Mental health and domestic violence in LGB+ persons during lockdown measures in Belgium

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TVGEND 24 (2): 143–160
DOI: 10.5117/TVGN2021.2.005.DESC

Abstract

Background: To contain the COVID-19 pandemic, governments worldwide restricted social and physical contact by issuing lockdown and social-distancing measures. Yet, lockdown measures may induce mental health problems and increase the occurrence of domestic violence (DV). We examine mental health and DV in lesbian, gay, bisexual, pansexual, and asexual (LGB+) persons under lockdown. *Methods:* An online self-report questionnaire on relationships, stress, and aggression was administered to a non-probabilistic sample of participants living in Belgium. Participants were sampled through national media, social media, and snowballing procedures. Occurrence of DV including psychological, physical, and sexual violence, stress, alcohol and drug use, suicidal ideation, suicide attempt, self-harming behaviour, and help-seeking behaviour in LGB+ persons during the first four to six weeks of the hygiene and lockdown measures in Belgium were assessed. *Results:* 383 LGB+ participants were included in the analysis. In addition to high levels of stress, alcohol and drug abuse, suicidal ideation, and self-harming behaviour, a third of LGB+ participants reported at least one incident of DV under lockdown. *Conclusion:* LGB+ persons have been exposed to DV and experienced lower mental health and well-being during the lockdown related to the COVID-19 pandemic. These findings highlight the possible need for public health measures and sociocultural changes preventing DV and improving mental health during lockdown in LGB+ persons.

Keywords: sexual and gender minorities, intimate partner violence, gender-based violence, quarantine, Covid-19

In March 2020, governments worldwide restricted social and physical contact by issuing lockdown and social-distancing measures to contain the COVID-19 pandemic. In Belgium, restrictions were gradually introduced, resulting in a first lockdown from public life issued from 18 March 2020, which had to be extended with a progressive exit strategy starting on 4 May 2020. The far-reaching measures entailed that public life was severely curtailed, including a ban on gatherings and the strict governmental advice to stay at home. Leaving the house was only allowed when deemed an essential activity (e.g. going to a supermarket, the pharmacy, or a doctor). Although these measures were installed to protect physical health in times of the pandemic, other threats to public health arose.

Periods of isolation are often characterised with increased levels of stress and feelings of helplessness, which negatively impact mental health. Quarantine measures can lead to post-traumatic stress disorder (PTSD), emotion regulation problems, increased levels of stress, depressive symptoms (Brooks et al., 2020), and maladaptive coping behaviours (Gillespie, Jones, Uzieblo, Garofalo, & Robinson, 2021). In turn, these mental health issues are strongly associated with the occurrence of domestic violence (DV) and this is a vulnerability as well as a consequence of DV victimisation and perpetration (Clemens et al., 2019; Filipas & Ullman, 2006; Straus & Douglas, 2019; Van Parys, 2016).

DV describes all acts causing physical, psychological, sexual, or socioeconomic suffering to another – within the family or a domestic unit (UNHCR, 2003). This is irrespective of biological or legal family ties; the assailant(s) and victim(s) may share or have shared the same residence. This also implies that the violence can occur between both current and former (intimate) partners (Council of Europe, 2011). DV does not only entail intimate partner violence but also includes child, sibling, and elder abuse (Vogel & Uzieblo, 2020). It is a major public health issue that causes a multitude of – both short-term and long-term – physical, psychological, sexual, social and, economic consequences that contribute to intergenerational transmission of violence that may even give rise to further violence (Gartland, Giallo, Woolhouse, Mensah, & Brown, 2019; McCloskey, 2017; Siegel, 2013; World Health Organization, 2013). Direct exposure (personal victimisation) and indirect exposure (witnessing or hearing violence) are often interrelated and are associated with similar negative outcomes (Antle et al., 2020; McCloskey, 2017; Siegel, 2013; World Health Organization, 2013).

Having to stay at home due to the COVID-19 pandemic may have created situations that catalyse the occurrence of DV. The combination of stress-inducing factors related to the quarantine measures and having to live

together with an assailant of violence without any options to escape may worsen already existing violent dynamics or create new violent dynamics within the family or domestic unit (Hsu & Henke, 2020; Hussein, 2020). In addition, the restrictions may cause victims to experience additional help-seeking barriers. This may cause a further increase of the violence as tension heightens and more opportunities for violence emerge (Hsu & Henke, 2020; Keygnaert et al., 2020).

