these could result in violence, loss of jobs, family difficulties and barriers to accessing services.

Sexual Orientations

Sexual minority is a term used in research to describe the type of sexual and/or romantic relationships people engage in outside of heterosexuality. Sexual minorities include people who identify as lesbian, gay, bisexual and pansexual. Commonly in research, this term has included people who engage in non-heterosexual activity but do not wish to be labelled as lesbian, gay,
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Bisexual or pansexual, yet it is not clear if those populations would see themselves as sexual minorities or as part of LGBTQ2S+ cultures. The traditional meaning of bisexual is usually seen as referring to having romantic and/or sexual attraction to cisgender men and cisgender women, but not all people define bisexuality this way, preferring to define bisexual as being attracted to both one’s own gender and another gender in order to be accepting of trans communities.

Pansexual is a term used to describe attraction to people of any gender in the gender spectrum, including non-binary genders.

Two-spirit is an umbrella term created at an international conference of Indigenous LGBTQ+ organizations in Winnipeg in 1990 to replace the term berdache, which was a derogatory colonial term for anyone who did not conform to the binary gender system and hierarchical heteronormative values of the colonizers of North America (Laframboise & Anhorn, 2008). There are words in many, but not all, Indigenous languages to describe gender, therefore the phrase “two-spirit” was created as a way to identify gender diversity across Indigenous language groups (Laframboise & Anhorn, 2008). Not all Indigenous people who are in a gender and/or sexual minority identify as two-spirit (Laframboise & Anhorn, 2008). Today two-spirit can indicate any Indigenous person who has “come in” to their identity as an Indigenous person and as someone who is gender diverse and/or is open to same-sex desire (Two spirit people, 2011). Two-spirit is a gender/sexuality that can be quite distinct from being part of LGBTQ+ communities in settler cultures, although there are also many Indigenous people who do not resonate with two-spirit and would rather be part of the LGBTQ+ communities (Two spirit people, 2011).

Finally, just knowing some of the history and terms for some genders and sexualities is not, in itself, enough to provide adequate and dignifying anti-violence services to a wider
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diversity in genders and sexualities. LGBTQ2S+ communities have been forced into categories and labels any time there is a form that asks if one is male or female, if the person is married, and whether they are a Mr., Mrs., Miss or Ms. Respecting a person’s language and confirming the client’s specific meaning of a term is just the first step in providing adequate services.

*Types of Violence*

In this study, I will be talking about several types of violence. Hate violence in this paper refers to violence enacted by a homophobic or transphobic person, organization or institution towards someone due to their gender or sexuality. Interpersonal violence (IPV) is another phrase for domestic violence, which in a queer context is defined as partner on partner violence in a familial, romantic, dating or sexual relationship. The standard definition of interpersonal violence includes acts of physical, verbal, emotional and economic violence. Interpersonal violence in LGBTQ2S+ communities also includes acts of gender violence like

- threatening the survivor’s gender and sexuality, including denying access to hormone medications or clothes of the survivor’s preferred gender;
- verbally putting down the victim’s gender and/or sexuality;
- threatening to disclose the survivor’s gender and sexuality to work or family;
- denying access to the victim’s LGBTQ2S+ cultures and communities (The Northwest Network, 2011).

**INTRODUCTION**

Searching for interpersonal violence services specifically for LGBTQ2S+ people on Vancouver Island has been an exercise in broken web links, outdated resources, and promising-looking organizations that had actually closed their doors years ago (Jacques, 2015). According to the National Coalition of Anti-Violence Programs in the U.S., “preventative measures, access
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to anti-violence services, public awareness, and national discourses surrounding LGBTQ [lesbian, gay, bisexual, transgender and queer] intimate partner violence (IPV) remain inadequate and that LGBTQ and HIV-affected survivors of intimate partner violence still face incredible barriers when seeking support” (National Coalition of Anti-Violence Programs, 2014). This is despite research evidence showing that the prevalence rates for IPV in the LGBTQ+ communities mirror the prevalence rates for IPV in cisgender heterosexual communities (Walters, Chen, & Breiding, 2013; Jacques, 2015).

As a European settler who identifies as a genderqueer pansexual future counsellor, I did this research because I believe that it is important to create local services for both survivors and perpetrators of violence that dignify all sexualities, genders, abilities, ages and ethnicities. As part of this work, I need to acknowledge that some of the gender violence I discuss in this paper has been enacted on unceded territories of the Lekwungen and WSÁNEĆ Coast Salish peoples. The research I did was on the land of the Lekwungen and WSÁNEĆ Coast Salish peoples. If service providers work to not assume cisgenderism, heterosexuality and whiteness and ability — to work past being inclusive towards being affirmative — that includes using models, processes and interventions developed with and by Métis and Indigenous communities, queer communities and settler cultures from a broad range of ethnicities and cultures, classes and abilities. While there are some counselling services available for LGBTQ2S+ communities, and some queer and transgender anti-violence organizations in the U.S. have created assessment tools for screening for victims and perpetrators of interpersonal violence, most anti-violence safety planning tools and services are geared towards a white, cisgender, heterosexual female survivor. I agree that in any situation of interpersonal violence, the safety and healing of the survivor is of primary importance. I wish to broaden the definition of survivor and victim to include all survivors and
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all victims, not just survivors who society sees as the most visible and compatible with standard treatments and popular with funders.

This thesis proposes that in order to heal violence across a broad range of genders, sexualities, ethnicities, ages, classes and abilities, LGBTQ2S+ organizations and practitioners need tools that can be used with survivors and perpetrators. These anti-violence tools need to be inclusive and affirmative of all people and come out of communities responding to systemic, colonial and institutional violence. We need ways to lower the violence other than isolating the perpetrator from already tiny and isolated communities. Currently, most anti-violence agencies serving LGBTQ2S+ communities work primarily with survivors. This thesis will take several ethical and practical stances. First, to lower violence in society, it is important to do healing work with victims. Second, it is important to work with perpetrators on being able to take responsibility for their violent acts and to control their violent acts. Third, in order to keep the survivor safe, it is important for counsellors to work with the survivor on keeping themselves safe and to work with the perpetrator to take responsibility for the violence and to lower the level of violence. Fourth, I will use the terms survivor and victim interchangeably, as most LGBTQ2S+ IPV is not reported to police, while acknowledging that not all people who have experienced violence resonate with the word “survivor” and others do not resonate with the word “victim” (Hardesty J. L., Oswald, Khaw, & Fonseca, 2011; Guadalupe-Diaz & Yglesias, 2013). Writings on response-based approaches tend to use the word “victim”, so when discussing response-based practices, I will use the word “victim”, and for the rest of the paper I will switch between using the words “victim” and “survivor”. As Richardson stated:

I have lots of views about different terms. I believe that people can choose the term that best fits for them. However, what I don't like about ‘survivor’ in the
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Indigenous context is that it does not honour the people who did not survive, the ones who were killed or died as a result of the violence. Resistance (and resilience) does not stop violence and seldom can because, due to the imbalance in power, perpetrators often are more powerful and have weapons. Over half of the Indigenous children in residential schools did not survive (Richardson, personal communication, 2016).

I am choosing to look at an aspect of response-based practice because I think that response-based practice and LGBTQ2S+ anti-violence activism both contain similar theories of interpersonal violence. What response-based practice lacks in a non-binary gender analysis, LGBTQ2S+ anti-violence activists can provide, while response-based practice can add a model for safety planning and healing that involves working with the perpetrator in greater safety, in a manner that complies with the B.C. Ministry of Children and Families guidelines for child protection and complies with current British Columbia law. Furthermore, in my review of the literature, I could not find research published on uses of response-based practice with LGBTQ2S+ communities, highlighting a gap in the research literature.

Response-based practice is a set of discourse analysis tools, therapeutic interventions, safety-planning tools and theories about violence developed primarily by Allan Wade, Linda Coates, Cathy Richardson and Nick Todd. Response-based practice shifts the therapeutic focus from looking at the effects on the victim to looking at the social responses to violence. According to response-based practice, using a language of effects conceals violence, mitigates the perpetrator’s responsibility for the violence, blames the victim and pathologizes the victim (Coates & Wade, Language and violence: Analysis of four discursive operations, 2007). Instead, response-base practice has stated that when there is violence, the victim resists the violence and
the perpetrator does everything they can to neutralize the victim’s resistance (Coates & Wade, 2007; Wade, 1999). Rather than treating the victim’s trauma by looking at the effects of violence within the victim, response-based practice uses discursive therapeutic approaches to draw out the ways in which the victim responded to the violence (Wade, 1999). Working with perpetrators through a response-based model involves working with the perpetrator to elucidate their responsibility and find their prosocial responses to violence (Reynolds, 2014; Adams, 2007).

The Islands of Safety model was a pilot program launched in 2009 by Cathy Richardson, Allan Wade and Cheryle Henry in conjunction with Métis Community Services and the B.C. Law Foundation to create a safety and risk assessment tool based on response-based principles that could be used with Indigenous families on Vancouver Island who were referred to Islands of Safety by the Ministry of Children and Families (Richardson & Wade, 2013).

**Study Purpose**

The purpose of this study was to test the statement in Richardson’s and Wade’s 2013 article “Creating Islands of Safety” that the Islands of Safety model could be adapted to other cultures by studying how LGBTQ2S+ communities respond to this model (Richardson & Wade, 2013). According to Richardson and Wade,

Although we developed Islands of Safety for use with Indigenous families in Canada, we believe it can be usefully applied with families from diverse ethno-racial cultures, drawing on what is most sacred for individuals within their own communities. We believe that cultural groups who have been displaced from a homeland and who look to their family traditions and spirituality as a source of inspiration are likely to be the most open to the Islands of Safety process (Richardson & Wade, 2013, p. 162).
I tested 1) the statement that Islands of Safety can be adapted to other cultures; 2) whether this model could be used outside of a child protection context for both LGBTQ2S+ interpersonal violence and homophobic/transphobic hate violence (Richardson & Wade, 2013, p. 162); and 3) looked at how LGBTQ2S+ practitioners adapt IPV treatment models to their work with LGBTQ2S+ clients. My current research question was: how would LGBTQ2S+ counsellors, social workers and anti-violence workers adapt the Islands of Safety model for use with LGBTQ2S+ victims and perpetrators of interpersonal violence?

As most LGBTQ2S+ anti-violence agencies researched by this author worked with survivors, the Islands of Safety model potentially could provide a container for working with both victims and perpetrators in a safe, rigorous manner. Furthermore, LGBTQ2S+ anti-violence agencies have valuable knowledge and tools for assessing interpersonal violence (IPV) in same-sex or queer relationships and have experience adapting therapeutic practices for use with non-binary genders, same-sex relationships and queer relationships, thus benefiting and expanding the Islands of Safety model for use with many genders and sexualities and highlighting that the current Islands of Safety model provides a view of family that pushes back against heteronormative, patriarchal, colonial norms.

LITERATURE REVIEW

Research on IPV in LGBTQ2S+ Communities

Most LGBTQ2S+ research has attempted to study a segment, or a specific set of segments, of LGBTQ2S+ communities. As such, the acronym for these communities changed throughout the literature review to reflect the communities studied in the particular study discussed. This study did not claim to speak for every LGBTQ2S+ community and did not speak for every individual in those communities.
What the research showed is that interpersonal violence has existed in LGBTQ2S+ communities at a prevalence similar to or higher than in cisgender, heterosexual communities and that LGBTQ2S+ survivors have discovered that there are many barriers to access mainstream anti-violence services and thus avoided mainstream shelters and instead depended on counselling and friend networks (Helfrich & Simpson, 2006). Unfortunately, many shelters and rape crisis centres have followed the traditional, heteronormative feminist analysis of patriarchy, which conceptualized IPV as a male perpetrating violence against a female victim. Therefore, LGBTQ2S+ survivors received negative social responses and have even been barred from services because their experience of IPV did not fit within the organizational policy of most women’s shelters and anti-violence centres (Malinen, 2014; National Coalition of Anti-Violence Programs, 2014).

Many of the lesbians Malinen (2014) interviewed about their experiences of accessing services received negative social responses from mainstream services like shelters, police and rape hotlines:

The person answered and I said, “I’ve been raped,” and she proceeded to ask the proper questions. And when I used the pronoun “she” for my assailant, the woman on the other end got indignant, seems to be the word of the day. She got indignant and told me that she didn’t appreciate the prank, and not to call back (Malinen, 2014).

While cisgender lesbian, queer women and bisexual women are able to sometimes access mainstream services, there are even fewer options for people who are gay, trans, non-binary or intersex.
In 2013, the same year that legislators passed updates to the U.S. Violence Against Women Act to compel domestic violence shelters to provide services to LGBT communities, shelters denied access to 20.3% of LGBTQ survivors who asked for help, the highest rate recorded by the National Coalition of Anti-Violence Programs to date (National Coalition of Anti-Violence Programs, 2014). While 38.77% of LGBTQ people reported that they had been injured during an abusive incident, only 18.8% reported seeking medical attention (National Coalition of Anti-Violence Programs, 2014). As Lambda Legal documented in their 2010 report “When Health Care Isn’t Caring”, health care professionals have consistently acted in discriminatory, verbally abusive and sometimes even physically abusive ways towards LGBTQ patients (Lambda Legal, 2010). Of the 17% of survivors who applied for a protective order in the U.S., 41.74% were denied a protective order (National Coalition of Anti-Violence Programs, 2014).

Gay communities used the services of Anti-Violence Programs (AVPs) more than any other gender or sexual minority (41% of all survivors accessing AVP services), showing that services have been needed and used by the gay community. What has been needed are services within the mainstream and within queer communities that follow an intersectional analysis of cis-normative heteropatriarchy, rather than an intersectional analysis of patriarchy (Barrett & St. Pierre, 2013; Malinen, 2014). Shelters need to begin to offer services to victims of all genders.

Methodological issues in the field. Researchers have been studying same-sex IPV since 1978, but the field is still small and most studies cannot be compared with each other or generalized to larger populations for various methodological reasons (Murray & Mobley, 2009). Most studies in this area are based on small convenience samples and do not use a consistent definition of IPV (Murray & Mobley, 2009). Most studies do not uniformly operationalize
genders and sexualities: some studies group bisexual men and women in the same category, other studies group lesbians and bisexual women and/or gay men and bisexual men in categories, while still other studies operationalize bisexual women as heterosexual if their abuser was male (Baker, Buick, Kim, Moniz, & Nava, 2013; Heintz & Melendez, 2006; Turell & Herrmann, 2008; Hassounuh & Glass, 2008; Poon & Saewyc, 2009; Guadalupe-Diaz & Yglesias, 2013; Edwards & Sylaska, 2013; Goldberg & Meyer, 2013). Including bisexual women in the same category as heterosexual women ignores the unique factors that may occur for bisexual IPV, such as a perpetrator trying to “rape the gay” out of their partner, forcing their partner to “pick a side” or abusing their partner out of homophobic jealousy.

**Prevalence.** Most of the research on IPV in LGBTQ relationships has focused on measuring the prevalence of IPV in sexual and gender diverse communities. These studies measure IPV rates in American LGB communities at rough ranges from 25% to 50% (Murray & Mobley, 2009). Widely different levels of IPV have been found for each separate gender and sexual orientation. According to Murray and Mobely’s (2009) meta-analysis of prevalence studies, only one study used a large, probability-based sample, Greenwood et al.’s 2002 study of IPV in a group of 2,881 urban men who have sex with men (MSM). Often, researchers of gay IPV will measure sexual behaviour — “do you have sex with men” — rather than sexual identity — “do you identify as gay” — to eliminate self-selection bias (Greenwood, et al., 2002; Murray & Mobley, 2009). Furthermore, many ethnicities and cultures, especially African-American, Latin and South Asian communities, heavily stigmatize gay identities, so some men may not self-identify as gay, even if their sexual behaviour is primarily homosexual (Ard & Makadon, 2011; Kubicek, Mcneeley, & Collins, 2015). According to Greenwood et al. (2002), 34% of urban MSM “experienced psychological violence in the past five years, 22% experienced
physical abuse, and 5.1% experienced sexual abuse. Some type of battering victimization was reported by 39.2% of the respondents, with 18.2% reporting multiple battering (more than one type of battering).”

Rothman, Exner and Baughman’s 2011 review of prevalence studies show the heterogeneous results of research in this area, as studies published between 1989 and 2009 report prevalence rates of 9.5% to 57% for gay and bisexual males and from 2% to 45% for lesbian and bisexual females. This study noted that overall, studies using convenience samples reported a higher rate of IPV than those using population-based samples (Rothman, Exner, & Baughman, 2011).

Canadian figures on same-sex IPV (SSIPV) were even more difficult to source than American statistics. Poon and Saewyc’s 2009 study of urban and rural sexual minority adolescents in British Columbia was one of a handful of studies that included data on dating violence in Canada using population-based samples. Poon and Saewyc reported that rural adolescent boys were three times as likely to report dating violence as urban adolescent males, while rural adolescent girls were half as likely to report dating violence as urban adolescent girls (Poon & Saewyc, 2009). Unfortunately, Poon and Saewyc did not report prevalence rates as a percentage of the population but reported their data as adjusted odds ratios between rural and urban sexual minority adolescents. However, their data did point out the need for victim services for gay adolescents in rural areas and lesbian and bisexual females in urban areas.

Another Canadian study of LGB IPV that added to the prevalence literature on same-sex IPV (SSIPV) was Barrett and St. Pierre’s 2013 study of within-group variations of LGB IPV in a nationally representative sample from the General Social Survey of Canada. This study was, at the time, most likely the only SSIPV study in Canada using a nationally-representative sample
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(Barrett & St. Pierre, 2013). Thirty-six percent of the 186 Canadian LGB respondents of the survey who filled out the IPV section of the survey experienced one or more incidents of IPV (Barrett & St. Pierre, 2013). Emotional/financial abuse was the most common (34.9%), followed by physical and sexual abuse at 20.4% (Barrett & St. Pierre, 2013). “Of those who experienced any physical/sexual form of IPV, 38.9% identified as bisexual women, 26.4% identified as gay men, 19.6% identified as lesbian women, and 15.1% identified as bisexual males” (Barrett & St. Pierre, 2013). Along with similar studies, Barrett and St. Pierre’s study revealed that bisexuals are at a higher risk of IPV and a higher risk of physical injury (28.8%) from IPV than gay or lesbian individuals (15.5%). As Barrett and St. Pierre did not measure whether bisexual violence occurred in same-gender or cross-gender pairings, it was not known if the increased risk for bisexuals was due to male perpetrators and bisexual female victims or if other factors were relevant. Barrett and St. Pierre (2013) also critiqued conflating bisexual IPV as heterosexual IPV, as biphobia in both heterosexual and queer communities can mean that bisexuals experience marginalization in both communities.

Goldberg and Meyer (2013) used a probability-based sample from the California Health Information Survey (2007–2008) to study aspects of the higher rate of IPV among gay men and bisexual women. This study was one of the few that has measured the gender pairings in bisexual relationships. They found that 95% of IPV among bisexual women occurred in the context of a male perpetrator and a female victim (Goldberg & Meyer, 2013). Goldberg and Meyer found that even “after controlling for race, educational attainment, age, employment status, binge drinking, and history of psychological distress” gay and bisexual individuals were at a higher risk of IPV than heterosexuals (Goldberg & Meyer, 2013). Latin men and women reported less IPV than
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white men and women, and black men and women experienced higher rates of IPV than either white or Latina men and women. Most gay IPV (97%) occurred in a same-sex context.

According to Edwards et al. (2015), very few studies have compared sexual assault, physical dating violence and stalking in large samples of heterosexual and sexual minority college-aged individuals. In fact, this was the only study I found that studied stalking as an aspect of dating violence or IPV. Edwards et al. (2015) compared 4,961 heterosexual students’ with 1,069 sexual minority students’ (SMS) experiences of dating violence occurring within the past six months. Sexual minority college students experienced higher rates of physical assault (30.3% for SMS versus 18.5% for heterosexual students), higher rates of sexual assault (24.3% for SMS versus 11% for heterosexual students), and higher stalking (53.1% for SMS versus 36% for heterosexual students) (Edwards, et al., 2015). Female sexual minority students experienced higher rates of IPV than heterosexual female students, whereas heterosexual, bisexual and gay males reported similar IPV rates (Edwards, et al., 2015).

I could not find much English-language academic research on IPV in transgender communities. Research on transgender IPV is usually focused on barriers to access services, on dynamics of trans-specific IPV and recommendations for service provision (White & Goldberg, 2006; Cook-Daniels, 2015; Walker, 2015). Most studies and anti-violence agencies quote prevalence rates from either the National Coalition of Anti-Violence Projects (NCAVP) yearly reports or the Center for Disease Control’s National Intimate Partner Violence Survey (NISVS). Of these two reports, only the NCAVP report (2014) contains any data on IPV prevalence rates in trans communities.
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**Relationship Dynamics of LGBTQ Interpersonal Violence.**

While the bulk of research has tried to explore the relationship and interpersonal dynamics of same-sex IPV, these studies were usually based on small sample sizes. Using this information to try to fit individual cases into a model of IPV relationship dynamics would be impossible and anti-therapeutic due to the wide variation of identities and relationship configurations that have existed in LGBTQ2S+ communities. This information has been provided to show how the research community has tried to define IPV in LGBT relationships and would not be a recommendation for practice.

Research on IPV in gay and lesbian communities has highlighted that often, first relationships contain abuse. Almost half of gay and lesbian first relationships studied were abusive (Ristock, 2003; Kubicek, McNeeley, & Collins, 2015). Sometimes perpetrators are more experienced community members who act as a gatekeeper to queer communities by controlling the victim’s first experience of queer relationships and the victim’s access to community and friend networks, as the victim’s first LGBTQ friends are also the friends of their partner (Ristock, 2003; Kubicek, McNeeley, & Collins, 2015). Quite often, the older partner will also be more financially established, creating an economic power imbalance (Ristock, 2003; Kubicek, McNeeley, & Collins, 2015).

Goldberg and Meyer (2013) found that psychological distress and binge drinking did not explain the higher levels of IPV in LGB populations, which belies some associations that have been hypothesized about the correlations between minority stress, substance use and victimization of same-sex IPV (Buller, Devries, Howard, & Bacchus, 2014; Wu, et al., 2015). Heintz and Melendez (2006) pointed out that in both heterosexual and same-sex relationships,
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negotiating for safer sex was associated with an incident of IPV 21% of the time and an incident of sexual violence 19% of the time.

Getting tired of the abuse and fighting back was a dynamic of same-sex IPV that has been documented throughout the literature. Researchers and the people they have interviewed have both labelled fighting back with intent to hurt mutual abuse or situational couple violence, while other researchers assert that all retaliatory violence is self-defence (Peterman & Dixon, 2003; Murray, Mobley, Buford, & Seaman-DeJohn, 2007). Researchers have documented this dynamic, but they have struggled to explain it through a gender lens (Peterman & Dixon, 2003; Murray, Mobley, Buford, & Seaman-DeJohn, 2007). This dynamic was not present in all relationships.

