6 Sexual and Gender-Based Violence in Lesbian, Gay, Bisexual, Transgender, and Queer Communities

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Introduction

Before the LGBTQ movement gained increasing visibility in the late twentieth century, gender and sexuality were regarded with rigid boundaries. However, the LGBTQ acronym now encompasses an ever-expanding spectrum of sexual orientations and gender identities. The chapter that follows will provide a basic foundation for understanding the continuously shifting landscape of gender and sexuality, before delving into a discussion of sexual and gender-based violence as it affects members of LGBTQ communities.

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V. Ades (ed.), *Sexual and Gender-Based Violence*,
https://doi.org/10.1007/978-3-030-38345-9_6

Defining LGBTQ

In Western society, gender has historically been constructed as a male/female dichotomy—in which one's genetic makeup and subjective gender identity were viewed as necessarily concordant, and with male the opposite of female. Gender was an "either/or" with no overlap. Those who did not ascribe to binary gender norms were pathologized and diagnosed with a psychiatric disorder. In recent decades, gender has become increasingly understood to fall along a spectrum, allowing for more nuanced approaches to self-identity and self-expression.

Cisgender and Transgender

The term "cisgender" (or simply, "cis") has emerged to describe individuals who self-identify with the gender concordant with their sex assigned at birth (i.e., a person assigned female at birth identifying as a woman). Transgender is an umbrella term referring to those whose gender identity differs from their assigned sex. Under this umbrella, a trans woman is a person who identifies as a woman and was assigned male at birth, while a trans man is a person who identifies as a man and was assigned female at birth. People who identify outside of the male and female binary may be non-binary, gender queer, gender fluid, gender non-conforming, etc. The acronym TGNC (transgender and gender nonconforming) can be used to refer to this larger population.

Gender Identity Versus Gender Expression

Another layer to add to our understanding of gender is the notion of gender expression. Complementary to gender identity, which refers to an internal state, gender expression refers to the external display of one's gender identity. Gender expression is how an individual conveys their masculinity and/or femininity through appearance, including clothing, mannerisms, speech, and hairstyle.

Gender Identity Versus Sexual Orientation

Gender identity and expression must not be mistakenly conflated with sexual orientation. Ascribing to a particular gender identity does not imply any specific sexual orientation (i.e., being cisgender does not imply heterosexuality). Sexual orientation refers to the types of people to whom one feels sexual attraction, and encompasses attraction to men, women, both, or neither. Some people identify as pansexual and are open to a range of attractions. Many people of various sexual orientations are attracted to transgender and nonbinary people.

LGBTQ Acronym

Since the turn of the twenty-first century, the LGBTQ acronym has expanded as new gender identities and sexual orientations come to light. The acronym itself stands for "lesbian, gay, bisexual, transgender, and queer or questioning." The term "queer" is often used interchangeably with "LGBTQ" in reference to the fluidity of identities and orientations that are not heterosexual and/or cisgender. Queer is not just an umbrella term for gender and sexual minorities, but also often represents a political stance against enforced heterosexuality.

Sexual orientation and gender identity intersect in unique ways for the LGBTQ community; accordingly, we must consider the particular ways in which sexual and gender-based violence affects this community, and practical implications for clinicians. In this chapter, we will examine violence against the LGBTQ community both as a whole and for specific subgroups.

Background

Prevalence of Sexual and Gender-Based Violence (SGBV) in LGBTQ Communities

Members of LGBTQ communities experience significant discrimination, stigma, and violence—underpinnings of elevated rates of morbidity and mortality [1]. Violence against sexual and gender minority individuals is considered a form of hate crime,

defined as "criminal offenses against a person (or property) motivated...by an offender's bias against a race, religion, disability, sexual orientation, ethnicity, gender, or gender identity" [2]. In 2016, the Federal Bureau of Investigation reported 1255 hate crime incidents based on sexual orientation (anti-LGB) and 131 based on gender identity (anti-TGNC), accounting for intimidation, assault, rape, and murder [3]. Yet these statistics likely represent only a portion of the true extent of anti-LGBTQ violence in the USA due to lack of mandatory reporting and difficulty assessing perpetrator motives [4]. Other forms of bias-driven victimization are also disproportionately felt by the LGBTQ community, including bullying; physical and sexual assault; and verbal and physical harassment [5].

Furthermore, greater rates of violence are seen when gender identity and sexual orientation are considered in the context of race and ethnicity. The 2011 National Transgender Discrimination Survey found that transgender people of color experienced greater discrimination than whites across the board, with African American and American Indian/Native American respondents reporting the highest rates of police harassment, workplace harassment, and sexual assault. This ultimately contributes to low levels of educational attainment, job loss, and homelessness. Therefore, violence anchored to gender identity must be evaluated hand-in-hand with race and ethnicity—the hate crimes stemming from their confluence elucidate the potentially devastating effect of racism on the wellbeing of LGBTQ people of color.

Special Considerations in Select LGBTQ Communities: Sex Work, Prisons

Sex Work

Public spaces portend visibility, unwanted attention, and subsequent harassment/violence for sexual and/or gender minorities. This ultimately corrals LGBTQ individuals into the only spaces open to them—those that occupy the margins of society. This often means sex work and other underground economies (i.e.,

illicit drug trade). Some transgender people make a choice to participate in sex work as a good source of income that feels comfortable and rewarding. However, others, especially those transgender people who have faced family rejection, poverty, homelessness, or barriers to employment—all products of systematic, institutional, and interpersonal anti-LGBTQ discrimination—often find themselves turning to sex work for income, food, a place to sleep, or other basic goods and services essential for survival [6]. Trans sex workers, many of whom are trans women, are at greater risk for being victims of homicide (17 times the rate of the general population) [7], police-perpetrated physical and sexual violence, and discrimination in access to social services and shelters [8].