At a global level, DV cases seem to have increased dramatically as a consequence of the lockdown and social-distancing measures (Hsu & Henke, 2020). In Belgium, one in four reported exposure to at least one type of DV during the first four weeks of the lockdown measure. One in five reported direct exposure and one in six indicated indirect exposure in this period (Keygnaert et al., 2020; Vandeviver et al., 2020). Although comparing studies on DV prior to COVID-19 and during the lockdown measures is challenging, the observed data suggests that these numbers could be higher than the observed yearly exposure of one in eight Belgian households in a study from 2010 (Pieters, Italiano, Offermans, & Hellemans, 2010). Further, as striking as the worldwide observations are, we should be cautious when linking these to the instalment of the lockdown measures alone as other factors could possibly have played a role here (Piquero et al., 2020).

There are reasons to believe that lockdown measures may have impacted vulnerable groups such as sexual minorities even more. However, it is remarkable how little media, political, and scientific attention is given to the possible increased vulnerability of DV in these groups. The problem lies in the ruling heteronormative approaches of DV, which depict DV as male assailants victimising women and children, aligning with particular feminist perspectives that consider DV to serve as a means for men to control women and children in patriarchal structures (Donovan & Barnes, 2019; Vogel & Uzieblo, 2020). As a result, DV – and specifically intimate partner violence – in sexual minorities and in non-heterosexual households is often forgotten or even taboo. Overall, studies on DV victimisation in sexual minorities are scarce compared to the number of studies on violence against women. However, several literature reviews show that sexual minorities, such as lesbian, gay, bisexual, pansexual, asexual, and other non-heterosexual identifying individuals (LGB+), report comparable or even higher numbers of domestic and intimate partner violence (Badenes-Ribera, Frias-Navarro, Bonilla-Campos, Pons-Salvador, & Monterde-i-Bort, 2015; Callan, Corbally, & McElvaney, 2020; Donovan & Barnes, 2019; Edwards, Sylaska, & Neal, 2015; Finneran & Stephenson, 2013; Hellemans, Loeys, Buysse, Dewaele, & De Smet, 2015; Longobardi & Badenes-Ribera, 2017).

LGB+ rights movement organisations (Cavaria, 2020; ILGA Europa, 2020) and scholars (Phillips II et al., 2020) emphasise the importance of addressing the impact of the COVID-19 pandemic on sexual minorities. As demonstrated by the minority stress model (Meyer, 2003), interacting sociocultural factors, including different manifestations of stigma, prejudice, and discrimination related to one's sexual or gender identity, create inequalities in terms of health and well-being. Though LGB+ relationships and families are, on many dimensions, similar to heterosexual relationships and they display resilience (Green, 2012; Lyons, 2015), sexual minorities not only report poorer mental and physical health in general, but they are also less likely to seek help to avoid stigma and discrimination (Ching, Lee, Chen, So, & Williams, 2018). In addition, specific minority stressors, such as the lack of social support (Meyer, 2003; Song et al., 2020), may be exacerbated by the instalment of the lockdown measures to prevent the further spread of the COVID-19 virus and may in turn affect their coping with stress and mental well-being. Social distancing can be particularly difficult for those who have not come out (yet) to their families, who have been rejected by their families, and who may face homo-, bi-, or transphobia (ILGA Europa, 2020). Not surprisingly, reports of sexual minorities struggling with mental health issues have increased since the beginning of the pandemic (Cavaria, 2020).

With this paper, we want to contribute to the knowledge about the occurrence of DV – including psychological, physical, and sexual violence – in LGB+ persons in a convenience sample under lockdown measures in Belgium. Secondly, we will look into mental health and well-being reported by LGB+ persons during this period. We will focus on stress, alcohol and drug use, self-harming behaviour, suicidal ideation, and suicide attempt since these factors have been identified in previous studies as both vulnerabilities and consequences of DV. As explorative analyses, we will compare the frequency of direct and indirect violence during lockdown and the frequency of different types of direct violence in this period and we will compare victims with non-victims of DV concerning mental health outcomes. Lastly, we will discuss help-seeking behaviour after DV exposure in LGB+ persons during the first four to six weeks of the lockdown measures in Belgium.