Gender is typically operationalized as masculine = dominant/violent, femininity = passive/nurturing. Some research has shown that gay men who embrace traditional gender norms, patriarchal values and/or misogyny tend towards IPV perpetration (Oringher & Samuelson, 2011; Kubicek, McNeeley, & Collins, 2015). Oliffe et al. (2014) propose that gender in gay IPV may be partially explained by competing types of masculinities struggling for dominance across a range of non-hegemonic masculinities. Several researchers have noticed how gay men competed for dominance and control while negotiating gender roles and grappling with how to fit together in a heteronormative world (Gillum & DiFulvio, 2012; Oliffe, et al., 2014).

IPV in trans relationships sometimes centred around transition and sometimes it did not. As an example, sometimes when one partner changes gender, the other partner could feel that it would change their own sexual identity and it would threaten their group membership in their queer community; for example, if a lesbian has transitioned into a male, non-binary or trans-masculine identity, the other partner(s) may worry about their own membership in the lesbian community (Kubicek, McNeeley, & Collins, 2015; Walker, 2015). There has been a political and
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personal struggle between some in lesbian and FTM (female-to-male) trans communities, and this larger struggle has played out in some personal relationships (White, 2002). In heterosexual relationships with trans feminine survivors, IPV will most likely, but not always, follow a heterosexual power and control dynamic (Smith C. M., 2014). Gender can be used as a tool of abuse against trans people: mocking their gender, threatening to out them as trans to work and family, denying access to clothes of their felt gender and denying access to hormone treatment or other supplies (packers, binders, wigs, hip/breast pads, makeup), (Cook-Daniels, 2015).

Gender norms may not neatly map over perpetration and victimization in lesbian relationships, where size may not indicate masculinity or domination or ability to do damage (Hassouneh & Glass, 2008). In fact, the gender norm that women are nurturing and non-violent has served to conceal IPV among women (Hassouneh & Glass, 2008). Often the people in the relationship may have co-constructed their norms around gender and around bidirectional violence: that violence in gay relationships was “men being men” and that violence in lesbian relationships was “just a catfight” and not serious (Hassouneh & Glass, 2008; Oliffe, et al., 2014).

Threatening to out the victim or belittling or policing the genders and sexualities of gays, lesbians and bisexuals could also be a component of IPV — not being “queer” enough or not passing in cisgender heterosexual society well enough, being too butch or too femme (Helfrich & Simpson, 2006; Hassouneh & Glass, 2008). Quite often, the police have arrested the person whom they perceive as the most butch person in the relationship, regardless of who perpetrated the violence (Helfrich & Simpson, 2006). Trans survivors may experience domestic violence from their birth family when they come out about their trans-ness or if they are outed by others (Grant, et al., 2011). Trans victims of family violence experience four times as much
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homelessness and entry into sex work, and double the number of suicide attempts and HIV infection, as the rest of the trans community (Grant, et al., 2011).

**Social Context and Associated Factors**

According to Greenwood et al.’s 2002 population-based study of men who have sex with men (MSM), age was the strongest correlate of IPV risk for MSM. The highest rates of IPV occurred among men under 40, and the lowest rates of IPV were reported in men over 60. Other research studies confirmed this finding (Greenwood, et al., 2002; Murray, Mobley, Buford, & Seaman-DeJohn, 2007). Having more economic resources was also a protective factor (Greenwood, et al., 2002). Barrett and St. Pierre (2013) noted that in Canada, lower education and having a “physical or mental limitation” was associated with a higher risk of IPV, which could support an intersectional analysis of IPV risk.

Several studies have attempted to make a connection between minority stress and the perpetration (or victimization) of IPV (Carvalho, Lewis, Derlega, Winstead, & Viggiano, 2011; Gillum & DiFulvio, 2012; Edwards & Sylaska, 2013; Lewis, Milletich, Derlega, & Padilla, 2014). Some data has shown higher rates of IPV perpetration and victimization associated with what some research called “internalized homonegativity” and what other studies called “stigma consciousness”. However, these associations varied based on the type of violence and on the study (Carvalho, Lewis, Derlega, Winstead, & Viggiano, 2011; Gillum & DiFulvio, 2012; Edwards & Sylaska, 2013; Lewis, Milletich, Derlega, & Padilla, 2014). Lewis, Milletich, Derlega and Padilla (2014) found that among the lesbians in their sample, there was a direct link between rumination, minority stressors, lower relationship satisfaction and perpetration, which possibly showed that other factors played into any association between minority stress and IPV perpetration. Figures from both the NCAVP (2014), the National Transgender Discrimination
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Survey (2011), Lambda Legal (2010) and the National Resource Center on Domestic Violence (2014) clearly showed higher rates of IPV and higher rates of receiving abusive service delivery among LGBT people of colour. The following chart from the National Resource Center on Domestic Violence (2014) showed IPV rates in the transgender community by ethnicity:

![IPV Intersectionality Chart](Munson, 2014).

Lesbian Mothers and the Absence of Gay Fathers and Trans Parents in the Research

According to the National Coalition of Anti-Violence Programs, perpetrators used children as part of their abuse towards their partner 0.44% of the time (National Coalition of Anti-Violence Programs, 2014). While it is not known which genders comprised this 0.44%, this figure showed that some queer parents accessed IPV services due to specific forms of IPV that involved children. As many lesbian parents in the U.S. lost custody due to their sexual orientation, this small number was not surprising (Oswald, Fonseca, & Hardesty, 2010). One-third of lesbian partnerships included underage children (Hardesty J. L., Oswald, Khaw, Fonseca, & Chung, 2008). Despite an extensive English-language research search, I could not find any study that covered the dynamics of gay/bisexual fatherhood and IPV or trans parenting and IPV. This was despite the fact that 38% of the U.S. adult trans community were parents (Grant, et al., 2011). In Canada, the 2011 census recorded 64,575 same-sex couple families, 0.8% of the total number of same-sex couples in Canada; 54.5% of the same-sex couples in Canada identified as
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male and 45.5% as female, and 9.4% of same-sex couples had children in their household (Statistics Canada, 2011).

One of the few English-language researchers to study lesbian mothering and IPV were Hardesty, Oswald, Khaw, Fonseca and Chung. According to Hardesty et al, the only other study on lesbian parenting and IPV was an article by Renzetti published in 1988:

In Renzetti’s (1988) groundbreaking [sic] study, 35 out of 100 battered lesbians had lived with their own or their partner’s children. Almost 30% of the lesbian mothers reported that their partner also abused the children, and 20% indicated they had been physically abused in front of their own or their partner’s children (Hardesty J. L., Oswald, Khaw, Fonseca, & Chung, 2008).

Hardesty et al.’s 2008 paper “Lesbian Mothering in the Context of Intimate Partner Violence” documented ways victims presented incidents of IPV to their children and worked to protect their children from IPV. Hardesty et al. interviewed 12 African-American, 9 White and 3 Latina lesbian mothers about the composition of their families, the nature of their relationship with their abuser, the abuser’s role in the child’s life and the mothers’ relationships with their children.

Mothers tended to use three different strategies with their children: hiding violence, minimizing violence and talking about the violence (Hardesty J. L., Oswald, Khaw, Fonseca, & Chung, 2008). Most mothers who hid or minimized the violence were African-American and Latina. All the people who talked about the violence were White, and most were employed in professional-level employment:

Similar to hiders, minimizers tried to protect their children from violence by sending them to their rooms or to friends’ or relatives’ houses. These mothers
also made active efforts to console children who cried or worried about the violence. At the same time, however, mothers told children that there was nothing to worry about and tried to preoccupy or distract children from thinking about the violence (Hardesty J. L., Oswald, Khaw, Fonseca, & Chung, 2008).

Perpetrators tended to be either co-parents, had little or no parenting role in the child’s life or were the primary parent of the child (Hardesty J. L., Oswald, Khaw, Fonseca, & Chung, 2008). Perpetrators in co-parenting roles also tended to try to hide or minimize the violence and did not abuse the children (Hardesty J. L., Oswald, Khaw, Fonseca, & Chung, 2008). Perpetrators who were primary parents tended to be abusive towards the children and used the children as leverage over the survivor, while survivors reported that those partners with no parenting role tried to reward the children in ways the children found disingenuous (Hardesty J. L., Oswald, Khaw, Fonseca, & Chung, 2008). In co-parenting and abusive parenting situations, survivors said that children had their own emotional attachments to the abuser and leaving was difficult for the children (Hardesty J. L., Oswald, Khaw, Fonseca, & Chung, 2008).

In 2010, Oswald, Fonseca and Hardesty published another paper, “Lesbian Mothers’ Counselling Experiences in the Context of Intimate Partner Violence”, based on a re-examination of the data set collected for Hardesty et al.’s 2008 paper. Survivors reported that a model of mutual abuse was used in most of the couples’ counselling received (Oswald, Fonseca, & Hardesty, 2010). Around 50% of the survivors found counselling “very helpful”, which depended on the counsellor’s knowledge of same-sex IPV and their support of their client (Oswald, Fonseca, & Hardesty, 2010). The majority of non-helpful responses involved the counsellor’s inability to recognize same-sex IPV or cope with abusive, controlling tactics in-session (Oswald, Fonseca, & Hardesty, 2010).
In 2011, Hardesty, Oswald, Khaw and Fonesca studied how lesbian and bisexual mothers sought for help for IPV. They discovered that the higher economic status the mother had and the more “out” she was about her sexual orientation, the more the mother sought and demanded help, and the more likely she was to explain the IPV to the child in age-appropriate ways (Hardesty J. L., Oswald, Khaw, & Fonseca, 2011). Police were usually called when mothers were property owners or had their name on the lease (Hardesty J. L., Oswald, Khaw, & Fonseca, 2011). This matched other research that showed that higher economic status was a protective factor for same-sex IPV (Greenwood, et al., 2002; Barrett & St. Pierre, 2013).

**Barriers to Access Services**

LGBTQ IPV has been virtually invisible in the majority of mainstream service provision, and at times has been ignored or repressed in the queer community (Turell & Herrmann, 2008; Duke & Davidson, 2009; Hardesty J. L., Oswald, Khaw, & Fonseca, 2011; Ard & Makadon, 2011; Malinen, 2014; Russell, Chapleau, & Kraus, 2015). Barriers included a lack of legal supports, refusal of care, homophobic and transphobic service provision and a lack of LGBTQ community acknowledgment of the existence of IPV in queer relationships.

**Legal Issues.** In the U.S., at the federal level, the changes to the Violence Against Women Act in 2013 compelled shelters to provide services for the LGBT community (National Coalition of Anti-Violence Programs, 2014). As of 2009, Florida, Maryland and Mississippi excluded LGBT people from protection under domestic violence laws (Duke & Davidson, 2009). In 2012, Florida amended their domestic violence statutes to include gender-neutral descriptions of relationships and included same-sex protections (Newberry, 2012). Oklahoma and South Carolina have introduced bills that would block funding for any enforcement of protection orders that acknowledge same-sex marriage (American Bar Association Commission on Domestic &
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Sexual Violence, 2015). South Carolina has refused protection orders for LGBT IPV outright, while North Carolina and Virginia have more gender-neutral language on the books, but case law showed that protection orders for LGBT people have been generally not granted (American Bar Association Commission on Domestic & Sexual Violence, 2015). In Louisiana, same-sex domestic violence has been considered a misdemeanor (American Bar Association Commission on Domestic & Sexual Violence, 2015). In 2009, 14 other states had domestic violence statutes that only applied to relationships that share a household (Duke & Davidson, 2009). Russell, Chapleau and Kraus (2015) tested how gender, sexual orientation and protection orders influenced the perceptions of IPV. They found that same-sex IPV was considered less seriously than heterosexual IPV, even if a protection order had been issued, while same-sex abuse was less likely to be considered abuse if no protection order had been issued.

Not surprisingly, many people in the queer community have not trusted the legal system, and LGBTQ2S+ people of colour have had less trust and more negative views of domestic violence laws (Guadalupe-Diaz & Yglesias, 2013). Most LGBTQ survivors depended on informal information networks rather than formal services, which has been hardly surprising, since it has only been three years since there has been a national policy on LGBT domestic violence (Guadalupe-Diaz & Yglesias, 2013).

The legal situation in Canada has seemed to be more equitable, but if we look past the smugness about legalizing same-sex marriage before the U.S., inequities surface. There have been far fewer LGBTQ2S+ IPV shelters, resources and research in Canada than in the U.S. On the local front, UVic’s Anti-Violence Project provided counselling and men’s groups, and we have had a Men’s Trauma Centre. The Victoria Sexual Assault Centre has become trans inclusive and has provided sexual assault response services to all genders. It will generally refer
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males and clients on the masculine spectrum to the Men’s Trauma Centre for counselling while providing counselling services to female and gender non-binary clients. Shelter access for multiple genders has been a trans and intersex activist project for several decades. In 1996, the Toronto YWCA was considering trans access (White, 2002).

Several Canadian researchers have noted that while we have some equal rights on the books for gays and lesbians, substantive citizenship — where legal rights are enforced and distributed equitably and justly — has not happened in Canadian health care or anti-violence services (Daley, 2006; Field, 2007; Dysart-Gale, 2010). It has been recommended by members of the LGBTQ2S+ community, by the B.C. Human Rights Commission and by American government sources like the Substance Abuse and Mental Health Administration that including LGBTQ2S+ community members in boards and on staff was a key element to LGBT-affirmative service provision (Darke & Cope, 2002; SAMSHA, 2012). Some B.C. research has shown that in 2002, the majority of other shelter services in B.C. (45 of 62) were inclusive of trans and intersex communities, although some trans identities were more welcome than others, and levels of knowledge about the trans communities varied (White, 2002).

As White (2002) notes, within the B.C. Human Rights Tribunal, “there is definitely a trend supporting the right of T/TS/IS [trans, transsexual and intersex] women to women’s organizations.” Yet White also recounted a personal experience of being a staff member at a sexual assault centre in Ontario in the mid-1990s and trying to integrate trans feminine staff into the agency, but agency staff eventually turned on the trans staff member and they were forced to resign (White, 2002). It was unknown how often this type of scenario has played out across Canada, but there has been one centre that has openly continued to exclude trans communities.
When the Vancouver Rape Relief and Women’s Shelter removed Kimberley Nixon from their peer counselling training program, the B.C. Human Rights Tribunal ruled against Vancouver Rape Relief and Women’s Shelter. The Vancouver Rape Relief and Women’s Shelter, despite the Tribunal and trans inclusion recommendations, went to the B.C. Supreme Court to defend their exclusion of trans volunteers (White, 2002; Vancouver Rape Relief & Women's Shelter, 2007). The only violence the Vancouver Rape Relief and Women’s Shelter has acknowledged on their website was male violence against women (Vancouver Rape Relief & Women's Shelter, 2010).

Vancouver Rape Relief’s statement on homophobia was not a stance against homophobia but instead primarily spoke to men calling their staff lesbians (Vancouver Rape Relief & Women's Shelter, 2010). The focus of this article was not to say that they support the LGBT community or stand in solidarity to the community or that they do any advocacy with the queer community; they spoke to the so-called stigma of being associated with us (Vancouver Rape Relief & Women's Shelter, 2010). They spoke of loving women in this statement, but nowhere did it mention that they would be willing to provide services to lesbians that had been abused by women (Vancouver Rape Relief & Women's Shelter, 2010). Maybe they did, but if they did, they certainly did not advertise it on their website. The Vancouver Rape Relief and Women’s Shelter showed that some Canadian mainstream services and the B.C. Supreme Court have been openly transphobic, and that some of our mainstream shelters and our courts have been actively hostile to the standards and guidelines of LGBT-affirmative service provision that have been around since 2001 (Darke & Cope, 2002; SAMSHA, 2012; Munson, 2014).
Refusal of Care and Homophobic and Transphobic Service Provision in Mainstream Services.

In 2004, a study of nurses revealed that 36% of staff nurses and 9% of student nurses would, if it were possible, refuse to care for homosexual patients due to fear, disgust, and disapproval (Rondahl, Innala and Carlsson, 2004 as cited in Freedberg, 2006). In 2010, Lambda Legal published their report “When Health Care Isn’t Caring”, the first U.S. national report on the barriers LGBT people have faced in accessing health care. What Lambda Legal found was that the health care system itself perpetuated abuse against LGBT people. They measured the following abuses:

- being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health status; or health care professionals being physically rough or abusive. Almost 56 percent of lesbian, gay or bisexual (LGB) respondents had at least one of these experiences; 70 percent of transgender and gender-nonconforming respondents had one or more of these experiences; and almost 63 percent of respondents living with HIV experienced one or more of these types of discrimination in health care. People of color living with HIV and LBG people of color were at least twice as likely as whites to report experiencing physically rough or abusive treatment by medical professionals (Lambda Legal, 2010).

Gillum and DiFulvio (2012) did focus groups with LGBT youth who stated that the culture of homophobia in the police meant that help from the police was not possible and may lead to double victimization by the abuser and the police. Reporting IPV or accessing LGBT
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Youth programs would mean coming out, which, for youth, may trigger parental abuse and neglect, while trying to go to mainstream services could lead to homophobic/transphobic responses or heterosexual forms of treatment misapplied to gender/sexually diverse people (Gillum & DiFulvio, 2012). This research matched my personal experience with police and IPV. I once had to call the Victoria police because my neighbour was choking and raping his partner and smashed out a window. When the police arrived, they banged on my door and shouted at me that men could not rape each other and that I could get in trouble for wasting their time. I yelled back at them that men could rape each other, that they had now put me in danger and that they should do their goddam job. The police then banged on my neighbours’ door and arrested both of them. I have always worried since about how they were treated. If there was anyone else to call, I would have, because calling the police put me and my neighbours in more danger.

Malinen (2014) reported how many police, shelters and violence-against-women advocacy groups did not see same-sex sexual violence as rape; even service providers who take in trans clients asked invasive questions about surgery and passing or saw lesbians or trans people as triggering for heterosexual clients, rather than looking for ways to make the space safe against the homophobic and transphobic violence the other shelter inhabitants enacted on their LGBT clients.

The National Transgender Discrimination Survey (2011) drew from a sample of 6,450 trans individuals. This graph from the survey showed the intersections of racism and transphobia among police, showing where some police had become the abusers of trans people:
This same survey also reports that students, school teachers and administration can become abusers of trans youth: 78% of trans youth were harassed, 35% physically assaulted and 12% sexually assaulted at school; 6% were expelled for being trans; 31% reported that teachers harassed them; and 5% were physically assaulted by their teachers (Grant, et al., 2011). Trans people resist this abuse in many ways: “Despite mistreatment in school, respondents reported considerably higher rates of educational attainment than the general population, with 47% receiving a college or graduate degree, compared with only 27% of the general population. These high levels of achievement appear to be largely due to respondents returning to school later in life” (Grant, et al., 2011). Fifty percent of trans respondents reported being harassed at work, 7% were physically assaulted, and 6% were sexually assaulted at work; 32% of respondents were forced to be in the wrong gender while working in order to keep their jobs (Grant, et al., 2011).

**Lack of Training.** Fifty percent of trans respondents (n=6,450) have reported that they have had to teach their health care provider about trans health care (Grant, et al., 2011). Despite there being a wide variety of guidelines and resource materials on LGBTQ-affirmative care, most counselling and health care training programs contained little to no training on LGBTQ-
affirmative care (Sinacore, et al., 2011; World Professional Association for Transgender Health, 2012).

**Queer Health Needs and Cultural Competency**

A lot of the research recommended a certain pattern to service delivery: once the research on prevalence, dynamics and social context has been completed, researchers will develop models and programs, will test the outcomes of those models and programs and then could deliver the services. However, this model would not fit LGBTQ2S+ communities, as queer theory and many queer lives have resisted and may even have defied categorization. While researchers have been trying to measure LGBTQ IPV, LGBT organizations, grassroots and mainstream, have been developing anti-violence models and services for the queer community (Darke & Cope, 2002; Román & Valentine, 2012; Cook-Daniels, 2015). Being locked into a model based on a totalizing description of what LGBTQ2S+ IPV looks like has not been relevant to a vastly heterogeneous and diverse community. What has been needed were empathetic, respectful services that would look closely at the social context and experiences of the individual and/or family.

However, there have been several studies that have asked the LGBTQ community what services they need and what service providers need to do to improve services. This was the data that would be important for the development of services, as it reflected the preferences of the community and what they deemed to be respectful service delivery. Helfrich and Simpson (2006) identified that to adequately serve lesbian clients, domestic violence shelters needed to create a culture of inclusion that covered both staff and clients, all the front-facing messaging of the agency and the assessment tools needed to be re-examined for heterosexist/heteronormative language, staff needed training and lesbian-knowledgeable supervision, and the agency needed to
have accountability and quality assurance reviews. Freedberg (2006) recommended that emergency medical staff re-evaluate their domestic violence assessment tools to ensure that they use gender-neutral language so that they do not silence the victim of IPV who saw the heteronormative language of most domestic violence assessments as a sign that they were not safe to divulge that their injuries were as a result of IPV, and also recommended that staff be trained out of negative reactions to IPV reported by an LGBTQ2S+ individual. Goldberg and Meyer (2013) recommended that IPV screening needed to be expanded to include screening for same-sex IPV, particularly for gay and bisexual populations (Goldberg & Meyer, 2013).

Murray et al. (2007) provided some data on people in the LGBT community who posed as victims to agencies in order to block the victim from accessing services, showing the need for a careful assessment of the people in the relationship to ensure that everyone accessed the appropriate service. While some assessment tools have been developed, they were based on a belief that the person with the most privilege was the most likely to be the perpetrator, and the assessment was used in some organizations to offer services to the victim, but not to the perpetrator (Román & Valentine, 2012). Several agencies have created a trans-specific power and control wheel and a trans-specific safety planning tool (Munson, 2014; Cook-Daniels, 2015).

Choosing who is included as family may be very important for queer families, but Hardesty et al. (2008) cautioned against a blanket approach to embracing the notion of chosen families:

Choosing family is typically, and positively, discussed as defining family to include same-sex partners. Ironically, lesbian mothers experiencing IPV may be well served by defining family boundaries in such a way that abusers are excluded. Well-meaning efforts to see the same-sex couple as legitimate should
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be tempered with an awareness that mother-childern ties may take precedence over the partnership when there is violence (Hardesty J. L., Oswald, Khaw, Fonseca, & Chung, 2008).

Hardesty et al. (2008) also found that lesbian mothers who were African-American hid violence from their children as a way to “promote their children’s survival by shielding them from the effects of injustice (e.g., IPV) for as long as possible”, whereas the only mothers who talked with their children about IPV were white and economically secure. Hardesty et al. (2008) warned practitioners: “given these class/race distinctions, we caution practitioners against assuming that open communication about IPV is always best”.