Methods

This study is part of a longitudinal cohort study to map victimisation during the COVID-19 pandemic. In this contribution, we present the findings of the first wave of the data collection that took place between 13 and 27

April 2020. The study was approved by the Committee for Medical Ethics of UZ Gent and Ghent University (project BC-07600, approval date 9 April 2020). It was designed and carried out according to the WHO ethical guidelines on research into violence (World Health Organization, 2016).

Procedure

An online self-report survey on relationships, stress, and aggression was administered to a convenience sample of Belgian residents who were 16 years or older at the time of participation. Participants were recruited through a variety of channels and methods, including press, social media, senior citizens' organisations, psychological emergency services, and snowball sampling via personal and professional networks. The survey was available in Dutch, French, German, and English.

Prior to the start of the survey, participants were informed about the aims of the study, possible negative consequences of participation (e.g. triggering recollections of violent experiences), their rights, and the method of data processing. Via an online link on the introduction page of the online survey, participants also received an information letter containing additional information about the nature of the study and a list of contact details of emergency services. Participation was anonymous. Only after participants gave their informed consent, they gained access to the survey. The online survey included the following sections: sociodemographic information, family and relationships, stress and well-being, victimisation, and help-seeking behaviour. Participants who agreed to be contacted monthly to participate in the following waves of data collection were asked to answer additional questions at the end of the questionnaire to generate a self-generated identification code. Participants who wished to be eligible for obtaining a coupon of € 25 were asked to complete a tiebreaker question and share their contact details at the end of the survey to receive the coupon. The contact details were stored separately from their answers.

Participants

A total of 6664 persons started the survey. Participants who did not give consent, who were younger than 16 years old, who did not live in Belgium, or who did not proceed with the survey until the end were excluded (n = 2541). The final sample consisted of 4123 participants.

Following guidelines on collecting data on sexual orientation and gender identity (Gates & Badgett, 2009; Motmans, Burgwal, & Dierickx, 2020), a self-identification question was used, namely 'Do you consider yourself to be ...: (a) Heterosexual (Being emotionally, romantically and/or sexually

attracted to people of the opposite sex); (b) Bisexual (Being emotionally, romantically and/or sexually attracted to men and women); (c) Gay/lesbian (Being emotionally, romantically and/or sexually attracted to people of the same sex); (d) Asexual (You do not experience sexual desire and you feel never sexually attracted to other people); (e) I don't consider gender important (pan-, omnisexual)'. Because no data on sexual attraction and behaviour were collected, we have chosen to use the acronym 'LGB+' here to highlight that we only talk about self-identifying non-heterosexual individuals.

Measures

The online survey started with sociodemographic variables along with more specific questions on employment status before and during the COVID-19 pandemic and their financial situation since the instalment of the lockdown measures. The section on family and relations covered the time they spent at home during the lockdown, the composition of their household prior and during lockdown, the quantity and nature of their social contacts, their sexual orientation, and sexual activity and satisfaction during the lockdown.

Mental health and well-being were measured using validated scales. Low, moderate, or high stress in the past four weeks was assessed with respective scores of 0 to 13, 14 to 16, and 27 or higher on the 10-item Perceived Stress Scale (PSS) using 5-point Likert-type scales (0 = never to 4 = very often) (Cohen, Kamarck, & Mermelstein, 1994). Acute stress symptoms (ASS) in the past four weeks were assessed by the Primary Care PTSD screen (PC-PTSD 5), a 5-item primary care screening questionnaire using a cut-off score of 3 to suggest probable post-traumatic stress disorder (PTSD) (Prins et al., 2016). The Alcohol Use Disorders Identification Test (AUDIT-3) assessed problematic alcohol use in the past four weeks with scores ranging from 0 to 12 and a cut-off score of ≥5 in men and ≥4 in women (Gual, Segura, Contel, Heather, & Colom, 2002). Higher scores indicate a possible risk of developing alcohol dependency. In addition, we asked participants whether they had used any – legal and illegal – kinds of drugs, whether they have had suicidal thoughts, had attempted to commit suicide, or had intentionally harmed themselves without the intention to take their life in relation to the period before (i.e. 'yes, more than 4 weeks ago') and during the lockdown (i.e. 'yes, in the past four weeks') or not (i.e. 'no, never'). In the current study, we will discuss ASS and not PTSD as the reference time used in the survey is too short to have developed a PTSD according to the DSM-5 criteria.

Detailed information was collected about different types of DV victimisation, the assailants, and help-seeking behaviour upon direct and indirect DV exposure in the last four weeks, which coincided with the first four to six weeks of the sanitary and lockdown measures in Belgium (between 13 March and 27 April). 'Domestic violence' was defined in this study as any type of psychological, physical, or sexual suffering that is caused to another person in one's household. In order to increase the participation rate over multiple waves, we chose to limit the number of items per type of violence to four items for both psychological and physical violence and 12 items for sexual violence. Since we were interested in both direct and indirect exposure to DV, half of the items referred to violence they experienced themselves (direct victimisation) and the other half to exposure of violence they were aware of that someone else they were living with during the lockdown experienced (indirect victimisation). The psychological and physical violence victimisation questions are based on previous research (Keygnaert et al., 2015; Pieters et al., 2010; Schapansky, Depraetere, Keygnaert, & Vandeviver, in press). For psychological violence, they were asked about being insulted, belittled, and intimidated (e.g. yelling, breaking objects, saying they will hurt or kill you, or threatening to commit suicide). Physical violence items included physically hurting or attacking someone (e.g. pushing, hitting, kicking, biting, pulling hair, throwing an object at them) and life-threatening forms of physical violence such as stabbing, burning, maiming, strangling, trying this, or trying to kill someone. For sexual violence, a broad definition was used to follow the recommendations of international research (Peterson, Voller, Polusny, & Murdoch, 2011), with inclusion of both sexual violence without physical contact (e.g. exhibitionism, being forced to reveal intimate body parts) and sexual violence with physical contact (e.g. unwanted touching, unwanted kissing) and (attempted) rape. The items were based on former and ongoing research (Keygnaert et al., 2018; Schapansky et al., in press) and internationally validated questionnaires including the Sexual Experiences Survey (Koss et al., 2006), the National Intimate Partner and Sexual Violence Survey (Walters, Chen, & Breiding, 2013), and the Sexual Aggression and Victimization Scale (Krahe et al., 2015).

The reference period for victimisation was the past four weeks. Depending on the time of participation, participants reported thus on incidents that occurred during the first four to six weeks of the lockdown measures in Belgium. We will further refer to this period as 'under lockdown'. Per item, they were asked to indicate – both in relation to the past

four weeks and the period before the lockdown – whether this occurred once, several times, or never, and who the assailant was. Participants could also indicate that they did not want to answer.

Informal and formal help-seeking behaviour were questioned in relation to the incident that, according to participants, had the greatest impact on them. If respondents reported only one form of violence, this form of violence was automatically addressed. Informal help-seeking behaviour refers to discussing the incident with someone within the respondent's personal network such as a partner, a (step)parent, another family member, friend, or someone else. Formal help-seeking behaviour includes contacting health care services (i.e. a general practitioner, a specialist, a mental health practitioner, a sexual assault care centre), aid organisations (i.e. sexual assault chatline, helplines & support groups, services assisting victims), a family justice centre, another service and/or the police. If participants reported not to have sought formal help, they received the follow-up question 'Which are the major reasons why you haven't sought help or advice from these people or services (so far)?' with 15 multiple choice answer options, namely: I don't need help (1); I don't know where to go (2); I don't think that help would change anything (3); I feel embarrassed about what happened (4); I think I will not be believed or taken seriously (5); I don't trust anyone (6); I am afraid of further violence (7); I don't want the person who did this to me to get in trouble (8); I don't want to bring a bad name to my family (9); Due to financial or transportation limitations (10); Someone is not allowing me to seek help or advice (11); I don't want the person who did this to find out (12); I don't want to leave the house because of the corona measures (13); I don't want to stress the health care professionals even more in this crisis (14); Other reason (15).