White and Goldberg (2006) recommended many of the points listed above, adding that workers employ an intersectional analysis of the client’s social context and that workers needed a working knowledge of legal and economic barriers and some ways to work around those barriers. They needed to create a safe environment, not just for the client, but for their friends and family. Strickler and Drew (2015) wrote about their experiences in starting a LGBTQ anti-violence centre in the southern U.S. They recommended increasing survivor leadership and safety within anti-violence organizations and running prevention campaigns. Not only did agencies need to change internally; researchers and activists have highlighted the need for outreach about legal rights, awareness and interventions so that the LGBTQ2S+ communities know that there have been supports and services available that were aware of their needs and were respectful, and also that IPV existed in LGBTQ2S+ communities, which can help to validate survivors and raise awareness (Duke & Davidson, 2009; Guadalupe-Diaz & Yglesias, 2013).
Finally, and most importantly, we need to begin to integrate all genders into shelter services. Some successful all-gender shelters have been running in the U.S., and groups like Forge Forward, as well as others, have been providing technical assistance to women’s shelters on how to integrate more genders into transition houses and shelters (Darke & Cope, 2002; Munson, 2014). Until that happens, Forge, a trans survivor–led anti-violence service provider, has made a decision-making flowchart to help service providers and trans clients navigate sex-segregated services:

![Decision-Making Flowchart](image)

(Forge, 2011)

**Theories of Queer Community Health**

**Queer Theory and Heteronormativity**

Queer theory arose primarily out of the work of Judith Butler, especially her book *Gender Trouble*. Butler applied a post-structural analysis to gender, deconstructing the binary
notion of gender. Through her work, she posited that gender was performed socially, rather than being a based on biological sex. Queer theorists attempted to “queer” their topics of study through deconstructing daily practices and subject positions to reveal how they operated in fluid, non-normative ways that often resisted social norms (Cannon, Lauve-Moon, & Buttell, 2015). While too large a debate to fully trace in this paper, eventually queer theorists came under critique for some of queer theory’s more extreme post-structural stances, like their arguments about the illusion of coherent identity positions, for being overly utopian and for primarily being a theory of wealthy, white queer academics that could not be applied to the experience of the majority of the LGBTQ2S+ community (Cannon, Lauve-Moon, & Buttell, 2015). What queer theory did that is important to the conceptualization of both queer violence and a feminist approach to violence was “…to articulate identity binary constructions, with a central focus on those relating to sexuality, and their effects. In doing so, queer theory [42,43], like poststructuralist feminist theory, seeks to analyze, critique, and reveal normativity itself, such as heteronormativity, rather than focus on part of the binary with hierarchical power (e.g., man, heterosexual), which relies on the subjugated term for its definition (e.g., women, homosexual), as the traditional feminist paradigm of IPV does [15,16]” (Cannon, Lauve-Moon, & Buttell, 2015, p. 673).

Heteronormativity was the construction of heterosexuality as normal and natural and authorized by state, legal, medical, psychological, and social authorities (Cannon, Lauve-Moon, & Buttell, 2015). People living outside these norms have been labelled deviant, disordered (as in the DSM), or, more recently, as exhibiting “risk factors”. When legal, medical, psychological discourses only conceptualized gender and sexuality as heterosexual and cisgendered, the laws, medical treatment and psychological interventions have been inappropriate and often harmful
and usually aimed at trying to force people to conform to, or fit within, heterosexuality (Mananzala & Spade, 2008). As Cannon, Lauve-Moon and Buttell state, “heteronormative approaches may not only interfere with effective treatment interventions but may also add to the stress of those marginalized by their sexuality” (Cannon, Lauve-Moon, & Buttell, 2015, p. 674). This quote could most likely also apply to any colonized ethnicity.

Intersectionality

A queered intersectional analysis influenced the ideas presented in this paper. Intersectionality was a theory popularized in Crenshaw’s (1994) seminal work on intersectionality, “ Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color” and consequences (Crenshaw, 1994, p. 23). Crenshaw called for an analysis of what she called “intersectionality” as part of social justice work, by which she meant that systems of oppression and privilege occurred at the intersections between race, class and gender. Crenshaw stated that between-group tensions occur due to within-group differences in race, class and gender:

The failure of feminism to interrogate race means that the resistance strategies of feminism will often replicate and reinforce the subordination of people of color, and the failure of antiracism to interrogate patriarchy means that antiracism will frequently reproduce the subordination of women (Crenshaw, 1994, pp. 8-9)

In an intersectional analysis, people can hold both privileged and marginalized positions at the same time, and the systemic oppressions and privileges appeared at the intersections of different aspects of identity — usually at the intersections of race, class and gender (Crenshaw, 1994).

Crenshaw’s statement that power operated and was expressed in the intersections between race, class and gender moved identity from looking at single, discrete categories of race,
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class and gender to a theory that allowed researchers and counsellors to look at multiple identity
categories simultaneously by focusing on the interactions that occur at the intersections of
multiple identity positions. While in 1994, Crenshaw wrote about gender as if it were a binary,
integrating a queer theory approach to intersectionality could balance queer theory’s belief in the
fluid, performative and deconstructed notion of gender with the very necessary race and class
analysis that queer theory has been critiqued for ignoring.

According to both intersectionality and queer theory, identities have been multi-
dimensional, and queer people experienced systemic oppression and barriers to services that
heterosexual cisgender people had not (Lambda Legal, 2010). To point this out was not to erase
or minimize the very real patriarchal violence that men have enacted towards women in
heterosexual relationships; it was true that the heterosexual model of IPV in the literature
obscured and erased the existence of queer and trans IPV (Cannon, Lauve-Moon, & Buttell,
2015). While it seemed odd not to centre queer theory, Mananzala and Spade pointed out in their
seminal work on critical trans theory that claiming an identity separate from heterosexual and
cisgender people has been important for organizing for social change (Mananzala & Spade,
2008).

An intersectional approach to LGBTQ2S+ interpersonal violence has been important,
since a wealthy white gay man would have class privilege, male privilege, race privilege and
cisgender privilege while simultaneously experiencing significant oppression due to homophobia
(Crenshaw, 1994; Hankivsky, 2014). At the same time, a working-class, heterosexual Indigenous
woman would have sexual orientation privilege but has experienced significant marginalization
due to colonial racism, classism and sexism. Until we have named these intersections of
simultaneous privilege and oppression, we can not understand how our experiences have differed
and how our experiences have connected us, and we re-enact unacknowledged power-over, especially in LGBTQ2S+ relationships, where a heterosexual analysis of male perpetrator/female victim has been inapplicable:

But to say that a category such as race or gender is socially constructed is not to say that that category has no significance in our world. On the contrary, a large and continuing project for subordinated people — and indeed, one of the projects for which postmodern theories have been very helpful — is thinking about the way power has clustered around certain categories and is exercised against others. This project attempts to unveil the processes of subordination and the various ways those processes are experienced by people who are subordinated and people who are privileged. It is, then, a project that presumes that categories have meaning (Crenshaw, 1994, p. 23).

*Family Systems and Feminist Theories of Violence*

Currently no theory of violence, whether it comes from family systems or feminist theories, adequately operationalizes violence. Family systems theory of violence was caught in the illusion of the equal playing field of bidirectional violence, while the Duluth model denied the possibility that women could use violence against their partner as power-over (Frankland & Brown, 2014; Cannon, Lauve-Moon, & Buttell, 2015). Family systems theorists may have been resisting the notion espoused by the Duluth model, that women utterly lack any agency to use violence unless in self-defence (Cannon, Lauve-Moon, & Buttell, 2015). Without a deep understanding of genders and power in each relationship studied, it has been impossible to adequately operationalize gender violence. Ironically, the couples in the studies quoted in Frankland’s and Brown’s (2014) study of same-sex IPV may have been resisting the
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heteronormativity and victim/perpetrator dynamic in the Duluth model or in the study’s application of Johnson’s typology of gendered violence by claiming equality in their violence. In other words, the participants may have seen both typologies as heteronormative and resisted attempts to cast their relationship in a one-up/one-down power dynamic. Research showed that part of couple negotiations in same-sex partnerships was how to divide household tasks and roles that would usually be split along male/female gender lines in heterosexual relationships (Clunis & Green, 2004). Therefore, the pressure to be equal partners may have been more palpable in LGBTQ2S+ relationships, and the different gender divisions in LGBTQ2S+ relationships may have affected any attempt to apply either the Duluth model or Johnson’s typology of violence to these communities. Bi-directional violence does not mean power was experienced the same way by both partners; while not all violence is male perpetrated on female, nor is violence a tactic available and a power equally accessed by all involved (Cannon, Lauve-Moon, & Buttell, 2015).

Recent studies that measure gender based not on biological sex but on behaviours and beliefs deemed to be on a range from traditionally masculine to traditionally feminine found that those who identified with masculine practices were not more likely to perpetrate IPV and those on the feminine side of the scale were not less likely to perpetrate violence. Masculinity and femininity in and of themselves are not markers for determining risk to perpetrate or be victimized (Cannon, Lauve-Moon, & Buttell, 2015). Therefore, the qualities of a single identity category, gender, was not an accurate measure of perpetration or victimization risk, resulting in looking at interactional and contextual guideposts (Cannon, Lauve-Moon, & Buttell, 2015).

So far in the literature, those who have studied bidirectional violence tend to conceptualize that type of violence as a tool that both people in the relationship accessed equally, as if violence is something that was just another “relationship tactic”, as if bidirectional violence
was some sort of equal and innocent post-structural jouissance (Jacques Derrida’s concept that the subject can operate playfully outside of categories) that can be absolved of any analysis of power and social context (Cannon, Lauve-Moon, & Buttell, 2015; Frankland & Brown, 2014). Feminist analyses, like response-based practice, have typically stated that violence is unidirectional, from man to woman, which foregrounded the analysis on power and social context of violence, but have not commented on the research that showed that women did use violence and that queer and trans violence occurred outside of a male/female gender binary (Wade, 1999; Coates & Wade, Language and violence: Analysis of four discursive operations, 2007; Richardson & Wade, 2013). Where response-based approaches differ from feminist analysis, according to Richardson:

> We just look at who is doing what to who. Statistics show that it is more often delivered by men towards, but we would look to each case. We understand that women use violence against men and/or against women, but that the social responses to each particular case are different and relate to the intersectional analysis (Richardson, personal communication, 2016).

It is time for feminist analyses of violence to incorporate non-normative forms of violence and to embrace current research on violence, without erasing any analysis of power and domination due to the labelling of bidirectional or differently-gendered violence as occurring “equally” or outside of power (Cannon, Lauve-Moon, & Buttell, 2015). As intersectional theory clearly states that due to everyone’s unique identity positions, every person’s experience of the social is different, that means that even when violence is bidirectional, that violence is experienced differently by each person involved and that there are most likely unacknowledged privilege and marginalization operating in each act of bidirectional violence. Rather than
exclusively measuring gender, we need to trace power and social responses to violence. We need
to measure relational domination as a risk factor, which is often, but not always, gendered, and
when gendered, not always gendered male towards female.

Response-based Practice and the Islands of Safety Process

Response-based practice has been an approach towards working with violence and
resistance to violence (Wade, 1999). According to Richardson, “I would call it a praxis. It was a
‘generative theory’ perhaps drawn directly from practice situations, not applied onto them from
abstract principles. We call it a practice because we do not think of it as a theory” (Richardson,
personal communication, 2016). Response-based practices have facilitated dignifying, positive
social responses when violence has occurred and have been the basis for preventative advocacy
work to lower violence (Wade, 1999; Coates & Wade, 2004; Richardson, 2009; Todd, Weaver-
Dunlop, & Ogden, 2014). Most theories of violence have focused on the psychological effects of
violence on victims and the pathology and etiology of perpetrators (Wade, 1999). Instead,
response-based practice has focused on the responses of people to violence, which moved the
focus from the individual to the social context around them (Wade, 1999). When perpetrators
have committed violent acts, victims resisted violence and work to make themselves and others
as safe as possible, often in ways that are not recognized as resistance, or may be even labelled as
problematic behaviour (Wade, 1999).

Response-based views stated that the fields of psychology, law and media focus on
effects, leading to the characterization of victims as passive and mentally disordered (Wade,
1999; Coates & Wade, 2004; Coates & Wade, 2007; Richardson, 2011a). Coates and Wade
(2004 & 2007) focused on a discourse analysis of media and court transcripts that revealed what
they called the four operations of the language of violence: that most public discourse on
language has used the passive voice to blame and pathologize victims. A lot of public writing about violence in media and police reports grammatically separated perpetrators from their violent acts, which has served to hide violence (Coates & Wade, 2007). These agentless acts of violence excused the perpetrator from responsibility for their violence (Coates & Wade, 2004). This language of effects implied that victims let violence happen to them — that the internal attitudes and mental states of victims (low self-esteem, lack of boundaries, etc.) “attracted” perpetrators (Wade, 1999; Coates & Wade, 2004; Coates & Wade, 2007; Richardson, 2011a).

Thus, according to the majority of mainstream psychology, legal, and anti-violence services, violence was resolved and/or lowered through changing the mind of the victim to empower them to stop letting violence happen to them or to stop spending time with perpetrators (Coates & Wade, 2004; Coates & Wade, 2007). The language of effects has often characterized perpetrators as unable to control themselves or self-regulate their emotions and thus not able to stop their violence (Adams, 2007; Todd, Weaver-Dunlop, & Ogden, 2014). Situating the problem of violence within the mind conceptualized violence as an individual, internal problem with individual, internal solutions, concealing the systemic and social factors at work when violence occurred (Wade, 1999). Violence in society has quite often been portrayed as mutual, whereas response-based practice stated that violence is almost always unilateral, perpetrator acting violently toward the victim.

Shifting to a language of responses moved the analysis of violence from violence as an individual problem to violence as a social problem (Wade, 1999; Coates & Wade, 2004; Coates & Wade, 2007; Richardson, 2011a). Shifting to a social, systemic view of violence changed the view of the victim and perpetrators to people who were active agents: the perpetrator deliberately acted, the victim resisted in covert and overt ways, and the perpetrator acted to overcome and
neutralize victim resistance. The victim was active but may have been blocked in their attempts to resist violence by the perpetrator, who chose their actions; the perpetrator was not controlled by outside forces (rage, actions of the victim) but deliberately worked to overcome victim resistance and to control the victim.

The social responses to the victim have made a huge difference in the ability of the victim to resist and heal from violence. Negative social responses have been a key predictor of traumatic responses to violence (Wade, 1999; Richardson [Kianewesquao], 2013). Often family, friends and service providers did not recognize the victims’ acts as agentive and purposive and responded in ways that minimize and deny the violence or blame the victim for the violence (Wade, 1999). Police, media, courts and service providers could also be sources of negative social responses when they mistreat victims by misbelieving, pathologizing, and hiding a perpetrator’s violence and mitigating perpetrator responsibility (Coates & Wade, 2004; Coates & Wade, 2007). Responding to invalidation and blame usually drains the victim’s resources and sabotages their efforts to be safe, despite the victim’s ingenuity in dealing with the violence (Wade, 1999).

Positive social responses lowered the victim’s suffering and helped the victim to recover and protect themselves and others (Wade, 1999). Response-based practice has created positive social responses through exploring victim resistance and treating people with respect and dignity (Richardson & Wade, 2010). Through highlighting the victim’s purposive acts of resistance, the victim’s choices and acts have been validated and supported. The victim then can build upon the story of how they resisted and can fully articulate their pre-existing abilities, which can help them self-advocate with friends, families and service providers and be confident in their ability to handle violence. Creating a safe place to have an open, consensual dialogue about victim
resistance created a clearer picture of the violence that occurred, hopefully leading to more accurate assessments and safety plans (Wade, 1999; Richardson & Wade, 2010). Response-based contextual analysis posited that to understand an act of violence, we needed to look at the social material conditions around the victim, how they lived in the world, what happened, how they responded, how the people and institutions around them responded and the victim’s responses to the social responses (Richardson [Kianewesquao], 2013; Richardson & Wade, 2013).

The Islands of Safety Process

The Islands of Safety process was a pilot project launched in 2009 as a mediation process between Métis and urban Indigenous families and the B.C. Ministry of Children and Families (Richardson [Kianewesquao], 2013). Islands of Safety provided a container for culturally safer assessments and safety planning (Richardson & Wade, 2010). Cathy Richardson, Allan Wade and Cheryle Henry, a team of therapists who are from Métis, European settler and Indigenous backgrounds, created Islands of Safety in consultation with community, Métis Community Services and with funding from the Law Foundation of B.C. (Richardson [Kianewesquao], 2013).

The Islands of Safety process centred around the mother, who was the person who chose the people she would like involved in supporting her and the people she identified as family during the Islands of Safety process (Richardson & Wade, 2010). Taking the stance that the mother was an expert in keeping her and her children safe offered a way to challenge the portrayal of mothers in “failure to protect” policies. These policies have placed the onus on the mother to protect the children and leave the home regardless of what the perpetrator did to make it unsafe for the mother to comply with these policies (Richardson & Wade, 2013). Islands of Safety gathered information the mother could use to present how she kept her family safe and the
family’s culture and ways of being when things were going well (Richardson & Wade, 2013). This presented an alternate narrative to challenge “failure to protect” narratives. As Richardson stated, “This was based on the understanding (or the situations where) the mother was the target of the violence. If it had been the father or a same-sex woman partner, we would have given the most say to them, the one being the most vulnerable in the situation” (Richardson, personal communication, 2016).

Islands of Safety contained four sets of meetings. It is recommended to have at least two facilitators of different genders, and if safe, children may attend the meetings. The four sets of meetings covered response-based contextual analysis. The first round of meetings gathered information about the social context around the family, their culture and preferred ways of being (Richardson & Wade, 2010) The second round of meetings explored what happened and how the people directly involved responded and acted when the violence occurred (Richardson & Wade, 2010). The third round of meetings gave victims and families a chance to talk about how people found out about the violence and how people and institutions around the family reacted (Richardson & Wade, 2010). The fourth round of meetings was a place for the victim and family to express how they responded and handled the reactions of people and institutions (Richardson & Wade, 2010). The second-to-last meeting was used to decide the format of the final meeting; the final meeting was a long meeting to develop and agree upon the safety plan that could avoid going to court and address the concerns of child protection workers (Richardson & Wade, 2010). The Signs of Safety assessment tool (1999) is used for the actual safety planning.

In 2009, Emerson and Magnuson wrote an evaluation of the original Islands of Safety pilot project. Emerson and Magnuson (2009) found that in most cases, Islands of Safety fulfilled the goals of creating trusting relationships, facilitating perpetrators to be involved and to take
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Responsibility, and creating a safety plan that met child protection standards. That said, the numbers of families taking part in the program was too small and there were not the right conditions and context to do any outcome research. Islands of Safety had not been compared to other mediation processes, and the sample was too small to measure the effectiveness of the Islands of Safety process (Emerson & Magnuson, 2009). Feedback from family members was positive:

‘I think that Islands of Safety actually brought our family together; no matter what the outcome was, we were brought closer together.’ Her comments are especially interesting, considering the fact that in this case, the safety plan that was drafted and informally agreed upon by family members and facilitators did not receive Ministry approval and therefore did not get put into action. Thus, even in situations where the drafted safety plan was not considered ‘successful,’ adequate, or applicable to what the Ministry’s protection mandates or concerns were, it still had the potential to create more safety than what was previously there (in these cases, by connecting and supporting family members in a way that they previously were not) (Emerson & Magnuson, 2009).

Queering Response-Based Practice

The response-based literature I read gendered the victim as female and the perpetrator as male. I posit that using response-based practice within queer communities may require a queering of response-based practice that goes deeper than changing pronouns. As Crenshaw’s examples of organizing within feminist domestic violence organizations has shown, incorporating differing intersections of identity has required more than a place in the organization:
They thought that they could simply incorporate us into their organization without rethinking any of their beliefs or priorities and that we would be happy.... The coalition ended a few months later when the women of color walked out. Many of these women returned to community-based organizations, preferring to struggle over women's issues within their communities rather than struggle over race and class issues with white, middle-class women. Yet as illustrated by the case of the Latina who could find no shelter, the dominance of a particular perspective and set of priorities within the shelter community continues to marginalize the needs of women of color (Crenshaw, 1994, pp. 20-21.).

One of the limitations of this study was that some people in LGBTQ2S+ communities felt that working within heteronormative organizations and models has been pointless. Yet I do believe there is value in raising awareness with people who have power to create models to improve safety for LGBTQ2S+ peoples accessing mainstream service provision, whether these clients chose to share their gender and/or sexuality with their health care providers or not.

Hydén, Gadd and Wade (2016) have recently updated their theoretical background and recommended skipping over intersectional feminism in favour of ecological frameworks, highlighting articles from the early 2000s that critique intersectionality as “post-modern identity politics”. Stating that intersectionality has been too divisive of identities seems like a strange critique, as Crenshaw’s original article on intersectionality was from a Black feminist who was highlighting the injustice and barriers that women of colour experience while trying to access domestic violence services. If anything, Crenshaw’s paper and the research on LGBTQ+ barriers to service access cited in this paper clearly showed that the source of the divisiveness has been in
mainstream service providers’ lack of appropriate services, and lack of non-racist services and sometimes even outright abuse of LGBTQ2S+ communities, especially LGBTQ+ communities of colour (Crenshaw, 1994; Lambda Legal, 2010; National Coalition of Anti-Violence Programs, 2014; Malinen, 2014).

Jacobs’s and Potter’s (1998) critique of intersectionality sourced by Hydén, Gadd and Wade (2016) conflated intersectionality with identity politics and blamed the victims of racial injustice for speaking out and trying to gain justice and safety from violence as divisive to mainstream leftist politics (Jacobs & Potter, 1998). In turn, this critique of intersectionality has been itself critiqued by many activists, critical trans theorists, feminists, intersectional theorists and critical race theorists during the 2000s:

In recognizing the shifting intersections in which power operates,
intersectionality moves beyond what Martinez (1993) terms the ‘Oppression Olympics,’ which occur when groups compete for the title of ‘most oppressed’ in order to gain political support, economic resources, and recognition.
Intersectionality rejects an additive model of oppression that leaves the systems that create power differentials unchanged (Hancock, 2007). Within an intersectionality-based policy analysis (or IBPA), the focus is not just on domination or marginalization, but on the intersecting processes by which power and inequity are produced, reproduced and actively resisted (Dhamoon, 2011) (Hankivsky, 2014).

As we can see from this quote from Hankivsky (2014), the critique sourced by Jones and Potter (1998) was based on a view of intersectionality as identity politics that somehow excluded working-class white people or housewives. As the multitude of intersectional writings on
working-class whiteness has shown, this critique would now be inaccurate. Intersectionality posited that most people encompass sites of privilege and oppression in their lives, making it less chaotic and divisive than has been pictured in the critique of it (Hankivsky, 2014).

In fact, ecological and multidimensional post-intersectional approaches that attempt to move beyond identity do so due through identity:

…the "post-intersectionality" legal literature fails on its own terms (Chang and Culp, 2002, p. 4). That is to say, the post-intersectionality move cannot be explained as analytically or conceptually distinct from intersectionality, a point conceded by even Mutua (2013) who admits that Darren Hutchinson's employment of multidimensionality theory to address partially privileged individuals can be traced back to intersectionality: "as noted earlier, each of the underlying ideas for [Hutchinson's] insights was arguably implicit in the initial articulation of intersectionality theory and/or could have been easily incorporated into it" (p. 358). Nor can multidimensionality be understood to be more politically "effective" (Cho, 2013).

In summation, the multidimensional, ecological framework described by Heise (1998) and sourced as the alternative to intersectionality by Hydén, Gadd and Wade (2016) is not materially very different than intersectionality. Cho (2013) stated that many proponents of ecological and multidimensional frameworks theorized Crenshaw’s work in ways that were not culturally accurate and too narrowly defined Crenshaw’s intent.