Analytical strategy

As a consequence of possible item non-response, the number of participants included in the analyses discussed below varies. We will use the valid *n* in the reporting. The absolute and relative frequency of different types of reported DV is reported below together with the 95% Wilson Score confidence interval (CI). The frequencies of direct and indirect violence and the frequencies of different types of direct violence during lockdown were compared using McNemar tests. Comparisons between victims and non-victims of DV concerning mental health outcomes were performed using Fisher's Exact tests.

Results

Out of the total sample included in the cohort study, 9.3% indicated to identify as LGB+ (n = 383). They constitute the population under study for this paper. The LGB+ participants in the sample were mainly cisgender (96.1%) and self-identified females (72.3%), had a mean age of 37 years old (*SD* =13.97). Most participants have completed higher education (82%) and were born in Belgium (88.5%).

Domestic violence victimisation

In total, 32% of LGB+ persons (n = 111) have experienced at least one type of DV during lockdown. Table 1 shows the frequency of (in)direct DV victimisation within LGB+ persons during this period. Within the group of 366 persons with valid data on both direct and indirect physical violence during lockdown, the frequency of indirect physical violence (n = 11) was estimated to be 3.7 times higher than the frequency of direct physical violence (n = 3, p = 0.039). Direct psychological violence (n = 76) was only slightly more frequently reported during this period than indirect psychological violence (n = 60) (N^1 = 353, p = 0.052), but direct sexual violence (n = 15) occurred three times more often during lockdown than indirect sexual violence (n = 5) (N = 352, p = 0.021). Concerning all types of DV, we found that the risk for direct violence (n = 79) during lockdown was 1.3 times higher than the risk for indirect violence (n = 63) (N = 335, p = 0.044).

Table 2 shows the analysis of the difference in occurrence of psychological, physical, and sexual violence during lockdown.

Table 1: *Occurrence of violence during the first four to six weeks of the lockdown measures.*

	Direct victimisation		Indirect victimisation	
	% yes (n/N)	95%CI	% yes (n/N)	95%CI
Psychological violence	21.7 (81/374)	17.8.–26.1	17.5 (63/360)	13.9–21.8
Physical violence	1.1 (4/379)	0.4–2.7	3.0 (11/368)	1.7–5.3
Sexual violence	4.3 (16/372)	2.7–6.9	1.4 (5/360)	0.6–3.2
Total domestic violence	24.1 (88/365)	20.0–28.8	19.0 (66/347)	15.2–23.5

Table 2: *Comparison of differences in occurrence of direct psychological, physical, and sexual violence during the first four to six weeks of the lockdown measures.*

	Psychological violence	Physical violence	Sexual violence
Psychological violence	-	<.001 (N= 371)	<.001 (N= 367)
Physical violence	<.001 (N= 371)	-	.0012 (N= 370)
Sexual violence	<.001 (N= 367)	.0012 (N= 370)	-

Help-seeking behaviour

Out of the 88 LGB+ victims of DV answering the questions on help-seeking behaviour (22.99% of LGB+ persons in the sample), only 72.7% (n = 64) have disclosed this violence. Of those who sought help upon violence exposure, 70.1% (n = 61) disclosed to someone in their personal networks, 31.0% (n = 27) sought professional help and 6.3% (n = 1) contacted the police during the lockdown. As for indirect violence, a similar pattern emerges: LGB+ persons were most likely to disclose to someone in their personal network (72.1%, n = 31), followed by a professional (33.3%, n = 14), and again only one person (25%) contacted the police.

With regard to the three most common reasons why they did not seek any formal help (not including the police), LGB+ victims of DV indicated that they did not need any help (65.0%, n = 39), they did not want to bring the assailant into trouble (8.3%, n = 5), or because of other reasons that were not specified in the answer options (13.3%, n = 8). As for filing a complaint, the three most frequently cited reasons were that victims did not think that the incident was serious enough (16.2%, n = 62), because they felt responsible for what had happened (3.1%, n = 12), or because of other reasons not mentioned in our list (3.1%, n = 12).

Mental health and well-being

Table 3 shows the reported alcohol and drug use, perceived stress, acute stress symptoms, suicidal ideation and attempt, and self-harming behaviour in LGB+ persons (N = 383) under lockdown. Comparisons between victims and non-victims of DV (all types) concerning mental health outcomes are also presented in Table 3, indicating lower levels of mental health and well-being compared to the cut-off scores and norm groups relevant for each outcome.