Intersectionality, especially recent forms of intersectionality, have involved both praxis and theorizing from grassroots activism and community responses to violence, as evidenced by the work of groups like INCITE! Women of Color Collective, Forge, and Philly’s Pissed (Forge,
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I believe response-based approaches could be read through different theoretical lenses, and in fact, it would be good to diversify theoretical approaches, so I am going to work within an intersectionality framework as it explicitly has worked to centre the voices of people from a wide range of ethnicities, genders, classes and is already in use in LGBTQ2S+ anti-violence communities. Intersectionality has been one of the ways other queer and trans people have to articulate our lived realities, both within our communities and outside our communities, to mainstream service providers (Chen, Dulani, & Piepna-Samarasinha, 2011).

Admitting that sometimes women have enacted violence and that men have been victims or that perpetration/victimization is not specifically determined by static gender positions does not undercut response-based approaches, especially if we use an intersectional lens to examine the context of violence. As Cannon, Lauve-Moon and Buttell (2015) have stated,

The poststructural feminist framing allows us to frame violence by female perpetrators in heterosexual couples in a different way. Rather, based on her social location (e.g., race, gender, sexuality, class, nationality, etc.) certain tactics and strategies for using power are available to her. Violence may be one of these strategies. However, the violence she performs cannot be understood in the same way that a man using violence against a woman would be understood. Because of his social location, different tactics and strategies are available to him. Since we live in a patriarchal and heteronormative society, he has distinct advantages over the female batterer. Although both may punch, how we understand their acts of aggression and power differ because of the ways society is gendered and sexuality is organized (Cannon, Lauve-Moon, & Buttell, 2015, p. 673).
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Where I differ from Cannon’s, Lauve-Moon’s and Buttell’s approach is that I believe that queer violence operates within cis-normative heteropatriarchy and they do not:

…both women and men, queer and straight, have access to different strategies and tactics to deploy power. The amount and type of power will vary depending on many attributes (e.g., social location), but they all have access nonetheless. From this vantage point, it is easy to see that queer identified people are just as capable of exerting violence in intimate partnerships, though how we understand their use of violence may differ. In this way, a lesbian batterer’s violence is not an extension of patriarchy, but rather just one relationship tactic available to her, which she can deploy against her partner at her discretion (Cannon, Lauve-Moon, & Buttell, 2015, p. 675).

I am not sure how these authors reconcile this stance with their later quote from Butler, stating that, “Heterosexual desire defined as an erotic attraction to difference, connects femininity and masculinity together as constructed complementary opposites. This ontological shift in understanding the construction of gender difference establishes the meaning of the relationship between masculinity (dominant) and femininity (subordinate). In this way, heterosexual desire is not only the foundation of the construction of masculinity [59–65] but the foundation of the “difference between and complementarity of femininity and masculinity” ([58], p. 90” (Cannon, Lauve-Moon, & Buttell, 2015, p. 675). However, if, as Butler states, patriarchy is inextricably linked with heteronormativity, then any engagement with, or resistance to, heteronormativity is necessarily simultaneously engaging and/or resisting cis-normative heteropatriarchy.
By contrast, I believe that as a queer feminist working with an intersectional lens, it is important to note that the existence of queer violence operates within the combined forces of cis-supremacist, heteropatriarchal and colonialist societies, and queer violence should not be erased due to the fear that acknowledging queer violence or bidirectional violence would undercut men’s violence against women. If violence is bidirectional, or outside of the heterosexual, cisgender paradigm, that conceptualization of violence does not automatically deny the cis-supremacist, heteropatriarchal and colonial roots of violence, as long as we centre our analysis of violence in responses to violence, social context and the intersectional enactments of power. As Leanne Betasamosake Simpson states, there is a direct link between the colonizing of gender and violence against Indigenous women:

I think it’s in all of our best interests to take on gender violence as a core resurgence project, a core decolonization project, a core of any Indigenous mobilization. And by gender violence I don’t just mean violence against women, I mean all gender violence. This begins for me by looking at how gender is conceptualized and actualized within Indigenous thought because it is colonialism that has imposed an artificial gender binary in my nation (Betasamosake Simpson, 2014).

This quote points to points of possible commonality in which Indigenous communities and LGBTQ+ settler and immigrant communities, each in their own ways, can work to recognize and lower gender violence. What I am suggesting is to update response-based theory from the Duluth model of patriarchal violence to a model of cis-supremacist heteropatriarchal violence — a queered, intersectional view of gender that integrates queer and heterosexual violence. This way,
response-based practice can acknowledge and conceptualize other forms of violence, like queer violence.

Identities are multi-dimensional, and, as the research has clearly demonstrated, queer people experience systemic oppression and barriers to services that heterosexual cisgender people do not. Claiming an identity separate from heterosexual and cisgender people is important for organizing for social change (Spade, 2008; Spade, 2013). That is why an intersectional approach to this research is important, since a wealthy white gay man would have class privilege, male privilege, race privilege and cisgender privilege while simultaneously experiencing significant oppression due to his sexual orientation, especially when accessing anti-violence services. At the same time, a working-class, heterosexual indigenous woman has sexual orientation privilege but experiences significant marginalization due to her race, class and gender. We need to recognize that both people may have barriers to access services and work to make services accessible and aware of these intersections of privilege and marginalization. It is important to create anti-violence services that do not pit man against woman, straight against queer, cisgender against trans, in a way that also does not erase these differences under a “we treat everyone equally” policy that ultimately conceals barriers to accessing anti-violence services. Until we name and become aware of these intersections of simultaneous privilege and oppression, we cannot understand how our experiences differ, and we re-enact unacknowledged power-over (Crenshaw, 1994). That is what is meant by an intersectional analysis: that people can hold both privileged and marginalized positions at the same time, and the systemic oppressions appear at the intersections of different aspects of identity — usually at the intersections of race, class and gender (Crenshaw, 1994). When white people say “all lives matter” to people in the “black lives matter” movement, it erases the lived experience of black
people and ignores that things like the police treatment of black people are totally different than police treatment of white people. When “violence against women” agencies or the police say that they treat all survivors of violence equally, it erases the fact that the system’s treatment of a gay survivor trying to escape an abusive relationship will be different than the system’s treatment of a heterosexual female survivor.

METHODS

A fair amount of the research outlined in this paper on LGBTQ2S+ violence identifies being LGBTQ2S+ as a risk factor for violence and/or uses heterosexual, cisgender populations as a control. An identity is not a risk; a homophobic and transphobic society that operates within gender and sexual privilege is the risk. Under a theory of intersectionality, these two methodologies are highly problematic and structurally enact heteronormativity, which has been identified as oppressive by several critics (Cannon, Lauve-Moon, & Buttell, 2015; Diamond, 2006; Smith A., 2010). Furthermore, I am concerned that a queer adaptation would be normed to the original “Island of Safety” model created in an Indigenous context, so I believe this study needs to be positioned so that families from the original Islands of Safety model are not seen as the “norm” to which genders and sexualities are seen as the “different” population.

In this research, I would like to try to not replicate this type of research methodology and give LGBTQ2S+ communities an opportunity to comment upon and give input into theories brought to our community. I did not include people who were both cisgender and heterosexual in the study, in order to center the voices of people in queer and trans communities. I am not using control groups or comparing differences between identities. To honour non-binary identity, I formulated my questions to be non-binary, refusing to use the typical binary focus group question “what did you dis/like”? Since it is impossible to include every gender and sexuality in
a way that would ensure generalizability, I chose to use focus groups as my methodology. I can only hope for transferability, not generalizability, as I will present a range of opinions from a range of identities and let the reader of the study decide for themselves if the results presented in the study can apply to their situation (Krueger & Casey, 2015, p. 244).

I was born as a European settler, and the Islands of Safety process was created with Métis and Indigenous people and for Métis and Indigenous people. Therefore, I believed that it was important to ask permission of the creators of Islands of Safety before assuming that I could do the research simply because Islands of Safety is in the public domain. Before I submitted my proposal to the IRB board, I talked to Cathy Richardson, Cheryle Henry and Allan Wade and asked their permission to do the research. I obtained permission from all three creators of the Islands of Safety process. My positioning for this research needed to be acknowledged, and I needed to shape the research in a way where it would be appropriate for me to do in my identity positioning. That is why I am looking at 1) how LGBTQ2S+ health care and mental health care professionals would adapt this model; 2) how LGBTQ+ health care and mental health care professionals, who may or may not be Métis or Indigenous, work with issues of cultural appropriation and cultural respect when using models developed with and for other cultures.

I ran an online, asynchronous confidential focus group February 1–7, 2016. The focus group was asynchronous because participants could log on at different times during the week, and participants did not complete all activities and questions in one session. A Canadian professional research focus group service called Recollective hosted the website and created the focus group functionality. Recollective was chosen because it is compliant with the U.S. Health Information Portability and Accountability Act (HIPAA) and Canadian Personal Information Protection Act (PIPA) and offers secure servers in Canada and the U.S. I asked them to host this
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study on Canadian servers, thus providing less surveillance than information hosted on U.S. servers, which must comply with the USA PATRIOT Act.

Participants were granted anonymous access with username and password. Recollective did not collect their emails as part of this log-in process. Recollective did not monitor content within the focus group. Participants were identified by a unique numeric identifier, and I could not match participant emails with either username or unique ID.

In the focus group, participants watched a series of mini-presentations and answered 11 questions. These responses were only seen by the researcher. At the end of the presentations and questions, participants were sent to the discussion board, where they responded to key questions and commented on each other’s posts. This was expected to take two hours to complete. During the week, I moderated the discussion board and fielded tech support requests from participants. All participants who agreed to participate in the study received a $25 Amazon gift card.

On the morning of February 8, 2016, I closed the focus group. I generated several transcripts: one organized by my initial code book, and one without any codes. I used NiVivo software to code the data in more depth. I did a simple categorical coding data analysis on the transcripts using the constant comparative method, using grounded theory and coding with initial, process, focused and theoretical coding (Saldaña, 2013).

Sampling

Active participant recruitment occurred between January 3 and 11, 2016. As it is more common for focus group methodology to use purposive sampling rather than random sampling, I used maximum-variation purposive sampling and snowball sampling by employing friend networks, Facebook and Reddit to recruit participants. Maximum-variation means that I tried to find participants from many genders and sexualities, and I also tried to find participants from a
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I employed a modified version of snowball sampling: I started by asking key practitioners and organizations in the gay, trans and queer communities and in my counselling networks to pass my recruitment message to their networks.

I am also a member of several LGBTQ Facebook groups. I also searched for Facebook groups related to LGBTQ and two-spirit issues, especially in areas of counselling, nursing, social work and anti-violence. Before posting in a Facebook group, I asked the moderators about their protocols for posting in the group and gained permission to post my recruitment message. If someone on Facebook asked if they could forward my recruitment message to their networks, I thanked them and agreed. My recruitment message instructed people to email me for more information if they were a counsellor, social worker or support worker in an anti-violence agency and identified as either lesbian, gay, bisexual, gender-fluid, genderqueer, trans, transgender, non-binary, two-spirit, pansexual, asexual, aromantic or intersex. I also posted my recruitment message on its own blog and posted the link on only a few carefully selected subreddits on Reddit.com in order to protect my identity as a queer person on Reddit.

As I was recruiting on social media sites, if an interested person contacted me on social media instead of email, I asked them to email me so that I could send them more information on the study. Several participants heard about the study by word of mouth, indicating that snowball sampling had been successful. Several moderators required that they screen me, and I did so by sending my study information script. Furthermore, as high school and undergraduate students who are not part of the queer community tend to spam queer subreddits with surveys designed to “learn more about people different from us cisgender heterosexual folks”, I asked moderators for

wide range of public health and mental health fields to ensure deeper conversation from the widest possible number of identities (Salmons, 2015, p. 35).
permission to post and posted my links with my personal Redditor identity to prove that I was a Redditor of long standing and not a spammer just creating a Reddit profile to do research. I primarily post feminist content and virtually no personal content on Reddit, so it is not a personal social media site for me.

Thirty-one people expressed interest in the study, and of those 31 people, 26 agreed to participate. Fourteen participants filled out a consent form before entering the study website. Twenty-six participants logged on, and 18 completed all questions. What I discovered about email recruitment is that participants gave me much more unsolicited information about themselves than I was expecting to show that they matched my exclusion criteria. As this information came to me before consent, I did not use this information in the study, although I was able to reassure myself before the study started that my participants came from a large range of genders and sexualities and from a wide range of professions within the health care, social work and mental health fields from all over Canada and the U.S. I was also able to target my recruitment to groups with less representation among my participants to ensure more balance and variety, but still had just under 70% identify as European settler ethnicity, with the other 22.31% of participants stating they were from other settler and/or immigrant ethnicities, mostly from Asian and South Asian backgrounds, while 7.69% of participants identified as Métis/Indigenous. I took a rather broad interpretation of my exclusion criteria, as medical professionals also screen for interpersonal violence and do research on IPV, and shelters and outreach organizations also work with survivors. As I did not do any statistical analysis by gender, sexual orientation and ethnicity, and due to the wide range of descriptors participants used to describe their gender, sexuality and ethnicity, I am not going to provide a specific and detailed breakdown of categories here to resist the urge to label and categorize and to avoid possibly misinterpreting participants’
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self-locations. In many descriptions, the boundaries between gender and sexual orientations were not entirely clear to the researcher — for example, when “queer” described sexuality, gender or both. However, I did obtain enough coverage of genders and sexualities to confidently use “LGBTQ2S+” as the acronym for this study.

Focus group plan and guide

I created a focus group guide for these focus groups that included a description of basic response-based ideas and the Islands of Safety model. Cathy Richardson and Allan Wade looked it over and gave feedback to make sure that I correctly operationalized response-based practice and the Islands of Safety process itself. It was important to ensure which parts of the Islands of Safety model are protected first nations cultural practices and which parts are open to being adapted to other cultural groups. It was also important to confirm what the creators of Islands of Safety meant by “connection to family tradition”, “spirituality” and “being open” to the model. As it is common to update the guide and questions based on feedback from earlier groups, this protocol would fit entirely into common focus group methodology, especially if this first group is seen as a pilot test (Krueger & Casey, 2015, p. 32).

When I was converting the PowerPoint of my original focus guide to an HTML page in the focus group software, I added some formatting to make the text more readable and changed the point where I asked questions 5-7 to move the questions closer to the relevant parts of the presentation and changed the order of the questions to match the order of topics in the presentation. I also shortened the first video because it contained the word “bitch”. Even though the use of the word was in the context of an academic talk, use of this word would have contravened the company’s terms of service, which said that the website content could not contain foul language.
Confidentiality

**Ensuring double-blind methodology.** My participants worked in the same or similar fields that I plan to join when I graduate. It was important to protect their identity. I wanted to ensure that they could feel safe enough to be frank in their opinions and to not collect information that would potentially affect a future working relationship. The queer and trans communities can often be close-knit, and even if people are geographically disparate, they may have personal relationships that I would not know about, and these relationships could affect the data. Furthermore, as a queer person, I have my own beliefs, projections and experiences of different genders and sexualities. I also suspected that I could guess the common trends in what participants would say. Therefore, I chose a simple version of double-blind methodology, where participants could not identify each other and I could not identify the participant to try to lower researcher bias and increase safety for participants. It was not a complete double-blind, because I showed the same content to all participants, although participants did not know that there were other focus groups running simultaneously. I needed to ensure that I could not trace the participants’ usernames back to their email and that I maintained the promised level of privacy to my participants.

*Focus Group Website Setup*

**Challenges in ensuring confidential website access.** There were some initial challenges in setting up the focus group site that were eventually fixed satisfactorily. The company did have the functionality to do anonymous access with username and password, but it was not a commonly used function in the company. Accessing the correct technical data to implement participant access to a double-blind focus group required some negotiation and second-tier technical support and stubbornly insisting on ethical standards. I asked for a demonstration of
anonymous access with every contact, but it took 11 days and moving to second-tier support to get the demonstration and help to actually set up this functionality.

When I initially tested anonymous access with username and password, it brought me to the standard login page for returning participants so it looked as if people accessing anonymous access had to enter their name and email address to register for the website. However, the implementation consultant I was assigned did not know how to set up anonymous access with username and password and said that even with this access, I would be seeing participant names and emails. They instructed me that I should import the participant emails into their Panelist tab and told me “just do not look at the Panelist tab”. As this meant that I actually could trace their emails back to their responses, I tried to ask them to change my analyst permissions to lock out my access to that tab. They refused, mostly likely since that change would affect every other client’s ability to work with that tab. I also asked if they could set up a new permission called “anonymous analyst” that would lock out just the Panelist tab, but they declined. They suggested that my permissions could be bumped down to moderator and someone else could be the analyst, but I had promised throughout my methodology that I would be the only researcher to look at the raw data. I asked if it was possible that no one could be assigned as analyst, but they refused.

This consultant told me that if I did not want to see emails in the system, I had to use an anonymous access link without username and password. In order to make this secure, and to ensure confidentiality of responses, I would have had to change my study to a survey with all responses set to only be seen by the researcher, and eliminate the discussion board portion of the study to ensure that I could track access to the site.

After seven days of negotiation, a second-tier support person was able to explain that I was seeing the wrong website access page because I had just logged in as an analyst with admin-
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level permissions and did not clear my cookies before testing participant access. They demonstrated anonymous access from a participant perspective and demonstrated what information the Panelist Tab would contain so I could see what would happen when the site went live. They also explained which settings to use in site administration in order for participants to be able to log back into the website. I re-tested the next day and saw the proper anonymous login which only requires participants to enter a username and password and confirmed that the site does not collect name or email.

As a person with analyst-level website administrative permissions on the Recollective site, I could see both username and unique ID. Therefore, on recommendation from Recollective staff, I asked participants to create their own username following a username-generating protocol to avoid usernames that inadvertently gave away identifiable information and to break any connection between email and username. To generate their usernames, I asked participants to use the word “dignity”, think of a four-digit number and put that number either before or after the word with no spaces. Participants generated their own password, which had to be at least six characters long and contain at least one symbol, to avoid participants using their username as their password. This password protocol increased security on the website and ensured that no one, including myself, could log in as other participants. I set log-on attempts before lock-out at six and for the system to email me if multiple attempts were made on a participant’s account so I could track unsuccessful website access attempts.

The Challenges of Online Field Research

I did speak to Recollective about their services before writing up my IRB proposal and thought that I had a good handle on their services. I discovered that online research in the field is messier than it is on paper. I submitted scripts to participants as part of my IRB form that
included how I thought the instructions for logging on would work and how their activity function worked. In the end, I should have just noted where I would insert technical instructions to give myself more freedom to adjust to the minute details. Really, the only way to have known these details would have been to purchase the service and speak to tech support before even filling out the IRB form.

**Setting the Privacy of Responses.** I thought that all responses on the site could be set to either be seen only by the researcher or to be seen by both participants and researchers. There are two sections or “tabs” where participants can interact with the researcher: the Activities Tab and the discussion board on the Discussions Tab. The Activities Tab is the more natural place to collect data: researchers can collect different kinds of data like q-sorts, poll questions, image mark-ups, grid sorts, text responses, video and picture uploads and so on. I thought that participants could mark their responses as public or private. However, in the Activities Tab, the researcher must set all responses as public or all responses as private. In the Discussion Tab, participants can mark their comments on posts as either public or private. I decided to make all the 11 questions private to the researcher and give instructions that all public responses would go on the discussion board. I posted three of my key questions on the discussion board to spark discussion among participants:

1. If you used this process with LGBTQ2S+ clients, how would you approach the Métis concepts and knowledges in this model?

2. How would you adapt this model to use with LGBTQ2S+ clients outside of child protection situations (for people without children, people dealing with hate violence)?
3. What was your response to the Islands of Safety process? Thoughts? Feelings? Gut reactions?

I also put the Further Reading section of the mini-presentations as a post on the discussion board rather than including it in the presentation. As the site automatically re-directed participants to this page, I felt it was a more appropriate spot, rather than having participants click the web links in the references and navigate away from the site before they finished answering questions.

**Usernames and passwords.** I thought that the website generated usernames and passwords to send out to the participants, so I said in my script that the participants would be issued a username and password. Well, the website does generate usernames and passwords to send out if you do not want anonymous access and do not mind uploading participant emails into the system. With anonymous access, only the participant determines the username and password, so I needed to give participants a protocol for generating their username and password rather than issuing them a username and password.

**Notifications and reminders.** I was told that I could use the system to auto-generate reminders to participants who have not logged in. In order for this to work, I would need to upload emails into the system, and if I did that, I would have to have a methodology where I could see them. The wrinkle to this functionality is that the system also auto-generates a digest of all the activity that all the participants have done on the site that is not set to be private to the researcher. While it does not send all the data, it sends a bread crumb of data, thus possibly compromising confidentiality. I thus had to completely turn off this function, and instead, I sent blanket, generic reminders to participants outside of the system by setting up generic emails in my Outlook program before the start of the study and used the delay mail delivery function to
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deliver the emails during the study so that I could avoid interacting with participant emails manually throughout the study and afterwards.

**Amazon.com versus Amazon.ca.** I said in my IRB form that I would give all participants, even if they dropped out or withdrew consent, a $25 Amazon gift card. Most of my participants were Canadian, but a few were American. I assumed that I could give $25 USD gift cards from Amazon.com to Canadian participants, and thus everyone would get the same value for dollar. I discovered that Canadians cannot use Amazon.com and Americans cannot use Amazon.ca. Therefore, I converted $25 USD to Canadian funds and gave Amazon.ca gift cards with the converted dollar amount. I bought the cards on Amazon in bulk before the start of the study and delayed delivery until the evening of February 7, 2016.

**Collecting Consent Over the Internet.** I also negotiated with the company over the display of my consent form. The company promised that the first thing participants would see would be my consent form and that they would have to click “agree” in order to access the site. What this meant in reality was that they wanted to have a simple radio button that said “I agree to this consent form” with a link to the consent form. This meant that participants could click “agree” without actually viewing the consent form. I insisted on the consent form being visible. It was possible to have the consent form visible; however, City University electronic consent forms contain both an “agree” and a “disagree” button. The company had told me that I could customize the website to whatever I wanted. Like most large websites, it turns out that that promise came with many caveats, as it is very standard in the industry to only have customizable content but very static web page structure to ensure consistency across platforms and clients. That meant that they could not add a disagree button or move the agree button. The agree button for the consent form could only show at the top of the form.
I received permission from my thesis supervisor to change the wording of the electronic consent portion of the form to indicate that the agree button was at the top of the page, and to indicate disagreement by closing their web browser. I changed the wording of the agree button to say “I have read this consent form and I agree to participate in this study”. Participants also had to scroll down the page to agree to Recollective’s terms of service for participants at the bottom of the form and click a “continue” button at the bottom of the form, so participants actually did have to scroll through the whole consent form in order to access the website.

At this point, I sent out manual consent forms in PDF format to my participants and told them that I might have to cancel the discussion board. If I received a good response rate to the PDF form from the participants, I would have eliminated the consent form from the website due to the clumsiness of the consent page. I only received 14 back, so I kept up the consent form. As I suspected, about half of the participants who returned forms had difficulties with PDF forms, which was why I was trying to avoid collecting consent in that way.