Discussion

The aim of this paper was to present the occurrence of DV during lockdown in LGB+ persons based on a study in a convenience sample in Belgium. Further, we wanted to discuss their levels of perceived stress, alcohol and drug use, self-harming behaviour, suicidal ideation, suicide attempt, and both informal and formal help-seeking behaviour during lockdown.

The current study shows that a third of LGB+ persons in our sample was exposed to at least some form of DV during the first four to six weeks of the lockdown measures in Belgium. Given the convenience sample, our

Table 3: *Occurrence of mental health problems and alcohol and drug use during the first four to six weeks of the corona measures (N = 383 for total, N = 236 for no DV, N = 111 for DV).*

		Total % (n/N)	No domestic violence % (n/N)	Domestic violence % (n/N)	P value for Fisher's Exact test
	All LGB+ participants	100% (383/383)	236	111	
Alcohol use					
Problematic alcohol use		11.8 (43/365)	10.8 (24/223)	10.4 (11/106)	.069
Risk for alcohol dependency		9.6 (35/365)	7.6 (17/223)	16 (17/106)	
Drug use					
Medication to sleep or calm down		16.1 (61/380)	11.9 (28/235)	24.3 (27/111)	.004
Cannabis		6.8 (25/366)	5.3 (12/228)	11.4 (12/105)	.065
Cocaine, amphetamines, XTC, heroine or other similar substances		1.6 (6/367)	1.3 (3/228)	1.9 (2/105)	.652
Perceived Stress					
Low		33.3 (127/381)	38.7 (91/235)	18.0 (20/111)	<.001
Moderate		54.9 (209/381)	53.2 (125/235)	60.4 (67/111)	
High		0.1 (45/381)	8.1 (19/235)	21.6 (24/111)	
Acute Stress Symptoms		38.4 (147/383)	31.4 (74/236)	55.0 (61/111)	<.001
Suicidal ideation		13.5 (51/372)	10.3 (24/233)	22.7 (25/110)	.003
Suicide attempt		0.0 (0/372)	-	-	
Self-harming behaviour		0.0 (14/372)	2.6 (6/235)	7.6 (8/105)	.039

findings cannot be considered as representative for the entire LGB+ population in Belgium. As a result of selection bias and possible confounding, it is neither possible to draw conclusions about whether LGB+ persons are at higher risk of DV victimisation under these circumstances compared to heterosexual persons. Nevertheless, this study clearly shows that LGB+ persons have indeed been exposed to DV victimisation during the lockdown. We found that LGB+ persons in our sample were more exposed to direct than indirect victimisation and mainly to psychological violence, followed by sexual and physical violence. Vandeviver et al. (2020) also found more direct DV (one in five) than indirect DV (one in six) during lockdown in the sample consisting of both heterosexual and LGB+ participants. However, they found direct physical violence to occur more frequently than direct sexual violence. That trend also appears in an earlier Belgian study on DV: almost half of the participants reported DV, with more psychological than

physical violence and sexual violence respectively (Pieters et al., 2010). However, further research is needed to compare trends in occurrence of DV in heterosexual and LGB+ persons before and during lockdown. Moreover, since no questions were asked about specific DV risk factors for sexual and other minorities, understanding the vulnerability for victimisation will only be possible to a certain degree. Literature on DV in sexual minorities points to minority stress as a specific risk factor for violence exposure and experiencing barriers for help-seeking in different contexts (Edwards et al., 2015).

Further, in line with the expectations (Brooks et al., 2020), LGB+ participants reported elevated alcohol and drug use, perceived stress, acute stress symptoms, suicidal ideation, and self-harming behaviour under lockdown. Victims of DV showed more perceived stress, acute stress symptoms, suicidal ideation, self-harming behaviour, and usage of medication to sleep or calm down during this period compared to LGB+ participants who were not exposed to DV.

Unfortunately, this study suggests that help-seeking behaviour for DV victimisation is not self-evident. Approximately one LGB+ victim in three did not seek help at all. Help-seeking is a complex process starting by recognising that there is a problem, the decision to do something about it, and selecting a suited source of help (Donovan & Barnes, 2019). Barriers for recognising the experienced as 'violence' and deciding that disclosure of DV will improve the situation relates to the binary and gender biased patterns of approaching DV (Phillips II et al., 2020; Vogel & Uzieblo, 2020). Nuancing the prevailing binary images of female victims of intimate male terrorists is vital to better meet the complex reality of DV in all genders as well as non-hetero couples (Donovan & Barnes, 2019; Keygnaert et al., 2014; Phillips II et al., 2020; Vogel & Uzieblo, 2020). Showing mutual violence (Johnson, 2010) in couples and even same-sex couples could help to diversify the existing ideas about DV and to eliminate patterns of victim blaming (Donovan & Barnes, 2019; Phillips II et al., 2020; Vogel & Uzieblo, 2020).

In line with studies prior to and during the COVID-19 pandemic and in heterosexual samples (Donovan & Barnes, 2019; Sylaska & Edwards, 2013; Vandeviver et al., 2020), disclosing one's experiences seems to be easier within one's personal network compared to seeking professional help or reporting to the police. Although informal disclosure may provide instrumental and social support, linking victims who experience social, health, and judicial needs with professional care services may be needed when informal help sources prove to be insufficient (Cho, Shamrova, Han, & Levchenko, 2020).

Interestingly enough, reasons given for refraining from seeking help did not seem to be related to the COVID-19 crisis. Based on the reasons mentioned in this study, raising awareness about DV dynamics may help to promote help-seeking behaviour. Lowering thresholds for LGB+ individuals to seek any type of help can contribute to prevent further violence and the physical, psychological, sexual, and socio-economic consequences associated with it. As such, investing in making the pathways towards diversity sensitive and LGB+ friendly professional care and help visible is crucial. LGB+ victims should not refrain from help-seeking because they may not feel safe to disclose or report their experiences with DV out of fear for being dismissed, blamed, or made ashamed for what has happened. As with all victims of DV, striving for timely and adequate care for all individuals involved in DV is key to stop violence and its intergenerational transmission (Vandeviver et al., 2020; Vogel & Uzieblo, 2020). LGB+ individuals should not be forgotten in this story.

Limitations and suggestions for future research

The limitations of the current study should be acknowledged. First, aside from psychological, physical, and sexual violence, including exposure to economic violence in future studies could add to our knowledge on DV. Second, the sampling method used in this study does not allow for a generalisation to the Belgian sexual minority population. However, this longitudinal cohort study allows us to detect and study associations and risk factors in the near future and will also allow us to make a comparison between the situation before and after the instalment of the lockdown measures in March 2020 and between heterosexual and LGB+ individuals. Third, only one dimension of sexual orientation – self-identification – was used in this study to make a distinction between heterosexual and non-heterosexual individuals. As such, bias may be introduced as non-heterosexuals who do not (yet) identify with either one of the presented labels in the questionnaire may refrain from continuing with the survey or may be wrongly categorised into the heterosexual group. In addition, considering degrees of 'outness' and minority stress may be important factors to understand differences in risk and protective factors for DV (Edwards et al., 2015). Fourth, no questions were asked about sex at birth, which does not allow us to compare cisgender with non-cisgender sexual minorities. Moreover, relation to and the gender of assailants were not asked, making it impossible to make deductions about the kinds of households and relational contexts in which

DV takes place. Finally, the dynamic between victim and assailant should be mapped as well. Based on this study, we cannot draw conclusions about whether the reported incidence concerned the more common type of mutual violence or rather the rare type of intimate terrorism (Johnson, 2010). Understanding how interpersonal violence emerges is needed to be able to design targeted prevention.

Conclusion

LGB+ persons have been exposed to DV during the lockdown related to the COVID-19 pandemic and experienced mental health problems. These findings highlight the need for public health measures and sociocultural changes preventing DV and improving mental health in LGB+ persons. Future research should incorporate an intersectional perspective and address both shared and unique vulnerabilities for the general population as well as minority groups to fully understand the dynamics underlying DV and its impact on sexual minorities.

Note

1 N = valid n or the number of cases without missing values on any of the variables used in the analysis shown in the table

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