**Updating Questions During the Week.** In the first two days, participants gave feedback about three of my questions, and I realized participants were interpreting the questions differently than I intended and not proceeding further through the presentation. I checked in with my supervisor and got approval to change the questions that reflected my intent more clearly. I sent an email out to participants thanking them for their feedback, explained the purpose of the study, the wording of the updated questions and an invitation to re-answer the questions on the discussion board or give me further feedback on the questions. I also posted the same message on the discussion boards.
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Recommendations for Future Online Research

Completing this study was possible due to my previous work experience on corporate web sites with complex user permissions and infrastructure. Therefore, I knew what could and could not be changed and how to negotiate with software vendors. Without this background, it would have been extremely challenging to set this focus group up with a double-blind. If double-blind is not required, setup with Recollective’s software would be much easier. However, complex corporate websites involving user permissions often have settings in non-intuitive places that can have large, unanticipated effects on the live study.

It is recommended that if the City University uses this software in the future, students and supervisors will need to insist on going over every setting and behaviour of the site carefully with an experienced support person and then test every aspect of the site carefully before going live with their study. I knew to keep my supervisor in the loop on my experience with the company, but if this software is used for future projects, supervisors will need to monitor their students carefully to ensure that the student is implementing the project ethically and properly, as the implementation options are very heterogeneous and careful attention to detail and website behaviour is needed to avoid unintended consequences. Luckily, the functionality to do some monitoring is built into the website as long as the supervisor has access to the website. All the challenges aside, the powerful research tools, the ability to generate custom transcripts and data visualizations, and privacy of the software made it an extremely promising tool for online research.
RESULTS

How Participants Currently Work with Victims and Perpetrators

Twenty-five participants answered the question about how they currently work with victims and perpetrators. Almost half of the participants (12) said that they use an analysis of systemic oppression in their work with clients; of those, four participants stated that they use an anti-oppression framework. Four of these participants also work from a trauma-informed framework. Of the participants who listed specific modalities, two used client-centred practice, two used strengths-based practice and another two used some form of narrative work. A few participants used a wide variety of practices, including cultural competence training, Generative Somatics, consent-based practice, solution-based, family case conferencing, harm reduction, and EMDR, depending on what fit for the client. Two participants already used response-based practice and combined it with an anti-oppressive framework. One of these participants stated they joined the study because they felt Islands of Safety would be a good fit for queer and trans families.

Several participants also have used tools and ideas pulled from grassroots activism, subcultures and the work of specific organizations:

- API Chaya
- Continuing Healing Consultants
- *The Revolution Starts at Home: Partner Abuse in Activist Communities* edited by Ching-In Chen, Jal Dulani and Leah Piepna-Samarasinha
- Andrea Smith and Incite! Women of Color Collective and their Creative Interventions Toolkit
- Vikki Reynold’s work on ethics of justice-doing
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- The work on consent coming from the BDSM and polyamory communities
- Northwest Network
- Aboriginal Patient Navigator program
- Alden Habacon’s TEDx talk

Several participants commented that it was very important to research both queer-friendly resources and non-queer-friendly resources to help clients navigate barriers to health care systems and receive the positive social responses from service providers that they should be getting from all service providers. For this reason, two participants stated that health care — physical, mental, emotional and spiritual — needs to be done by the LGBTQ2S+ communities. One of these two participants said that people not from those identities would have a difficult time understanding how different life is as a person in a gender and/or sexual minority. The other participant said that the peer work that is currently being done needs to be recognized and more fully supported within service provision, and the barriers removed to peer support, especially when mainstream providers are unable to provide competent and LGBTQ2S+-affirmative service provision. Reading through the lines of this participant’s remarks, there are at least three issues at work here: recognizing peer work skills financially and professionally, acknowledging and integrating grassroots treatment models and theorizing into wider practice and providing sustainable funding for LGBTQ2S+ community–run programs.

Several other participants recommended that self-education about queer and trans culture is needed, as well as ongoing anti-oppressive and queer-aware clinical supervision, ongoing analysis of personal privilege, and therapy. This was identified as part of practising in a sustainable, accountable manner. Referring people on to trauma-specific services if a client needs
more help than the service provider can give was identified as a key ethical practice by two participants.

Approximately nine participants did not list specific therapeutic modalities and talked about how they worked with clients. Even those who listed specific modalities also talked about which actions and beliefs were most helpful when working with LGBTQ2S+ clients. The most recommended healing practices were using the client’s pronouns and self-identification while respecting and dignifying the client’s identity. Participants stated that it was vital to avoid assumptions about the client’s connections to community or identities but to confirm meaning of identities with the client. This is confirmed by research into sexualities. People who identify as heterosexual may have sexual relationships with partners of the same or similar genders but are not given a space to talk about this in a standard mental health or medical intake that assumes heterosexuality and monogamy (Diamond, 2006; Helfrich & Simpson, 2006; Lambda Legal, 2010; Malinen, 2014; Smith C. M., 2014). Participants said that people may have transitioned without identifying with a trans identity, and people with a queer identity may not relate to queer communities for many valid reasons. Other people may have less information about their gender or sexuality or about LGBTQ2S+ communities than practitioners assume. Connecting people with supports in LGBTQ2S+ can be healing but must be done only when the person wants it, not when the practitioner thinks it is needed. Even though self-education about LGBTQ2S+ culture and affirmative practice is key to working with people associated with gender and sexual minorities, resisting assumptions about LGBTQ2S+ cultures, communities or the client is just as vital. Politics, terms and positioning are constantly evolving as community begins to embody and articulate experiences that may not have had language, especially language recognized outside these communities. Part of working with issues of violence outside of a cisgender,
heteronormative framework means recognizing that violence can be experienced differently based on many factors, including gender and sexuality.

Some of the challenges to this work are research and professional pressures to view survivors and perpetrators in extreme terms of villains and saints, active and passive, male and female. Therefore, a large number of participants said that as service providers, they work to resist seeing clients in simple binaries of victims and perpetrators and instead view violence as part of a complex cycle of personal responsibility, trauma and societal oppression, and that often former survivors of violence will also use violence. To avoid simple binaries, some participants said they separated the perpetrator from their behaviour, while encouraging them to take responsibility and accountability for their actions.

Creating safe places that signal to people that they can share their stories was fundamental to the listening skills described by participants. Being open, inclusive and accepting was a way to signal compassion, empathy and respect. Showing that the physical, emotional, mental and spiritual space is safe though having queer and trans art and books, rainbow signs, acknowledgement in mission statements and in promotional materials was part of the physical and tangible ways LGBTQ2S+ communities could know that a service provider would be willing to work with them in dignifying ways. At this point, service providers could then drop into a more standard active listening, client-centred practice by meeting people where they are at and following the client’s pace in order to empower and encourage open sharing of stories, followed by active listening with a non-judgmental stance. The participants’ descriptions of how they work showed that they have done a lot of pre-work on deprogramming assumptions in intake processes and client records, and participants have honed extra skills around dignifying clients and creating safe space for LGBTQ2S+ communities before and during their work with their
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clients. I would argue that the importance of this preliminary work has been often unacknowledged, minimized or even dismissed by a large number of mainstream services (Everett, MacFarlane, Reynolds, & Anderson, 2013; Baker & Beagan, 2014; Malinen, 2014). Therefore, I believe this data paints a picture of some practical approaches to begin dignifying clients from LGBTQ2S+ identities. The participants’ ways of working are supported by current recommendations from many health care governing bodies and grassroots organizations on LGBT-affirmative client care (Lambda Legal, 2010; Forge, 2011; SAMSHA, 2012; World Professional Association for Transgender Health, 2012)

Views on Violence

Out of 22 people who answered the question about violence as a unilateral act, 18 agreed with the definition of unilateral violence. Another three participants agreed that violent acts were unilateral and that there could be a cycle of violence over the course of a person's life, and they also resisted an unchallenged binary between victim and perpetrator. A further three participants had a different view of violence. One participant said that the legal system already holds perpetrators responsible, do not position the victim as passive and said that the language is archaic and only sounds victim-blaming — that these technical terms have a different meaning to practitioners in the legal field. The participant stated that this technical language is misused by media or people outside the legal field. Another participant said that they agreed that overall, violence was unilateral, but sometimes it was mutual, while one said unilateral violence contradicted their experience of violence. It was not clear if this last participant was referring to professional or personal experience. However, most participants acknowledged that survivors of violence in one relationship can be aggressors in another. A key statement was that most, if not all LGBTQ2S+ people are survivors of homophobic and transphobic systemic and institutional
and hate violence, complicating the binary between victims and perpetrators. Most participants, at some point in the focus group, if not in the question about violence, stated that they held the view that violence was unilateral and that there is what many participants called a cycle of violence, where most people using violence have also been survivors of violence.

During the focus group, it was noted that when violence is seen as an outcome of actions instead of an action, then violence is incorrectly seen as mutual, since seeing violence as a consequence of an action rather than an action plays into how family relationships are conceptualized in systemic theories, where the violence is a reaction to a previous action from another person (a subtle form of victim-blaming). It was also stated that dynamics in LGBTQ2S+ relationships are incorrectly interpreted through a heteronormative gender analysis of violence, leading to incorrectly labelling violence in LGBTQ2S+ relationships as mutual due to not recognizing forms of power and control specific to LGBTQ2S+ relationships. The point was raised that ethics of resistance could be complicated, especially in the use of violence in self-defence, physical violence to resist emotional/verbal/financial/gender/sexual abuse that is unnamed or perpetrators claiming that they are victims to deny services or to claim mutuality. False comparisons of active aggressors and passive victims, big stature versus small stature leads to authorities incorrectly assessing who is the victim and who is the perpetrator. Participants anticipated there would be pushback from institutions who unknowingly enact institutional violence, and from the internet. Interestingly, they also identified that perpetrators labelled violence as mutual to mitigate their responsibility for violence.

**Working with Families**

Twenty-two participants answered the question about describing LGBTQ2S+ families and what practices they wish more services providers used with LGBTQ2S+ families. I asked
this question to see how participants approached the concept of family structure in families that include LGBTQ2S+ members. While some participants answered the question by giving broad, gender-neutral descriptions of family, other participants noted that it was important to resist the idea of an “accurate description” as family structures are too complex to create one definition for the LGBTQ2S+ communities. There was wondering about the liminal spaces in families: about parents who come out to their children or about cisgender heterosexual parents who have a child and ways they can be seen as part of the LGBTQ2S+ spectrum. Welcoming cisgender heterosexual parents of a child who identifies within the LGBTQ2S+ spectrum into the broader LGBTQ2S+ communities can help create a circle of support and acceptance for both parents and child that lowers negative social response (stigma, homophobia and transphobia) within families and between families and their social networks.

Most participants felt that an individual family could be described, especially if the families had the power to self-describe, but firmly resisted the idea of categorizing or labelling LGBTQ2S+ families in general. A key theme that came up was how important it was to honour the families’ self-descriptions, collaborate on the description with the family and create an opportunity for the family to consent to any description of the family. This approach contrasts with the recommendations of much of the IPV research done on LGBTQ2S+ communities that state dynamics and family structures must be studied and described before therapy models and interventions can be then generated from that data. In the field, the participants were very concerned about service providers making assumptions and applying normative views of family structure onto clients. Making sure all people the client considered to be family were included and not excluded was a key recommendation for working with families.
Participants talked about how they work from a set of ethics and practices that dignify and advocate for clients. Honouring self-description by using the family’s language and self-identification was said to be important because most intake forms, therapy models and theories of family systems assume that a person is heterosexual and cisgender in a marriage relationship. One of the key themes throughout the study was how vital it is to self-educate about gender and sexual diversity and then confirm the meaning of the client’s self-identification and use of terms, rather than expecting the client to teach the practitioner. A willingness to be open to all people and listen with compassion and empathy were the most cited therapeutic practices that participants use with clients and wish more service providers used with LGBTQ2S+ clients.

Families span many identities and come in infinite variations. There is no standard or normative family structure. One family may contain many different privileges, oppressions, cultures and beliefs, and levels of closeness and support fluctuate dynamically. Service providers need to signal to families with LGBTQ2S+ members that they understand the complexity and creativity of their families by asking questions that show knowledge of LGBTQ2S+ culture, having images of LGBTQ2S+ cultures in their office and through a LGBTQ2S+-affirmative intake system that honours pronouns, gender diversity, and relationship diversity.

LGBTQ2S+ families creatively combine people connected by biology, friendship, identity into a social support network of emotional ties, comfort, belonging, safety and commitment. Only one participant said that love was an important family value. Participants recommended strengthening connections between family and the LGBTQ2S+ communities, especially if the family members were socially isolated. However, they also noted that many people do not identify with LGBTQ2S+ communities or want to connect with the broader LGBTQ2S+ cultures; participants said that it was important to check in with families about their
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willingness to identify with and connect with their local LGBTQ2S+ cultures before offering to give them information and referrals to LGBTQ2S+ community resources. Connecting to the idea of LGBTQ2S+ culture as a family was another key theme that emerged. Many participants pointed out that LGBTQ2S+ families can include more than one mother/father, chosen family, friends, ex-partners, lovers, egg/sperm donors, surrogates, mentors, adopted, self-selected, foster or biological children from current or past relationships, subculture families (LGBT, leather, poly, spiritual, cultural), extended relatives. A family group can include many gender and sexual identities and come in infinite variations of relationship configurations, including monogamous and polyamorous. One family may contain many different privileges, oppressions, cultures and beliefs and may share cultures and beliefs. Participants also spoke of the tension of balancing their own desire to advocate for LGBTQ2S+ families and communities with ensuring that they have the consent of the people they work for to do so. Participants stated that they worked to align with the values of the family and individuals when safe to do so.

Working with Survivors

Twenty participants answered the question about LGBTQ2S+ survivors of violence, with a broad range of ethics towards assessing survivors and a broad range of views about survivors. One person stated that they have not worked with survivors of violence. Several found the question confusing and wondered if it was framed incorrectly. Some mentioned that they would prefer to comment on a specific case scenario rather than describing their views and attitudes towards survivors as a group in general. Views on the ability to build an accurate description of survivors ranged from any attempt to describe would be problematic, to survivors can be diagnosed and treated. Several participants felt that descriptions would be fragmentary, provisional and dynamic, changing with context and time. Several did not answer the part of the
question about description and focused on the part of the question about what they wished service providers would do more in their work with survivors. This range of responses is possibly due to the participants coming from a large variety of public health fields and theoretical backgrounds, as well as resisting the ideas of description as a totalizing and unhelpful process.

The reason I focused on the phrase “accurate description” in the three questions about attitudes and beliefs about describing families, survivors and perpetrators is that currently practitioners who are trained to assess couples and individuals are told that perpetrators will often claim to be victims to block the victim’s access to services. Therefore, current intake clinical interview models that are being recommended and promoted by some LGBTQ-affirmative agencies state that accurately assessing whether the person is the victim or the perpetrator at intake is possible and will determine whether the client is treated as a victim and accesses victim services or is denied victim services. Furthermore, assessment and intake itself is a descriptive act, where practitioners build a picture of the client and the client’s context and base interventions and treatments on the description the practitioner has created about the client.

Many participants stated that accuracy lies in self-description, building on the theme of honouring self-identification. One participant pointed out that honouring self-description requires combining self-identification with another theme, confirming meaning of culture-specific language and knowledge. Accuracy in description depends on both people agreeing that they both assign the same meaning to that description. Not only does the client need to make sure their language is understood, but the practitioner needs to confirm that they have the same understanding of the language as the client. The difficulty is that in any exchange of information, there is an unavoidable drift in meaning between the person who is speaking and the person who
is listening. Accuracy usually relies on standard descriptions (like models) to try to counteract drifts in meaning and ensure that both parties agree on meaning. However, most people in LGBTQ2S+ communities do not fit standard descriptions, meaning that creating shared meaning between client and practitioner is less likely, and instead creates an illusion of accuracy. Based on these participants’ views, I begin to wonder how we can avoid drifts in meaning that affect assessments that have the power to determine who receives services and who does not. I was not the only person to wonder about the purpose of assessment; participants stated that we need to ask why we need to build accurate descriptions, be critical of what we mean by an accurate description and be very careful to ensure that those descriptions are in service to the client rather than primarily useful to the agency and funders.

Participants complicated the binary between people experiencing violence and using violence. Some raised the point that if virtually all people in gender and sexual minorities have survived hate violence, systemic violence and institutional violence, then most, if not all, LGBTQ2S+ people are already survivors of violence. In that case, there are few people in the LGBTQ2S+ communities who can be only labelled as perpetrators or aggressors. Others noted that survivors of violence are people who have experienced violence, regardless of gender or sexual orientation, both as a way to promote the equality of LGBTQ2S+ survivors and cisgender heterosexual survivors and also to contest the notion that only cisgender, heterosexual white women are survivors of violence.

Several participants noted that they agreed with the ideas and ethics of response-based practice but found that the language of the presentation was very academic and that if they used response-based practice in the field, they would make the language more accessible to people. They also suggested that any training processes for response-based practice be written in
language that is more accessible to people. Participants stated that keeping language clear and non-academic creates more safety by ensuring that the practitioner is enacting less ability and class privilege based on literacy access to university education. Some participants felt that having more information about how to structure the process and create safety in the room before asking the questions in the Islands of Safety process would be helpful to help understand how to use the process.

Participants agreed that victim-blaming happens and is unjust. There were a wider number of opinions about where victim-blaming and excusing perpetrators occurs. Several participants expressed strong emotions about victim-blaming in the courts, while others stated that courts do not victim-blame or excuse perpetrators. It was expressed that courts victim-blame but medical professionals do not. Other participants stated that they had seen health service providers blame victims; these participants said that they resisted victim-blaming by learning from those experiences and providing services that dignify victims.

Many participants found the section on victim resistance useful and said that they would begin to use this knowledge in their current practice or said that they already use an analysis of victim resistance in their work with survivors. Questions arose about how highlighting resistance connects to survivor resiliency. Naturally, to support victim resistance, it was stated during the focus group that we need to be very clear on what is meant by resistance and be clear on when a violent retaliation is considered resistance or violence. Several participants said that part of deciding what is resistance and what is violence is to name and recognize gender violence that typically goes unrecognized and unnamed. Some of these acts include withholding hormones, packers, gaffing or other supplies that help people live their felt gender. Gendered institutional violence can include misusing pronouns, “deadnaming” people by using the name on their birth
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certificate instead of their chosen name, gatekeeping access to hormones with mental health assessments, and forcing trans people to visit endocrinologists when people with menopause or prostate cancer can access hormone treatment by visiting their family doctor. Verbal abuse occurs in the relationship, in families, in public and while accessing health services: making comments about someone not being lesbian enough, gay enough, trans enough, or queer enough; being too gay, lesbian, queer or trans; telling people their identity is a phase; saying that a client is just trying to be part of a trend and that they are not really trans.

Respectful language and naming violence builds trust, comfort and safety with survivors. The most recommended practice for every question, including this question, was to ask for the client’s pronouns and use them and to use the client’s language and self-descriptors, not the agency’s self-descriptors. It was also important to ask if there were any contexts where that person would not feel safe using their pronoun, especially if their workplace, home or other members of the agency are not safe places to be out. Almost equally emphasized was the recommendation that practitioners listen to individual stories rather than assigning people to labels or categories. Participants strongly felt that service providers need to contextualize a survivor’s personal story of IPV within a context of systemic and institutional violence that includes an analysis of oppression. Most participants wished that service providers would contest mutualizing violence in relationships and families and contest victim-blaming. Service providers need to see both people as complex beings who are not villains or saints and keep the focus on the context around the violent acts.

Primarily, participants listened with empathy and worked with the survivor to promote safety within their family and for the survivor. Being strengths-focused and trauma-informed was mentioned, with emphasis on empowering clients. Educating clients on resiliency, self-
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Esteem and boundary-setting with the perpetrator was also mentioned. Participants recommended referring people to long-term, expert services unless trained in working with trauma. Some felt that helping people move from an identity of victim to an identity of survivor was helpful, while others stated that some people do not relate to this model as a healing process. Participants who said that survivors could be diagnosed also stated that it was important to help survivors change the irrational beliefs and low self-esteem that allows perpetrators to harm them and could distort their memory of the violence. Separating shame and guilt could help process the experience. Boundary work and determining that the survivor is responsible for their own behaviour and not the behaviours of others was also felt to be part of work with survivors. Most participants took a stance that advocacy was part of their work, while some felt that their primary responsibility was to focus on supporting the survivor rather than addressing societal bigotry.

**Working with Perpetrators**

Seven out of the twenty people who answered the question about perpetrators said that they have not worked with perpetrators. Three participants said that they have only worked with survivors who have used violence. Participants also expressed that they wanted to be asked more specific questions about perpetrators to guide them in how to answer and in what was meant by “accurate description”. The group was evenly split on whether perpetrators could be described, with slightly more people saying that perpetrators could be described by service providers than when asked about describing survivors. All participants who described people who perpetrate defined perpetration in terms of choice. Some stated that violence was a choice made by hurting and scared people. Others pointed out that many people using violence have experienced violence, homophobia and transphobia from parents and caregivers, often in ways that are not recognized by society or justified by society.
Only one participant stated that while they had not worked with perpetrators, it was important to work from the perpetrator’s self-identifiers and self-descriptors, which was down from the five participants who stated that using a survivor’s self-descriptors is important. Five of the ten participants who said they cannot describe perpetrators also said they have not worked with perpetrators, and some of those participants stated that they could not describe perpetrators because they had not worked with perpetrators. Four participants felt that perpetrators were too complicated to describe and one said there was not an objective way to describe perpetrators. Participants did state that it was important to use the perpetrator’s pronouns and current name with the perpetrator, rather than the information on official documents.

In working with aggressors, creating an open and safe discussion was the most commonly cited practice that participants wished more services providers would integrate into their services. This included showing concern for the aggressor’s well-being by choosing to take a stance that violence is also taking a physical, emotional, spiritual and mental toll on the aggressor’s wellbeing. Respect, a non-judgemental attitude and dignity were also talked about as ways to build an open dialogue. Participants recommended seeing perpetrators as people who can choose pro-social values and also have chosen to use violence when faced with challenges. A few participants also felt that doing work on the individual’s internal states was a part of the work, stating that aggressors need to learn skills, confidence and awareness. One participant said they work protecting the client’s ego while gently and gradually confronting aspects of the client’s denial. Asking how willing aggressors are to change and stop using violence was an early step identified by participants as a way to gauge the aggressor’s willingness to take responsibility for their actions.
Participants stated that naming the violence perpetrators have experienced was part of therapeutic work with aggressors. These participants stated that perpetrators, like survivors, also experience violence within a world of systemic and institutional violence marked by child abuse, homophobia, transphobia and racism that goes excused or unacknowledged by society and service providers. As part of locating the aggressor’s violence within systems of violence, participants stated that it was vital to not use this context as an excuse for violence. Participants said they currently avoid accepting excuse-making by framing the aggressor’s violence as deliberate and working with perpetrators to acknowledge their acts and take responsibility for them. Many participants had very positive feedback about the part of the presentation about working with the pro-social aspects of excuses, saying that it had changed their perspective and that they would like to start using that idea in their current work.

Many participants at this point in the focus group said that response-based practice’s approach to working with perpetrators reminded them of restorative justice frameworks, and they said that RBP and Islands of Safety could be a valuable approach for working with perpetrators. Community accountability was an important concept raised here, which makes sense, as most of the grassroots organizations cited by participants are using community accountability processes to work with aggressors (Chen, Dulani, & Piepna-Samarasinha, 2011). Participants agreed that perpetrators also need social support systems, that these systems also can help aggressors get enough guidance and care to take responsibility and that these communities of support can hold the person accountable to their responsibilities, providing follow-up for accountability processes.

One participant wondered whether communities that share similar identities can gather together to start to talk about creating a culture of community accountability and within-group prevention education. That way, individual families and relationship groups can feel supported
by the larger social community and are not trying to heal and get justice in isolation. This also combats the exclusion and isolation of perpetrators from community while ensuring that aggressors are known within community and that they are being held accountable for their actions in community, instead of survivors negotiating for accountability that is not recognized or known or followed by the community (Chen, Dulani, & Piepna-Samarasinha, 2011).

Approaching the Métis Aspects of Islands of Safety

Seventeen participants responded to the question about how they would approach the Métis-specific elements of the Islands of Safety process. This data measures the community response to the Métis wisdom within the process and also takes a temperature on how practitioners who are aware of intersectionality and marginalization would approach cultural competency and awareness of cultural humility and cultural appropriation of Indigenous knowledge. In what ways could practitioners use a model found in academic journals and conference presentations without enacting cultural violence? These results can hopefully provide useful information on what elements of the model might need more context to ensure respectful cross-cultural use with clients who are not Métis. The wide range of responses showed me that I needed a deeper analysis of the traditional view of Métis families to understand the results. One participant noted that a non-authentic implementation of the process could lead to cultural violence, and that is a concern I personally echo and is one of the reasons I wanted to do this study.

The participant who identified as Métis and two-spirit did not answer this question, but in the next question about the gut response to the model stated that the model did not need to be changed at all to be used with LGBTQ2S+ communities. Another person who stated that they were raised in Indigenous ways also said that nothing needed to be changed or adapted to use the
process with LGBTQ2S+ clients. This is in stark contrast to all but two of the participants from a wide ethnic range of settler and immigrant cultures who said that they would change various elements of the process.

One participant would not use the model at all because it was not inclusive of queer or trans people. This participant felt that the model was culturally violent to LGBTQ2S+ communities. This participant called on the health profession to stop creating non-inclusive models that then have to be adapted to different communities to make them less problematic. This participant recommended that all health fields need to start creating models that are inclusive of everyone from the start. This participant viewed the rest of the presentation, but skipped the rest of the questions for the reason of “I don’t have time”. I interpreted this as the participant’s protest of non-inclusive models and wanted to acknowledge this response as a possible protest. It could also be that this participant wanted to view the rest of the information and did not have time to answer the questions.

One participant stated that they would not use the medicine wheel or the blankets because they are not from a Métis background. Others only indicated that they would use the types of safety and did not comment on using other aspects of the model explicitly labelled as Métis. These approaches showed that some practitioners might approach adapting a model from an ethic of avoiding cultural appropriation through avoiding elements that appear to be from a specific cultural background.

Two participants approached the model by only incorporating the Métis elements that also appeared at first glance to be gender-neutral, stating that they would only use the medicine wheel and not the blankets and traditional model of Métis families. This approach came from an ethic of incorporating elements that were shared by both Métis and LGBTQ2S+ communities.
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and removing elements of the process that, through a settler and immigrant lens, do not appear to be compatible with LGBTQ2S+ cultures.

Some participants would use both the medicine wheel and the blankets, but would change the blankets because in their view, the blankets appeared to display a heteronormative and hierarchical view of family. This group noted that the blanket representing fathers was larger than the blanket representing mothers and that the blanket representing fathers was blue. This group felt that the larger size of the blanket meant that the model valued male roles over female roles. Some in this group of participants would add a blanket for queerness and a blanket for people without children. Some in this group showed concern that people in queer communities would be not represented on the blankets otherwise, and thus the blankets would be taken as a microaggression by the family. Others in this group of participants felt that mothers and fathers needed to be pluralized throughout the model to show that there could be multiple mothers and no fathers, or multiple fathers and no mothers, or that a child has many mothers and fathers. One participant said that they would acknowledge the Métis origins of the process and then adapt the process to fit the culture of the clients. These approaches showed that some practitioners would use an ethic of locating and acknowledging Indigenous knowledges, and also comes from an ethic that is common in academics: that if the information is in the public domain, it is available to be adapted without input from Indigenous communities. However, this approach did not include self-location and self-examination.

Two participants stated that they would ask permission from Métis communities before using the model and that they would use the model in partnership with their local Métis communities. One participant from a settler/immigrant culture who has access to an Indigenous healing program through their workplace also stated that they would use the model as is, with
input and support of elders from this Aboriginal health access program. The other participant took a grassroots activism approach and stated that it was important to build relationship between queer settler communities and Indigenous communities as a way to resist white ways of practising healing. This participant was one of the only participants that stated that self-location as a settler and self-examination for blind spots and privilege was key in using the Islands of Safety process as a practitioner from a settler culture. This participant stated that we need to create ways of acknowledging peer healing systems in ways that people doing the healing can be recognized for their work and thus be properly supported in doing that work.

Most participants appreciated that the Métis aspects of the model was holistic, an important value for most participants. They appreciated that Islands of Safety came from a place of curiosity and dignity instead of a place of assumption, which was listed earlier as one of the most important stances for a practitioner to take in working with LGBTQ2S+ communities. They also appreciated that support during the process and the outcome of the process was shaped to fit the individual without losing sight of the social context around the person. Several participants noted that Islands of Safety reminded them of restorative justice processes and, even if they felt the blankets represented heterosexual family, liked that the process could be used to respectfully explore intergenerational, social and family contexts and to reflect on the lack of culturally safe parenting for children who are in gender and/or sexual minorities.

Some pointed out that both LGBTQ2S+ communities and Métis communities are small and that violence within families can affect the community and so appreciate that the process creates the opportunity for a community response. Participants felt that the imagery of the blankets, especially the idea that the elders cared for the children, could help queer communities reconnect with and dignify elders in the community as sources of wisdom and safety for younger
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people and children. This is an important piece, as both elders and youth can be isolated in LGBTQ2S+ communities. Others also saw that having a feminine blanket could work to combat stigmatization of femme identities. Several participants noted that they felt that they had learned to be more culturally aware from this section of the presentation. Quite a few participants recommended working with the family to create a model of the family that was rooted in the culture of the family in addition to or instead of the blankets. Most of the participants felt the blankets were powerful, and that when working with non-Indigenous families, having a display that directly related to the family’s structure, culture and ways of relating would be more powerful and personal than translating the blankets or mapping the family onto the blankets.

Several participants located gender and sexual orientation safety under cultural safety. This refers to Richardson’s quote about cultural safety. The original quote reads as follows:

Cultural safety relates to the possibility of an Indigenous person or member of a minority group being treated with acceptance and equanimity, without encountering racism or prejudice. Islands of Safety work involves acknowledging where the family comes from, which community they belong with, and how our relatives may have interacted with their relatives historically. Cultural safety overlaps with spiritual safety, which can be considered as freedom from imposed religion or medical/healing methodologies (Richardson, 2009a).

Participants recommended adding homophobia and transphobia to “racism or prejudice” in the first sentence. Virtually all the participants agreed that respectfully acknowledging and including all the innovative ways LGBTQ2S+ people are building families, support networks, advocacy and communities is vital to cultural safety. Two participants felt that acknowledging how
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colonization operates within these communities now and in the past was important for creating cultural safety. Other participants recommended explicitly acknowledging types of safety that relate to the experiences of queer and trans people to the list of types of safety.

Gut Responses to Islands of Safety

Of the 17 participants who talked about their gut response to the Islands of Safety process, 15 had positive feedback, one expressed concerns and suggestions, and one person said that the model did not match their experiences of their clients. Of the 15 participants with positive feedback, seven participants had only positive feedback, six had positive feedback with some suggestions for using the process with LGBTQ2S+ families, and two participants expressed positive feedback with a concern about an aspect of the process.

One participant said that the past did not always affect the client and found that sometimes clients have different responses to events. Another participant wanted the embedded assumptions about victim resistance and negative social responses clearly acknowledged as things that can be true, but not assumed that they are true, for the client. They also wanted mothers and fathers to be pluralized throughout the whole model to highlight that queer families may have a more communal parenting style and/or that there may be two mothers or two fathers.

The two participants who liked the process and had concerns both had reservations that related to an aspect of safety. One participant wanted to see that there were ways to make sure the participants were supported in staying grounded emotionally and physically while speaking about violence. Another participant had strong concerns about the perpetrator and the victim being in the same circle, as evidenced by the participant bringing up the concerns both in this question and on the discussion board. This participant said that the perpetrator would need to do a lot of healing work first and there would need to be a lot of work done by the facilitators to
ensure the safety of the other people in the circle. Two other people responded to the discussion post stating that they agreed with the participant’s concerns and would recommend similar safety processes, that they did believe that it was possible to do, and they cited other healing processes that included both victims and perpetrators.

It is my understanding of the process and the style of response-based practice that there is a strong focus on consent, grounding, and conversation over formal interviewing, and building safety around having victims and perpetrators in the same circle. Part of me wonders if some of this feedback is due to trying to limit the length of the presentation shown to participants and that that resulted in not enough emphasis on elements that are part of the process. While I do believe that consent was in the presentation, the elements about emotional support and the conversational nature of the process were not emphasized enough in the presentation viewed by participants. Also, as I have witnessed in in-person training in Islands of Safety and response-based practice, there are elements of the process that come from seeing the process at work and the creators of the process that were not or cannot be expressed on paper as clearly as they can be seen in person. This points to a possible need to emphasize these aspects of the process when creating training and resource material on the Islands of Safety process.

Several participants were curious about how follow up and accountability in implementing the safety plan would work. This would be a very valid suggestion to add to an Islands of Safety process used outside of a child protection process. In the current process, social workers assigned to the family would provide follow up on the safety plan. If the process was used outside of a child protection context, it would be vital to have a process for checking in to see how the plan was working, make adjustments and have accountability when someone does not follow the agreements and plans.
Stating some ways to engage people in the process, especially when distrust of group process may be present for very valid reasons, would also be another suggestion for the process, especially if the process is not being guided by facilitators and social workers. Participants thought that engaging family and friends in conversations about the process before starting the process could be a way to engage the community and create a sense of safety about using the Islands of Safety process.

Participants had a wide range of views on the questions, from feeling they were fine as is to suggesting some additional questions. Some participants said the question assumed victim resistance and negative social responses, while other participants said the strength of the questions was that they did not make assumptions about the family. It was recommended that Islands of Safety add specific questions about pronouns, where they are out and who they are out with, their experience of queer communities, their experience of family and confirming the meaning of the family’s gender and sexual journeys. Some participants said that removing the Métis pieces of the process would create the perception of whitewashing the process for European settlers. Instead, it was felt that this process, when used with settler cultures, could combine group therapy, family safety planning and social justice advocacy and that facilitators would need to be prepared to do some education of clients who are European settlers. As non-European settlers in the study also had similar responses to the overtly Métis elements of the Islands of Safety process, this educational piece may need to extend to most settler and immigrant cultures.

The positive feedback was that the Islands of Safety process was open, flexible, took enough time to really understand the family and their context, and was inclusive of people the family thought were important, rather than who the facilitators thought were important. The
holistic nature of Islands of Safety helped participants feel more aware of cultural competency for Métis families and left some participants wanting to learn more and advocate for more learning in their workplaces about implementing more cultural awareness. Most participants said they felt the approach to dignity and resistance was innovative, very useful in working with victims and perpetrators and would be easy to start using in their workplaces. Asking about previous experience with professionals was a popular aspect of the Islands of Safety and response-based model, as several participants pointed out that many LGBTQ2S+-identified people have been mistreated by professionals and have not had that mistreatment validated. The focus on the different types of safety gave many participants a new way to conceptualize safety that went beyond just physical safety, which they felt gave more depth to their work when creating safety plans with clients.

*How Would Participants Adapt Islands of Safety?*

Seventeen participants answered the question about how they would adapt the Islands of Safety process. The two participants who identified as Indigenous and Métis, as well as a small handful of settler/immigrant participants, stated that they would use the process without making any adaptations, while the majority of participants from settler/immigrant cultures stated that they would use parts of the process or would make various additions and changes to the process. This highlights the need to carefully look at the politics and ethics of using Indigenous models and traditional knowledge with settler and immigrant cultures, and I will expand on this further in the Discussion section.

There was a wide array of beliefs about adapting the process, and some of the responses to this question did not appear to involve overtly Métis-specific knowledge. As I am not Indigenous, I want to be careful that my perspective on this could definitely be flawed. The only
reason I bring this up is that the majority of the points made by participants in this section appeared to me to highlight that there were parts of the presentation that participants did not pick up on and/or were not emphasized properly in the study presentation. That is, many participants recommended adaptations that already exist in the model. This could be due to a failure of the study presentation to properly emphasize some key points. While I tried to cover the full range of information about the process in the presentation viewed by participants, I was also trying to make the study presentation as short as possible to avoid study fatigue. Some points that participants showed concern or confusion about are actually covered in more detail in articles and videos on the Islands of Safety process, but all details about the process are not covered in every resource on the Islands of Safety process.

Yet these areas of concern could also point out to topics that could be fleshed out further in trainings on the Islands of Safety process. Three participants shared concerns about having aggressors take part in the process; they stated that they thought there was a risk of power imbalances going unchecked by facilitators, that the process could become more about healing the aggressor than the survivor. These participants were unclear on what the facilitators would do to ensure that the aggressor had done enough personal work to be able to make a safe and positive contribution to the process. The Islands of Safety process does emphasize that the survivor of violence is centred at all times in the process; the aggressor can only participate if the survivor wishes the aggressor to take part, and the aggressor must agree to not use violence. Most people answering the question wanted more information about how to engage people who might be wary of group processes for very good reasons and wanted a bit more information about how to facilitate the group processes in Islands of Safety, especially groups that included
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survivors and perpetrators. Others pointed out that engaging the aggressors in cases of hate violence would be difficult, but had potential.

One thing that the study could have emphasized a bit more is that the four rounds of conversation do already take place in many meetings, not necessarily only four meetings. Some participants said that due to a lack of language and the need to take enough time to figure out what safety and justice would look like for the survivor, more meetings would need to take place than is usual. Some participants felt more time would need to occur in round one to fully explore personal identities and complex family and friend structures, while others felt the final meeting would need to be broken into several meetings. It is possible that this is true, and it is also possible that this flexibility is already in the model but was not properly emphasized in the study presentation viewed by participants. It is possible that participants did not understand that Indigenous families are also complex and are very different than European-settler nuclear family structures and immigrant family structures. Perhaps this was not as fully emphasized in the presentation as it could have been. More research would be needed to see if LGBTQ2S+ families would need more time and meetings than other families or not.

The rest of the recommendations were primarily additive — that is, adding to the model, rather than changing the existing model. Some participants stated the questions needed to be changed or additional LGBTQ2S+-specific questions added, while others felt the questions were already gender-neutral. Some felt that this process would be easily adapted to situations outside of child protection and to situations of hate violence. Participants wondered how to ensure that the process remained centred on the survivor and wanted more information on how to centre the work when working with relationships and friend networks that did not involve children. Some noted that the model did not centre children explicitly, and thus it would be easy to use in
situations outside of child protection. One point that came up was that if this process was used without working with child protection authorities, follow up and accountability would be more of an issue that would need to be explored further, as in the current Islands of Safety process, it is assumed that child protection authorities will be monitoring the family and ensuring that safety plans are followed.

A few participants felt that the only thing that would look different would be the safety planning during the last meeting, as LGBTQ2S+-specific safety planning looks different than safety planning for cisgender heterosexual women. This view is backed up by organizations that do work with LGBTQ2S+ survivors of violence, like FORGE, Anti-Violence Project, and the Northwest Network. However, this affects the Signs of Safety planning process more than the Islands of Safety process, pointing to a need for Signs of Safety to do research on whether their safety-planning process needs to adapt for queer and trans families. These participants felt that honouring elders and community healing was a real strength of the Islands of Safety process, as isolation and not acknowledging elders have been issues in some non-Indigenous LGBTQ+ communities.

Some indicated that they would use the concepts around safety and resistance and would add types of safety that were specific to gender and sexual identities. Other participants listed gender and sexuality safety under cultural safety. Discussing resistance with people was seen as an innovative way to validate stories and ensure that survivors’ actions were not minimized or seen as a pathology. It was noted that this process would not work for agencies that only work with clients on a short-term basis, which makes sense, as this process does take time and commitment on the part of both the facilitators, service providers and family.
DISCUSSION

The goal of this study is to generate a set of recommendations and concerns that could be useful to people wishing to adapt the Islands of Safety model for other communities. I also hope that this study can provide some guidance for response-based practice to acknowledge and conceptualize the existence of non-binary genders and IPV and hate violence as it occurs in LGBTQ2S+ communities. Furthermore, it is hoped that by articulating a position within the theories of violence that is queered and intersectional, this study can point to a position that incorporates research into different types of violence with a feminist approach, thus moving beyond the Balkanization in theories of violence between feminist and family systems.

I think we need to be aware that people may not be "out" in all their identities in front of a counsellor, social worker, nurse or other practitioner. Therefore, starting at a place of self-located, culturally-aware, LGBTQ2S+-affirmative practice rooted in the practices of the land and in Indigenous world views may be important healing work for working respectfully with people. What if counsellors, social workers and nurses practised from an assumption that the person who comes to us may be Indigenous or queer and/or trans instead of an assumption that the “average client” is white, cisgendered and heterosexual? Starting from a “standard” intervention and adding cultural competency in once we have found out the person is LGBTQ2S+, or is from another culture than European settler culture, is in itself not a neutral or objective position, but is enacting a position rooted in colonialism. At that point, practitioners are playing catch-up to the situation instead of being present in the situation. I agree, though, that when practitioners from settler backgrounds attempt to do this work, it would require building relationship, cultural humility, constant accountability and a constant monitoring to try to avoid cultural violence. This
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discussion section is an exploration of some ways practitioners may be able to work with a model created cross-culturally and some of the challenges in doing so.

Language Accessibility

There are at least two possible reasons that participants recommended looking at language accessibility in response-based practice and Islands of Safety process. First, I used the language of response-based practice and Islands of Safety process that is available online in Power Point presentations from conferences, videos of conference presentations and in academic journals. I wished to mirror the language that is currently being used to present response-based practice and the Islands of Safety process to service providers and academics to see what the response of service providers would be to that language. The language of response-based approaches is very academic, and the idea of what a response is usually needs to be explained when working with clients. Truthfully, the language is definitely of a certain culture and class, and I think the participants in this study did make a strong case that in practice, the language of response-based ideas needs to be more accessible. The second reason participants could have been reacting to the language was the way I presented it. I am a European settler who, while I do come from a working-class background, has always had access to books and certain language abilities that give me a blind spot around language access. I got jobs and then access to a relationship where I received enough economic support to be able to move from subsistence living as a single person to enough economic privilege to save for and pay for higher education. This is a research study at a graduate school rather than grassroots action research, which then shapes the language and ways the material is presented.

To be transparent, I anticipated that participants would respond to the language of response-based practice and the Islands of Safety process by stating that the language needed to
be more accessible. At the stage of the study where participants brought up language accessibility, most of the presentation had been focused on the ideas of response-based practice. Response-based practice, as presented in most training settings I have studied, does appear to me to have more academic language with very specific terms that have specific meanings. For example, whenever the theory of the four operations of language used to talk about violence in media and the courts is presented, the same language is used across academic writings: “(i) conceal violence, (ii) mitigate perpetrators’ responsibility, (iii) conceal victims’ resistance, and (iv) blame or pathologize victims” (Coates & Wade, 2004; Coates & Wade, 2007). Is it possible to say hide violence, excuse perpetrators, blame victims and say that victims are mentally ill, or does that change the meaning of the theory? I believe that making the language more accessible and varied would be useful for broadening the audiences for response-based approaches.

**Challenges of Labelling and Exploring Within-Group Attitudes**

The wide range of approaches participants said they used when working with survivors shows that while a large proportion of participants embraced similar theoretical and therapeutic approaches, there were enough differences to show that people accessing services from LGBTQ2S+ health workers may receive different responses based on the worker’s beliefs about effective healing, their theoretical backgrounds and where the services are being offered (hospital, shelter, private practice, etc.). I wondered going in if gender and sexuality would be a factor in the participants’ beliefs about survivors, perpetrators and violence, but it became very quickly apparent that in this sample, gender and sexuality did not seem to be a factor related to beliefs. These results could be different if respondents had been given specific scenarios and asked how they would act, but when reacting to LGBTQ2S+ survivors, perpetrators or violence
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in general, training, theory and area of health care practice seemed to be more of an influence on beliefs about response-based approaches.

As the sample size of this study was only 26, it is possible that results were artificially skewed towards using anti-oppressive theory and trauma-informed practice with survivors. It is definitely possible that participants self-selected for this focus group from groups that combined social justice theory with health care practices. Yet the presence of a wide range of practice and the presence of other theoretical ideas, like the use of DSM-V, shows that health care practitioners who identify as LGBTQ2S+ potentially use a wide range of theories and practices in their work with victims. This possibly could mean that even when services are provided by LGBTQ2S+ communities, people accessing these services could receive a wide range of helpful and unhelpful social responses. It would be worth further research to determine if differences in service provision within LGBTQ2S+ groups are dependent on the type of training received by health workers or by beliefs about clients held by those health workers or both.

I attempted to measure whether views of victims, perpetrators and violence would relate to a participant’s reception to response-based ideas and Islands of Safety but was unable to make any connections. My initial attempt to collect these views in a way that was not leading led to some participants expressing concern about the wording of the questions. Participants had what I interpreted as a strong reservation about attempting to describe victims and perpetrators due to a strong risk of pathologizing people through inaccuracy and assumptions. Describing victims and perpetrators was seen at odds with working in culturally appropriate and safe ways with victims and perpetrators. Mid-study I shifted the language of these two questions from “victim” to “survivor” and moved from asking participants to “accurately describe” victims and perpetrators to asking if they felt it was possible to accurately describe survivors and perpetrators and how
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they wish other service providers worked. I also sent an email reassuring participants that the study was not about trying to build “accurate descriptions” but about the Islands of Safety process and was more transparent about my reasons for asking the question. This highlights that there may be tension between traditional research, where researchers try to not influence the data, and “know and tell why” ethics of assessment in LGBTQ2S+ communities, where they are telling service providers to only collect data actually needed to perform the service and be ready to explain why they are collecting the data (Forge, 2012).

It may be that the participants were wary of me and my motives as a stranger to them. However, the data collected shows that many of the practitioners in this study were wary of descriptors in general. This could raise questions about the efficacy of assessment, as assessment is grounded in descriptions of people. Currently, one of the few LGBTQ+-inclusive IPV assessment tools that has been created in the LGBTQ+ community is an assessment of whether a potential client is a victim or is a perpetrator trying to block the victim from accessing services. In the case of this tool, being able to accurately define a victim is key to accurately assessing whether someone is a victim or not. If participants are concerned and state that describing victims is problematic, it could show that research into how to assess people for entry into survivor and perpetrator services is a key area for future research. Many participants stated that the client needs to be the one determining the accuracy and the shape of the assessment, not the provider. We need to be over the days of jamming people into gender and sex boxes to fit our assessment forms and case conceptualizations. Maybe part of accountability in assessment would be co-collaborating on the assessment with the client instead of just writing up our projections of the client afterwards. How would power between client and health care worker shift if we
checked in with the client about how we presented their file to our clinical supervisors and co-workers?

These findings could also show that we need to look at how we deliver services, rather than assessing whether people are survivors or perpetrators to determine who is worthy of a small number of spots in a survivor program. We still do need survivor programs and transition houses. Perhaps we could also develop a wider variety of programs, some of which do not judge the believability of a survivor but can work with the person where they are, especially in situations where people who have experienced violence also use violence. This could relieve some of the pressure on the anti-violence programs in place. I would posit that Islands of Safety process has some potential in this area.

*Violence is an Act, Not an Identity*

As I go into this section, I want to make it clear that naming oneself as a victim and/or survivor can be an important act of healing and empowerment. Naming oneself as a perpetrator can be a fundamental act of taking responsibility for one’s actions. The following thoughts about naming people and identity is more for how service providers work with acts of naming, labelling and identification so that when workers and organizations are offering services, they are examining assumptions and meaning surrounding labelling, naming and assessment. The words that practitioners use to assess and describe people need to be used with careful thought, attention to meaning and with the consent and co-collaboration of their clients. I think a lot of the data in this study showed that the identity position of victim/perpetrator as an uncontested binary has been problematized. This binary can be used as a tool of abuse and/or competition. It can be temporary, and people can shift or be in multiple identities. It is an identity that can be a snapshot of a point in time, and to know the power dynamics and the way violence works over the course
of that person's life, health care providers need to look at many snapshots in time and not accept
labels in an unconscious or static way.

This research is showing that processes and services based only on survivors or only on
perpetrators may be temporarily helpful and necessary but do not reflect everyone’s lived reality,
and there is a need for people to talk both about their experiences of victimization and
perpetration, to talk about lifetime and intergenerational violence. Is it that we need different
group formats, or do we need to construct safe-enough space differently in existing services? As
an example of the inability of identity-driven services to handle complex situations, Ristock
(2003) found that service providers offered limited services due to not knowing how to handle
people who both use and experience violence:

- two women who run support groups for survivors of same-sex abuse reported in
  the focus group that when screening for group members, they only accept
  women who have never used violence (not even in self-defence) because they
  feel they cannot address the complexities such behaviors may raise in the group
  (Ristock, 2003).

While this makes running a group simpler and safer for the service provider, it is obvious from
this response that by taking this approach, many people wanting services and assistance with
lowering violence are not eligible for the many of the available services.

Several participants were hesitant to call LGBTQ2S+ who use violence perpetrators, and
spoke of survivors who use violence. This hesitation points to something important: Identities
based on violent acts can shift to new identity positions based on past, present or future actions.
Violence is primarily an act, not a static, permanent identity (Hydén, Gadd, & Wade, 2016). That
shift is not often acknowledged in training materials on IPV for service providers, but some
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Grassroots writings on IPV have noted that victims in first relationships can go on to perpetrate violence in future relationships (Chen, Dulani, & Piepna-Samarasinha, 2011). Yet very few people seem to have looked at how these identities can shift, the ethics of naming and identifying people based on violent acts and how these acts of naming, identifying and labelling can relate to access to treatment and treatment itself. As Ristock (2003) states:

Because of a mandate to work with victims, women's organizations that are confronted with both members of a lesbian couple may define the initiator of the violence as the abuser. They can then work with a woman who has fought back or who now retaliates against her partner with physical violence. Yet, a consequence of this strategy is that ‘victim gets constructed’ as ‘the one who did not start it’ regardless of her subsequent actions or intentions. This then reinforces the dichotomies of victim/perpetrator; passive/active; innocent/evil that underlie gendered discourses of violence and mask complexities (Ristock, 2003).

Virtually all IPV services are identity-based — that is, the service rendered depends on whether the person is identified by others as a victim, survivor or perpetrator or identifies themselves as a victim, survivor or a perpetrator, so it would seem that the ethics of violence-based identity, labelling and assessment would be important questions to explore when thinking about creating LGBTQ2S+ IPV services.

For example, if a person identifies as a survivor when accessing services but uses violence at home, are they a survivor who uses violence, or does their identity shift to perpetrator who has been a victim, or to an aggressor? If a person is called a perpetrator/aggressor by their community and we discover that they have been a victim of violence, do we call them a
perpetrator who has been a victim, a perpetrator who has been victimized, or a survivor who uses violence? How would the labelling change based on who is applying the label of perpetrator, whether it is a court, a health care provider, a victim, a community? I notice my first urge was to label the person by their current actions, and meaning and context for violence can be quite obscured when the label applied to the person is based on past behaviour. Therefore, the question arises: when someone is applying for anti-violence services, does the label the person comes into the office wearing reflect the current situation accurately, or is it concealing aspects of the current situation? If the person has both used and experienced violence before arriving to access services, which behaviour has been chosen as that person’s so-called identity, and how then does that affect assessment, access to services, and treatment? How much does this identity reveal and/or conceal about the current situation?

A survivor who uses violence and a perpetrator who has been victimized can both describe someone who experienced violence in the past and is now using violence. Yet these two descriptors hold very different values and assumptions. The phrase “perpetrator who was victimized” identifies the person by their violent actions. The emphasis is put on their violent acts, and those violent acts are internalized as part of the person’s ongoing identity in the present and future, whereas the violence experienced by the “perpetrator who was victimized” was an action that was done to them that is externalized outside of the person, and is not part of their identity. Surviving violence was an act of limited time frame that is now past. The phrase “survivor who uses violence” puts the emphasis on the on the responses and resistance of the survivor as an identity. The act of surviving violence is internalized as part of the person’s ongoing identity in the present and future. The violence the survivor then does afterward is seen
as incidental and externalized, a moment in the present that becomes past events and is not associated directly with the person’s ongoing identity. Furthermore, as Richardson states,

In an Aboriginal context, because of cultural genocide and state violence, we understand that virtually all people with foster care or internment experiences have experienced violence. And, we believe it wasn't their fault, so we keep that in mind. We also draw from the statistics and knowledge that show that at least half the people who experienced violence do not go on to become perpetrators. It depends on the quality of social responses they received when they disclosed violence, as well as other factors, such as values and how other people treat/see them (Richardson, personal communication, 2016).

An embedded assumption in most writings on anti-violence services is that victims, due to their experience of receiving violence, would not wish to visit that experience onto another person. Yet the opposite might be true — that knowing the pain of violence, victims may wish another person to feel what they felt as a distorted justice-doing (Reynolds, 2014). Another assumption is that the phrase “perpetrator who was victimized” describes childhood abuse rather than past relationship abuse. It is then important to fully contextualize how people who both use and experience violence are described by both the person themselves and the service providers interacting with that person. It comes down to the idea that if I was hurt, I am now entitled to hurt others. It seems to me that contesting the idea that "if I was hurt, I am now entitled to hurt others" is important for lowering violence and being aware that how we label this person contains many embedded assumptions that can become problematic. We need to support and validate an aggressor's past victimization experiences while holding them accountable for current behaviour, rather than delving into the motivations or analysis of their mind (Richardson,
personal communication, 2016). I think that we should be cautious about using survivor, victim or perpetrator in uncomplicated or unexamined ways, especially since they do not describe details like who they used violence against — an adult or a child, retaliatory violence against violence they experience — or whether they chose to use violence in a new relationship. What violence and situational contexts are concealed and mitigated by the phrases "survivor who uses violence" and "perpetrator who was victimized"?

It is possible that both of these formulations are in themselves an expression of the four operations of language in response-based ideas — that when applied thoughtlessly, both of these ways of describing people who both experience and use violence can obscure violence and the responsibility for that violence and blame victims. I can see why participants preferred “survivors who use violence” because it is more dignifying and allows the person to access a broader range of trauma services, and it places responses and resistance in the identity position rather than violent acts. I did notice that this formulation contains what could be used as an embedded excuse for violence. Keeping a focus on responsibility and avoiding victimization as an excuse for violent acts is important, a belief strongly held by virtually all the participants.

Furthermore, several participants have pointed out that due to systemic and institutional violence, virtually all LGBTQ2S+ are survivors of violence. In this case, providing services to LGBTQ2S+ communities could involve seeing people as more than the sum of their actions and detaching violent acts from identity. This is not just a matter of semantics; how we identify the person determines the services they do (or don't) receive. Survivors and victims get access to trauma services and are centred in the Islands of Safety process, while aggressors go to batterers' programs (if there are any for LGBTQ2S+) or are part of an accountability and responsibility process in Islands of Safety or other community accountability or restorative justice processes.
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Perhaps, in many situations, there will be a clear aggressor and survivor. Yet if we can build processes that can withstand situations where the lines between aggression and victimization are fuzzier, it seems useful. Many participants agreed that individual acts of violence are unilateral and felt that when pulling out to view interactions in a whole relationship, or over a person’s lifetime, it made more sense to look at cycles of violence, as most people in the community have been victims of violence, and some who have been victims also use violence.

The assumption and what we are taught is that there is only one victim in a relationship. This may be very true in many relationships, and it is not the case in all relationships. There is no zero sum relationship for victim/survivor positions; the idea is to build enough space for all people in that situation to have a space to explore violence and responses to violence. However, there is a zero sum relationship for time and resources. I think making space for everyone’s experiences of violence and not asking anyone to prove their experiences is really important. I think it needs to be stated that violence is not a consequence of some action; violence is the action (Hydén, Gadd, & Wade, 2016). Violence itself is not an identity; violence is an action (Hydén, Gadd, & Wade, 2016). In situations where both people have used violence, we need services that run on safety and respectful, dignifying community accountability, not only services based on identity positions.

Who is Centred in the Islands of Safety Process

Islands of Safety has a definite promise to be a process that could be used in complex situations; the complication is that who or what is centred in the process would need careful analysis. An LGBTQ2S+ Islands of Safety process would not necessarily centre a mother, as a queer family might have many mothers, or only fathers, or people who do not particularly relate to the whole concept of mothers and fathers. This analysis would need to pay careful attention to
gender and the ways identities are formed around violence, as most participants felt that the victim and perpetrator have been misidentified in most violence that occurs in LGBTQ2S+ relationships due to misinterpreting gender dynamics and norms in LGBTQ2S+ groups. Several participants now have discussed how heteronormative views of violence result in institutions (academics, police, health care) mislabelling queer violence as mutual and that power and control is still exhibited, just not necessarily on gender lines but on intersectional and psychological lines.

I am not interested in taking away a claim to identity for people who embrace victim, survivor or perpetrator as an identity. This has been an important piece of healing and accountability. However, I would caution community and service providers against thinking of identity positions as static and based on a set of past actions that then goes unexamined in perpetuity, or as an identity that is then co-opted for an academic argument about mutual violence in the service of blaming victims, hiding violence, pathologizing victims or excusing perpetrator responsibility (Coates & Wade, 2007; Chen, Dulani, & Piepna-Samarasinha, 2011).

Many participants stated that what happened is very important to determine who is the victim and who is the perpetrator, while others felt digging into the details was damaging and focusing on impacts was healing. Many participants felt that an emphasis on what happened and on victim impacts was important to keep the focus on the perpetrator’s accountability for their violence. This brings up an question of the ethics around creating community accountability and safety with aggressors. Is the perpetrator accountable for their actions, for the impacts on the victim, or both? How would these different beliefs change what accountability looks like? If the perpetrator is just responsible for their actions, then would accountability be more about changing their behaviour and attitudes — i.e., lowering violence, consciousness-raising about
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oppression and privilege? If the perpetrator is responsible for the impact on the victim, then would we be getting into restitution, like paying for victim counselling, or reparation for damages (medical bills, moving expenses, costs to change identity)? While this restitution definitely could be just, it could also be used as another tool of control for the victim and a way to get information about the victim, which undermines any safety plan, which is the goal of this process. It seems like focusing on responsibility for impacts is focused on fixing a single event, while focusing on responsibility for actions is focused on current and future safety. What results would be centred in an LGBTQ2S+ Islands of Safety process, especially for relationship groups without children — lowering future violence, making reparations for past actions, or something else entirely? As so many participants brought up accountability for violence, determining who is centred when violence is being used by more than one person in the situation and what goals around safety planning would ground the process would be a key element that would need to be added to an LGBTQ2S+ Islands of Safety process.

Types of Safety

In order to create a safe circle in the Islands of Safety process, facilitators need to be aware of more ways power and control can be used to control someone through their genders and sexualities (Frankland & Brown, 2014; Cook-Daniels, 2015; Kubicek, McNeeley, & Collins, 2015). That means as a first step, we need gender safety and sexuality safety in the model. Most participants put gender and sexuality safety under cultural safety, but a few stated that gender and sexuality safety needed to be spelled out in the Islands of Safety model, which it can definitely be for LGBTQ2S+ communities. I worry that putting it under cultural safety would erase it a bit. If gender and sexuality safety went under the rubric of cultural safety, it would need to be explicitly stated. While an argument could be made that sexual safety covers this area of
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safety, none of the participants linked sexual safety with gender and sexuality safety. I believe this shows that sexual safety centres primarily about being safe from non-consensual and coercive sexual acts, and sexual activity is quite different than sexual identity, orientation and gender.

Cultural Respect and Islands of Safety

I believe one of the key findings for this question was that the two participants from Indigenous and Métis identities stated that they would use the model without making any adaptations to it, while most of the participants from various settler and immigrant cultures would either use part of the Islands of Safety process or would make changes to various parts of the process. This was the only point in the data where there was a notable difference based on ethnicity and culture. It should be noted that other settler/immigrant participants who expressed knowledge about cultural appropriation or self-location and territory acknowledgement also did not support adapting the Métis elements of the Islands of Safety process. This shows that practitioners from non-Indigenous backgrounds who plan to use this process need extra training to understand the cultural contexts in the Islands of Safety process to use the process in a more culturally aware manner. Most participants were able to identify that the blankets and the medicine wheel were inspired by Indigenous worldviews for some nations, but no one identified that the circle process itself, with its emphasis on including extended family and giving everyone time to speak, could also be seen as an Indigenous practice.

This result spoke to the ethics around eclectic ways of practising counselling, social work and nursing. It is assumed that if a model is written about in academic journals, that the ideas are in the public domain, and we can borrow, adapt and combine with other ideas as we wish. This is an ethic I followed myself and did not think about deeply; this study has changed my views
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around these ethics. I believe that the results of this study showed that if practitioners are choosing to be eclectic in the way they combine elements of models and make changes to models, care is taken to not make cultural assumptions. Just as participants strongly felt that the gender, sexuality and membership in LGBTQ2S+ communities should not be assumed, perhaps practitioners need to look at all their assumptions about race, class, ableism and gender before changing aspects of a model.

It is important to note that there is no pan-Indigenous culture and that there are a wide variety of world views, cultural practices, beliefs and customs across different Indigenous language groups and nations. Perhaps an initial step would be to research and confirm that any part of a therapeutic model that will be used on a particular land is aligned with the worldview and practices of the land on which it will be used. For example, in the Islands of Safety process, would the blankets as a representation of the traditional view of family be applicable to the land where a practitioner would like to use the process? As part of this, it would be vital to consult with two-spirit, Métis and Indigenous LGBTQ+ communities on ways to implement the Islands of Safety process in their communities and with Métis and Indigenous two-spirit and LGBTQ+ children, as the number of two-spirit, Métis and Indigenous participants in this study was very small.

This study speaks to the need for more knowledge around colonization and Indigenous worldviews so that if settlers use this model, they know that they are looking at the model through the lens of colonization and have some ideas of what assumptions to track and wrestle. I realized that I had colonial googles on when I looked at the blankets and the views of family that the blankets represent. Like many of the settler participants, I wondered what to do with a model of family with mothers and fathers. As Cathy Cohen stated, queer activists have a tendency to
create a false binary between heterosexual people and queer people, and queer activists sometimes fail to see that “non-normative procreation patterns and family structures of people who are labelled heterosexual have also been used to regulate and exclude them” (Cohen, 1997).

When I researched Indigenous two-spirit identity and views of gender, I discovered that I was looking at the metaphor of the blankets with a colonial gaze. Some of the other participants projected a heteronormative nuclear family onto the traditional view of family portrayed in the Islands of Safety model. This is one portrayal of Indigenous family, and there are many different views of family in Indigenous worldviews. However, the blankets actually represent a much broader view of gender and family: as the blankets show, elders (who are not gendered in the blanket display) care for the children (who are not gendered in the blanket display). Yes, there are mothers and there are fathers in the blankets, but the descriptions are not a singular “mother” and “father” but “mothers” and “fathers”, highlighting a communal aspect to family that is not a nuclear family (Betasmaskie Simpson, 2014). The roles of mothers and fathers in this model are not hierarchical, and work roles can be done by either mothers or fathers (Betasmaskie Simpson, 2014). Some participants interpreted the blankets as representing a hierarchical view of family, because the fathers blanket was larger than the mothers blanket. Some other participants recommended that mothers and fathers be pluralized throughout the model, which led me to realize that there was a difference between the way family was talked about in the model versus the way it was talked about in blanket display. I believe that is due to the other parts of the model speaking about a specific family and the blankets representing families in general, but it does point to a possibility that the part of the model outside of the blankets will look like a heterosexual family to people reading about the process in a journal.
However, there are many ways to be heterosexual in a non-heteronormative way. There are heterosexual trans people in queer and trans communities, and, as Betasamosake Simpson points out, it was colonizers who attempted to re-write more fluid gender and family roles in the Anishinaabeg lands where Betasamosake Simpson is from:

Strong communities are born out of individuals being their best selves. Colonialism recognized this and quickly co-opted Indigenous individuals into colonial gender roles in order to replicate the heteropatriarchy of colonial society. This causes the power and agency of all of genders to shrink, and those that are farthest away from colonial ideals suffered and continue to be targets of harsh colonial violence. People also had agency over their sexual and relationship orientations in Anishinaabeg society and this created diversity outside the heteronormative nuclear family. Anytime you hear or read an anthropologist talk about ‘polygamy’ in Indigenous cultures, read this as a red flag, because you need a severe form of patriarchy for that to play out the way the anthropologists imagined, and in the absence of that, plural marriage or non-monogamy in Indigenous cultures is something far more complex. There wasn’t just agency for adults. Children had a lot of agency (Betasamosake Simpson, 2014).

As a European settler, it is not appropriate for me to try to explain and define Indigenous and Métis views and politics around sexuality and gender, and to do so would to be beyond the scope of this paper. There are two-spirit, Métis and Indigenous LGBTQ+ activists already doing excellent work in that area. For now, I would like to invite both mental health practitioners and activists to be open to the possibility that family and relationship contexts in the Islands of Safety
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The model can be more complex than they appear, especially when looking at cross-cultural contexts, and to work in consensual and respectful relationship with local Métis and Indigenous communities. I would hope, rather, that all communities across race, class, gender, abilities and age can start to find ways to work together for justice and safety. Many ways of being in Indigenous and Métis families have been outlawed. Many ways of being family in queer and trans communities have been outlawed in Canada, and are still outlawed in several parts of the U.S. What ways can settler/immigrant LGBTQ+ communities and Indigenous and Métis work together to lower colonial gender violence? It is possible that models like Islands of Safety could be a way to open up conversations about gender violence across cultures and across genders and sexualities.

Several participants had strong negative reactions to the perceived heterosexuality in the model and felt that the views of family would not apply to them and that it was cultural violence to apply them to LGBTQ2S+ people. Others stated that it was important not to erase or alter the Indigenous aspects of the model to appeal to settlers. And that is very true. It would be an act of colonialism to change an Indigenous view of families to fit settler families. People cannot rewrite another culture’s tradition; it is what it is and needs to be respected as such. It would also be an act of cultural appropriation to map settler families onto the blankets. This speaks to the need to do something when using this model with settler families to contextualize this aspect of the Islands of Safety process to ensure that there is not cultural violence against Indigenous people and against LGBTQ+ people.

When working with the blankets that represent traditional Indigenous family in the Islands of Safety process, they do need to be properly contextualized for the views of family for the lands on which the process will be used. It may be that seeing a view of family that has not
been colonized, that is not a nuclear family and embraces a wider view of gender and sexuality and that is not the North American version of LGBTQ+ culture could be healing for both Indigenous and non-Indigenous LGBTQ+ families. Some participants suggested it could open conversations about parenting LGBTQ2S+ children in culturally safer ways, as well as the intergenerational effects of homophobia and transphobia as they operate in the family. If the blankets are presented as some original ways of forming family on the land, with an invitation for the family to make a different representation of how their family is structured, that could be a way to bridge views of traditional Indigenous families and non-traditional LGBTQ+ families, with the two sets of displays sitting side by side. Most queer and trans families would not look like the blankets display as represented in the Islands of Safety process, so an awareness of the many ways of creating family while respecting Indigenous families within the Islands of Safety process would be important for any use of the process in LGBTQ2S+ communities. Using the blankets as part of the process also opens the conversation for LGBTQ+ and two-spirit people in Indigenous communities who have experienced homophobia and/or transphobia in their home communities and have left for cities to speak to their relationship to culture and tradition. It would be key that if an Indigenous person is not on their lands, the views expressed in the model align with that person’s background (Lerat & Gray, 2004; Laframboise & Anhorn, 2008; Two spirit people, 2011).

**The Potential of the Islands of Safety Process**

Most participants felt very positive about the Islands of Safety process and about response-based approaches. The participants felt that the questions and the structure of the process matched best practices for working with LGBTQ2S+ people: the majority of the questions were gender-neutral, dignifying and explored areas of oppression and social context
that participants felt many practitioners ignore. The challenge was in how to respect both Indigenous and non-Indigenous family structures and to work with an awareness that gender dynamics of violence in LGBTQ2S+ communities will not fall into a female victim/male perpetrator binary. This requires some re-conceptualizing and being careful when writing about gender and the assumption that the parent who is the victim will be the sole mother. However, I believe that overall, response-based approaches are compatible to use with awareness of non-binary gender and more complex notions of sexualities and family structures. Most of the suggestions about adding questions about pronouns and not assuming gender and sexuality could be easily incorporated into this model and would help create safety for cisgender, heterosexual people to articulate their gender and sexuality, as quite often people have wider experiences of gender and sexuality than it is usually safe to talk about with a therapist, social worker or healthcare worker. This means that worker gets a clearer picture of the people they are working with.

**Benefits and Risks**

**Benefits.** This study has been one of the few to look at a safety-planning tool for LGBTQ2S+ people that includes safety of parents and child and occurs in community, rather than focusing on a single victim and their actions. This study will hopefully benefit response-based practitioners who work with LGBTQ2S+ communities, as this study will provide guidance on how to move response-based practice out of the formulation that the victim/survivor is female and the perpetrator is male and could provide culturally safer services for LGBTQ2S+ communities.

**Risks.** The risks are that this study would not generate actionable guidelines, or that this study would turn into yet another set of practitioner guidelines that already exists and is ignored. I attempted to mitigate the risk of participants experiencing or re-experiencing trauma by
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choosing participants who are LGBTQ2S+ and are working in the anti-violence field, but there is some risk that by talking about IPV, participants would experience emotional difficulty. Providing information on LGB and transgender crisis lines and a list of LGBTQ friendly counsellors was a way to mitigate this risk. A risk is that in-group or within-group cultural differences would influence the results by suppressing some opinions and over-emphasizing other opinions. There was also a risk that choosing practitioners as participants meant that they will work to defend their own ideas or schools of practice and response-based concepts would be rejected or debated in a way that does not generate useful results.

Limitations

By not working with victims/survivors directly, this study did not generate an accurate picture of what LGBTQ2S+ clients want for IPV and anti-violence services. I did not speak to survivors of violence about how they would like to be treated in this study. I did this for several reasons: I believed that if I was to speak to survivors, bringing a model to them to approve of would mean that I would need to “teach” them the model, and at that point I would enact power-over the participants. If I presented a model to survivors, I could potentially change their responses to fit this pre-existing model. Furthermore, to do the research properly would have been out of scope, due to the amount of data that would need to be collected for valid results.

It has not been possible to generate generalizability, so I am hoping for transferability. There may be differences in practitioner job levels, something that is considered a limitation in focus group methodology because it can influence results and create a lack of safety for participants (Krueger & Casey, 2015). While no two people worked at the same job location, and participants could not identify each other, I did not separate participants with different job levels, because then I could identify them. This study did not and could not measure the effectiveness of
the model with gender and sexual minorities, and thus cannot be used as outcome research. This study did not actually create a workable model of a queered response-based practice.

While not all the participants were European settlers, the ethics of inclusivity versus centring meant that I needed to step back and not broadcast my recruitment message in places that centred the voices of people of colour and Indigenous people unless I was given permission. While there were some places that did give me permission, there were other research recruitment calls posted from researchers who were people of colour. Therefore, I did not post there to make sure those researchers were centred. I did manage to centre the voices of the LGBTQ+ communities, but my research followed the politics of inclusivity rather than centring the voices of people of colour or two-spirit identities. Research that centres research by and the voices of Métis and Indigenous LGBTQ+, two-spirit, and queer and trans people of colour is needed, especially in the areas of violence research, as people of colour experience violence at a much higher rate, as we live in a racist, homophobic and transphobic society.

Research should follow a “not without us” policy, and ideally should have been done with a team of queer Indigenous and non-indigenous people, led by queer Indigenous people, as the model was created as a group effort between indigenous and non-indigenous people (Smith L. T., 2012). Due to the constraints of time, lack of funding and the problematic nature of being a European settler and spearheading the research, since it is for my master’s thesis, I was not able to accomplish this within the deadlines set. I hoped that consulting with Richardson and Henry would be a way to start building these bridges, and it is something I plan to continue doing. This study points to the need for settlers to step back and support Indigenous-led research and to confirm that the research is not being done by Indigenous peoples before proceeding. More
research on using this model with two-spirit and Indigenous LGBTQ+ people is needed to confirm if this model could be used in these communities.

This study examined how LGBTQ2S+ health workers think LGBTQ2S+ clients in their care should be treated, and thus says more about in-group beliefs about healing with one’s community. This opens up the possibility for research into the difference between the perceptions of needs as identified by LGBTQ2S+ health workers and the stated needs of LGBTQ2S+ survivors of violence. While this research could potentially generate recommendations on adapting the Islands of Safety model, a larger study on survivor’s beliefs about best care practices and their beliefs about violence in LGBTQ2S+ communities is needed. Lastly, some of the drop in responses could be due to technical difficulties or a lack of support for using the Islands of Safety process with LGBTQ2S+ communities, and I was unable to determine the reasons that not all participants did not complete the study.

CONCLUSION

Being a queer, pansexual counsellor sometimes feels like swimming through a sea of counselling modalities set up in a heteronormative, colonial framework while trying to find islands of affirmative practice (Everett, MacFarlane, Reynolds, & Anderson, 2013; Jacques, 2015). I believe that in order to adequately serve LGBTQ2S+ community members who experience and use violence, we need to not only work with clients on an individual counselling basis, but we also need to advocate for community services (Jacques, 2015). In order to respectfully and effectively work with LGBTQ2S+ communities in B.C., we need to hear recommendations from the community on how to use therapeutic tools with that community before working in the area of violence prevention in LGBTQ2S+ communities. This research showed that much more work and dialogue between LGBTQ+, setter and immigrant
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communities, Métis and Indigenous communities needs to occur to begin to unravel colonialism, homophobia and transphobia in anti-violence services and in our communities. More conversations and actions need to happen in queer and trans communities around how the critique of heteronormativity sometimes happens within a colonial worldview. How do we critique the critique of heteronormativity in a way that creates purposeful, culturally respectful actions in the world? Hopefully, by soliciting a range of opinions from a wide range of communities, we can begin to think about a response-based practice that can conceptualize gendered responses to violence in ways that reflect the complexity of all the genders that exist on these lands.
Cathy Richardson Responds

Dear Sonder,

Thank you for taking on this study and exploring applications of “Islands of Safety” in your Masters work. It was my hope that we could create safe social spaces (e.g. Islands of Safety) similar to those described in Imelda McCarthy/Nolag Byrne’s “Fifth Province” (McCarthy & Byrne, 2007) or André Gregory in “My Dinner with André.” There, they talked about sacred spaces in which people could come together to talk about anything, have “risky” conversations, in a climate of respect and equality. It was a space free of judgement. Of course, that seldom happens in child protection settings because there the state is actually all about making judgements and assessments of one’s parenting. Nonetheless, this was part of the vision for child protection work in cases of violence, where the truth needs to be articulated for the safety of children and those who are being harmed (e.g. mothers).

In this interesting and courageous study, you have helped broaden the ways that I can conceptualize and articulate the unilateral nature of violence. It’s interesting to me how people can be blamed not only for the violence for the context, as if they created it themselves.

The fact that some of the folks in your study saw violence as mutual, rather than mutualized, makes me wonder again about the presence of self-blame in our society, often as a pre-emptive tactic to spare ourselves the blame of others. It is true that people participate in mutual aggression at times, but most typically we have seen violence and then resistance to it. Sometimes this resistance takes the form of self-defence. And, this can differ across situations and contexts, with the same parties involved. Our main point is that we need to assess each situation uniquely to decide who is doing what to whom and how the other is
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resisting/responding. Only then can we develop an analysis and intervention plan. One thing Shelly Bonnah explained to me about getting at the unilateral nature of violence was this... I ask “would the second or subsequent act of violence not have taken place without the first one?” (I’d love to hear more about how you analyse and contextualize these statements, as researcher). In our research over the past decade, it seems clear that self-blame is understandable because there is so much social blame in the air. People often adopt common and popular self-pathologizing constructs because they are like “common currency” or they do it tactically knowing if they blame themselves a bit first, others will be more likely to hold back blame and offer support. It seems that “others” are really keen about us taking responsibility for our own actions, probably again because of the prevalence of new age discourse that we create our own realities independent of context or the situation we are facing.

In terms of applying “Islands of Safety” beyond the urban Métis and First Nations community, I believe the process has something to offer but I have never adapted it. Therefore, I am glad that you have taken on this project. I do think these types of collaborative processes work better with groups who are used to holding group meetings to solve problems... such as anarchists, social activists, feminists and Indigenous peoples. Cultural groups who have a more collective orientation tend to be more comfortable than say middle-class white families who live in nuclear families with a view to privacy and upholding their reputation.

This process was aligned with traditional Métis teachings in mind, in order to restore to families, at least symbolically, what was taken away through colonial and state violence. There may need to be a LGBTQ advisory that meets to explore and discuss the shared values of this community. This can come out of a focus-group type exploration of the experience faced by this
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group and the social responses to their parenting. Is there a community that shares support and resources with each other or are LGBTQ parents relatively isolated in society?

The traditional Métis teachings tended to reflect a heteronormative kind of family life based on what we learned (from elders) about roles of individuals in families. In this sense, LGBTQ- Two Spirit people may be a part of these families but their experience would likely be marginalized and problematized in this culture, particularly by those who were involved with the mainstream religions of the day.

In my facilitation process, I try to use the terminology and conceptualizations that are presented by a particular family. I believe that I would work with a same-sex/gender fluid couple\(^1\) because I would be guided by them around how to address the parties. As a heterosexual woman, I would remain in a “learning position” and would probably stumble through in a clumsy way, at least some of the time. This may or may not make participants uncomfortable based on other contextual factors at the time that may influence their willingness to have patience with me in the face of other forms of ongoing oppression.

In terms of heteronormativity around men being the perpetrator... this has been the case most of the time. However, there are lots of instances where the woman/mother is the perpetrator, both towards the men and towards the children, but the stats indicate that the man is the perpetrator approximately 85% of the time. We don’t just assume it’s the man, but we do ask. When working with a family where there are two women, I would probably ask them about their roles in the family while coming in with the view that they are “two moms”. I understand that the typical “failure to protect” and mother-blaming analysis would require new analysis in this situation. We aren’t looking to treat one of the moms as a “father” but to understand the

\[^1\text{Here I am also thinking of a couple where one partner has gone through a sex change/gender reassignment, so they may now present as a hetero couple although they do not fit neatly into a gender binary.}\]
larger context of homophobia, and violence towards LGBTQ individuals/parents. We understand that these parents may experience prejudice every day of their lives. In that case, I might tell them directly that I do not want to reproduce dominance or social violence and ask them about how I can avoid doing that? I often ask the therapeutic question, “if I were to do a really bad job here today, what would I do/not do?” People tend to like that question and answer in detail.

If I were going to be working with LGBTQ families, I would hold consultations first to 1) see if they saw me as a fit ally to do this work, given that I know little and would be in an ongoing “learner” role, which could be taxing for them and, 2) to take their recommendations on what would need to be changed... what could be conceptualized (what metaphors and references used, for example) in a LGBTQ human-rights oriented context. I know that there are different roles in a couple and I would imagine it would be unique for each couple and, like you say, just because someone is more masculine-presenting or feminine-presenting (in relation to as heterosexist norms), doesn’t mean one is more likely than the other to use violence. Another thing I am noticing in feminist discussions on the internet is that there is a lot of Trans-bashing, a refusal to receive M to F in the ‘women’s community’ as if they are imposters or don’t count because they have only presented themselves as a woman for a shorter time than cys-gendered people. It is sometimes presented as a ‘safety issue’ in relation to women-only spaces, such as bathrooms or shelters. My view is that people who have done gender transition are not more likely to use violence against women than any other person. There are a lot of gender claims being made that overtly exclude Trans individuals who they think have only recently become “women” and therefore are not entitled to the rights of womanhood. It seems narrow and threatening.
In terms of the conversation about intersectionality. I don’t take strong positions on whether this analysis is sound or not, but I do think that earlier structural social work (from a marxist, rights perspective) did already talk a lot about important things but in a context of patriarchy. This meant that theories were often taken up in sexist, racist, homophobic ways at the time. Intersectionality seems like a form of theoretical analysis with less focus on action. What I see limiting about “category politics” is this. As an Aboriginal woman with a disability, I could be seen as being in a few deficit categories there. One would assume that I would be treated badly, if one applied an intersectional analysis. However, when I went out into the world, I met with discrimination and obstacles about 50% of the time. The other 50% of the time I was met with kindness, helpful people and over-the-top good care. In this situation, I don’t mind being treated well, even better than others, and so this kind of thing is not really explainable for me by intersectionality. I also liked your conclusions about these types of analyses.

best wishes,

Cathy

*Allan Wade Responds*

Dear Sonder,

Thank you for an informative and beautifully written thesis!

The crystal quality of your writing is especially important for this thesis/topic because you are able to explain some complex ideas and terminology that is unfamiliar to many readers. The writing is plain, direct, orderly and personal. By the end of the first paragraph, I know the community you are writing for, what you are writing about, and how you want to locate yourself. You then go immediately into de-reifying binaries and category terms. This was an excellent
way to begin. More than a “Definition of Terms”, you define an ethical position for the thesis as a social justice project.

I am much older (than you), cisgendered, male, heterosexual, over educated, under-smart, European-descended, father-grandfather and director of the program you are now graduated from… and as such I feel the urge to link what I am learning from your thesis with what I learned from some other important teachers. So, with apologies, I have connected your discussion of category terms and binaries to some early and, I fear, forgotten influences in the family therapy and brief therapy fields. In saying this, I hope to put your work in good company, not to reduce it to something else.

The Milan family therapy team wrote a book called “Paradox and Counter Paradox”, first published in English in 1978. The two men in the team, Luigi Boscolo and Gianfranco Cecchin, did not much like to talk about violence, power, gender and related matters. They tended to agree with Bateson, who argued that “power” was more or less illusory and just another way of “punctuating” interactions. Bateson was wrong, I think, and the Milan men were wrong: It would be nicer to say they were just typical for their time but it’s also okay to say they were wrong.

And for this they were rightly help up to fierce criticism. The feminist critique of family therapy – which was initially a kind of white, liberal, upper middle class analysis – developed in response to the denial among professionals of the violence by men against women and children. It was not an intersectional analysis of the kind you present in your thesis, far from it, but it was and remains important. Your own work in this thesis, and that of the many writers you cite, criticizes and vastly extends this early work.
I agree that there is no theory yet that adequately operationalizes violence, as you say. I would add that this is so, in part, because there is no theory yet that adequately operationalizes responses (and resistance) to violence.

At the same time, the entire Milan team was quite radical in its way and profoundly influenced by two important texts. The first and best known was “Pragmatics of Human Communication”, which foregrounded social interaction. In keeping with Goffman and others, they argued that “social interaction” is its own best explanation, so to speak. Taken seriously, this means that the quality of social interactions in social and material contexts is crucial to understanding human suffering. Today, when we are told that everything is “socially constructed”, this is a deceptively radical position, one that leads directly into the analysis of social injustice and the lived realities of those with whom we work.

The second text was “The War With Words”, by the U.S. Psychiatrist Harley Shands. This is a forgotten classic, I believe. In “Paradox and Counter Paradox”, the Milan team included a chapter called “The Tyranny of Linguistic Conditioning”, in which, drawing on Shands, they showed how the verb “to be” is so often used in mental health circles to construct an identity out of an experience. When a person says, “I am depressed”, they fuse their identity with an experience. “I am” can work as an identity term. The same is true when a therapist says, “he is depressed”: Now, thanks to the verb “to be” (“is”), the identity of the person is fused with the state “depressed” and, by extension possibly, with the category, “depression”.

Talk about people often reduces to talk about categories. Any time you use the verb “to be” (e.g., they are, he is, I am) combined with a category term (e.g., white, lesbian, black, straight, settler, two-spirited, perpetrator, activist, depressed, victim, bi-polar, cool, creative, fat, tall), you produce an identity. Some categories suggest nothing about the essence or character or
actions of a person (e.g., they are green, they are tall). A wall can be green and tall. So can a person, but that tells us little about what kind of a person they are (i.e., the verb to be).

Categories deny the complexities of social life: They say too little about people, not too much. The Milan team offered a kind of antidote and positive alternative to the production of deficit identities and categories. If a person said, “I’m so depressed”, for example, they would ask, “Who notices?” and “How do they notice?” and “When they notice, what do they do?” In this way they would shift the focus from identity and category terms, which are particular kinds of abstractions, to social interactions in context (i.e., social realities). The observation that people resist violence stems from this kind of focus on the fine details of social interaction: We refer to this as “contextualizing”.

I believe this is consistent with the emphasis you place on getting beneath categories to ask people how they self-identify, what particular terms mean to them, and how they relate to the social realities in which they live. Your literature review is rich with examples of this. And, for me, this is a real contribution.

Too often these days “intersectional analysis” becomes “category politics” – the practice of attributing certain qualities to a person because of the category(ies) they “are in”, are “put in”, or “identify with”. For me, your thesis exemplifies a much more affirmative (your word) and nuanced analysis that always brings us back to the local and particular in relation to the structural and large scale. You point out problems with binaries and category terms, caution the reader to avoid certain assumptions, and clarify which terms can be used for which purposes and in relation to which people – at least for now.

To use old jargon, you bring the macro and micro into close relation without dimming either. None of the prevailing models in the social sciences or mental health field adequately
examine how “the macro” meets “the micro”, how the large scale and structural come to bear on the lives of individuals and communities. In sociology and much social justice work, the macro is seen to cause the micro: The individual is thus a social product – an effect. In psychology, the micro is seen to cause the macro: The large scale and structural is just the sum and effect of individual actions. Neither approach grasps the precise and nuanced manner in which a person responds to hateful acts.

In “Islands of Safety”, Cathy and I were more concerned with how colonial assumptions and discourses, which are written into the genetic code of the helping professions, are used to violate and oppress Aboriginal people, and how Aboriginal people respond to such practices/actions. Your analysis significantly challenges and extends our work and provides a sorely needed dimension. And, honestly, we could not have included your analysis even if we had consulted our colleagues who identify as LGBTQ2S+.

You also take the next step to ask people who identify as LGBTQ2S+ to evaluate the model produced by two professionals and to suggest revisions. For this, I can only say “Thank you”. This practice inverts the usual power dynamic, in which the professional gets to name (identify, categorize) the client. It also creates space for critical analysis of work produced by people in positions of relative power in this arena (Cathy and Allan) and, within the context of your study, for participants to self-identify and mess with (problematic, re-invent) the categories and binaries. There are too few safe spaces for people who identify as LGBTQ2S+ to engage in such critical analysis.

The “Islands of Safety” work was for me a kind of love affair. Or better, maybe, it was like being invited into a space you always wanted to be invited into… and welcomed. Cathy Richardson did the creative work and heavy lifting: She conceived of the project, obtained the
funding, made the key connections, directed the development of the practice model, consulted key Métis advisors, and so on. I brought along the ideas we now call “response-based practice”, developed with Linda Coates and Nick Todd. Cheryle Henry, our friend and close colleague, and President of the Orcas Society, joined along the way, bringing her cultural and spiritual awareness into the practice. It was balanced and provided us with a means to work for families who were under investigation by the state and whose children had been apprehended.

It was also a moment in time and place, one iteration of “response-based practice”. Since then, we have further developed many of the core practices and ideas through a series of collaborations in practice and research. It is a real privilege to read your research and analysis. The literature review and discussion of violence in relation to people who identify as LGBTQ2S+ is very helpful by itself. The comments of the participants in your study are immensely valuable. They have pointed out the need for broader and more inclusive analysis in the model and to how we – the larger “we” – can better work for and with people who identify as LGBTQ2S+.

Thank you for giving us the opportunity to respond to – and affirm – your work.

Cheryle Henry Responds

Dear Sonder,

Thank you for giving me the opportunity to read your beautiful thesis, “Adapting the Islands of Safety Model to LGBTQ2S+ Communities.” It has taught me a lot about the challenges that LGBTQ2S+ communities face in general and specifically in relation to seeking assistance and support in relation to IPV in their lives. I have really enjoyed reading your paper and I think you have done a very thorough, human centered job. I say human centered because I believe as you do that as humans we do not fit into neatly, constructed categories and in dealing
with violence in any community it is important to always listen for the under-stories (the “details”, in response based language) versus our own assumptions. Islands of Safety worked to provide a safe space to do that.

I am a wholistic counselor/community support counsellor in private practice. I have a BA in Child and Youth Care. I am in my 50’s, an Indigenous mixed blood woman, cisgendered, heterosexual, mother, grandmother, community volunteer. I have been walking beside people in need of support and counsel for 30 years. I worked for Islands of Safety as a co-therapist in the pilot project phase. It has always been and continues to be an honor to be invited into people’s lives to assist in the sacred work of holding space for new possibilities and healing. Ultimately, this is what I believe we do as human service professionals.

This was the foundation that the Islands of Safety model practices were developed on.

If I use weaving as a metaphor for this practice the warp would be the Medicine Wheel from Indigenous teachings and the Fifth Province Approach as talked about by Nolaig Bryne and Imelda McCarthy in “Marginal Illuminations: A Fifth Province Approach to Intracultural Issues in an Irish Context” 1998, while Response Based Practice would be the weft. The warp being where the tension is held, and the weft being the threads that are woven in, in this case through questioning and conversations at the edges of safety and risk.

In your paper I see that you have been doing this as well by exploring how the IOS model could be used and adapted for developing a safety model for LGBTQ2S+ communities in relation to IPV. This is delicate and important work that you have brought forward and not unlike the first round of enquiry in the IOS practice. The IOS questioning was curious and open yet structured and intentioned, with an ear to “listening people into speech” (Parker J.Palmer,
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“The Courage to Teach” 1998), an important piece of this process especially with marginalized communities that can experience multiple levels of violence, seen and unseen.

The relationships we invited people into in the IOS centered the people we worked with as the leaders by the questions that were asked and the way we “listened” and responded to their stories of strengths, history, loss, suffering, concerns and how we treated them in these sacred, tender spaces of vulnerability. Of course the victim/s of violence were the first priority, then the offender was given their space to tell their story, then social workers and then other connected community others. In your paper it is clear that you are listening to the LGBTQ2S+ community/culture as a whole; victims, offenders, families, friends, service providers while also recognizing the cultural significance of the IOS model and the mainstream services and resources. There are a lot of voices to hold even in this first step and yet you have done this with rigour, grace and compassion.

Compassion that is born of recognizing the risks…while still being able to be open to otherness even though we do not know where it will take us, knowing also that it will be uncomfortable and probably disturbing at times but is where we need to go in order to see something different, in hopes of doing something different, is what is being asked of all people involved in the IOS process, your thesis’s invitation, and our overlapping communities and cultures. Victims, offenders, professionals, families, regardless of culture all have an opportunity to see where their safety knowledges live and where their risks are. In the best outcome it can allow victims the acknowledgement and safety they need and offenders the space they need to name and accept their accountability, which in turn makes space for a possible, living safety plan that doesn’t have to blow the family/community apart. Of course the professionals need to be as open as everyone else to being questioned and challenged at the borders in order for this to grow
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into a livable resolution. Quite often this can be harder for the professionals than the people we work with. It is still a good starting point.

Your thesis speaks of places to begin...by questioning at the borders with the hope of somehow opening them even just a bit to risk experiencing some new possibilities in how to work with one another collaboratively and compassionately, recognizing we are all in the circle together whether participating or not. The Islands of Safety model and project to me was a sort of Avalon in the sense that it carried so much dignity and possibility for freedom from a very, challenged service system not only for victims and offenders and their families but also for the professionals involved. We had a wonder team who were open to taking risks and working through the tough stuff together, the families, Cathy, Allan and I and some social workers. The idea that the IOS model may be of service to the LGBTQ2S+ is exciting. It was meant to be an adaptable model. Thank-you Sonder for being bold enough and courageous enough to step onto the edges in service to dignity, safety and a sacred space for the many voices involved in interpersonal violence in the LGBTQ2S+ community and for stretching my ideas and hopes for what is possible also.

All the best,

Cheryle
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