Sex workers face major barriers to reporting SGBV due to the criminalization of sex work in the USA and in many other countries around the world. Due to the criminalizable nature of sex work, violence that occurs in the context of sex work is not monitored by any formal bodies, and sex workers can claim little protection from the legal system [9]. As noted previously, contacting the police may only serve to incite additional SGBV against sex workers. Therefore, transgender individuals who engage in sex work are an especially vulnerable population and require considerably more attention from service providers.

Prisons

Prisons are intimately linked to the sex work industry, and represent another site of disempowerment for the LGBTQ population. Sexual minorities are incarcerated at disproportionately higher rates relative to the general adult population (1882 per 100,000 LGB people vs. 612 per 100,000). Furthermore, those who are incarcerated experience higher rates of sexual victimization by staff and other inmates, higher rates of punitive isolation and other measures of punishment, and longer sentences [10]. Such discriminative measures converge onto the higher prevalence of psychological distress and mental health problems seen in incarcerated LGBTQ people. For this uniquely vulnerable population, excess sexual victimization and violence places them at higher risk for

detrimental health outcomes. Providers who find themselves working with these marginalized populations should be aware of their heightened need for quality healthcare and likely distrust of providers or those in powerful positions.

Intimate Partner Violence

An often-overlooked space in which SGBV against LGBTQ people occurs is the home. In contrast to other forms of bias-motivated violence (e.g., religion, race) in which perpetrators are more likely to be strangers, LGBTQ individuals are more likely to suffer verbal, physical, and sexual violence at the hands of close relatives or intimate partners [5]. This type of violence is classified as intimate partner violence (IPV), which includes "physical violence, sexual violence, stalking, and psychological aggression (including coercive acts) by a current or former intimate partner" [11].

Statistics from the Center for Disease Control's 2010 National Intimate Partner and Sexual Violence Survey (NISVS) found that lifetime rates of sexual assault were highest among bisexual women (46%) when compared to heterosexual women (17%); overall, a greater percentage of lesbian (44%) and bisexual (61%) women experienced physical or sexual violence by an intimate partner over the course of a lifetime, compared to heterosexual women (35%) [12]. Estimates of the lifetime prevalence of IPV among men who identify as gay (25–33%) and bisexual (37–87%) are strikingly higher than rates of IPV among heterosexual men (8–29%) [13, 14]. (This range comes from three studies that used representative sampling to examine IPV prevalence among gay men. Goldberg and Meyer [13] estimated 26.9%, Walters et al. [14] estimated 25.2%, and Messinger [15] estimated 33.3% lifetime prevalence of IPV among gay men. Other studies [16, 17] using purposive sampling report a greater range of estimates for the lifetime IPV prevalence among gay men, ranging from 13.9% to 44.0%.) Limited data inquiring into the rate of IPV among TGNC populations suggests that transgender people are more likely to experience IPV (31.1%) in their lifetime than cisgender people (20.4%) [18]. Taken as a whole, these numbers speak to

the disproportionate impact that sexual and gender-based violence has on the LGBTQ community, with bisexual individuals and transgender people being most severely victimized.

Underreporting of Violence

It is important to remember that the prevalence of violence is likely higher than what the data show. A discrepancy can be expected because the nature of IPV within the LGBTQ community may present differently from that between heterosexual partners, and thereby fail to be identified as IPV. Since the prevailing paradigm of IPV is the combination of a male perpetrator/female victim, deviations from this societally-defined "rule" of violence are more likely to be missed. Unconsciously ascribing to this ingrained perspective likewise informs the way we speak of the "ideal rape victim"—a conservatively-dressed woman who is sober, tells a consistent story, and was raped by a man who is a stranger [19]. This stereotype of the "ideal rape victim" was first identified by sociologist and criminologist Nils Christie, who explored the particular attributes of victims and perpetrators that legitimize their status as victim and perpetrator, respectively [20]. When these expected characteristics are not met, the public (i.e., media, police, doctors, etc.) is biased to reject the case as less believable. Therefore, in LGBTQ relationships, which largely fall into the category of "not ideal" perpetrator/victim stereotypes, there is a greater possibility that IPV and sexual violence fails to be correctly identified and compliants are less likely to be believed.

This theoretical framework is supported by the unique methods of abuse specific to LGBTQ relationships that are not seen in heteronormative relationships. The relationship between a perpetrator and victim can be illustrated by the widely recognized "Power and Control" wheel [21], which describes methods of perpetrating physical, emotional, and sexual abuse in a manner that renders victims powerless and without self-autonomy [22]. The prototypical pattern of IPV in simplified form, applicable to heteronormative relationships, comes down to an abusive man exerting control over a powerless woman. In LGBTQ relationships and

in many heterosexual relationships, this well-defined male/female power dynamic is not always present. While the principles of perpetration remain the same, the arsenal of abuse differs: threatening to "out" one's partner, questioning whether one's partner is a "real" woman/man, or words and actions otherwise reinforcing internalized homophobia, biphobia, or transphobia [23]. Sexual and gender-based violence often manifests differently in LGBTQ relationships, in a way specific to the gender identities and sexual orientations of those involved, and therefore recognition requires a shift in mentality.

While all identities on the LGBTQ spectrum are subject to greater risk of victimization relative to the general population, research indicates that TGNC individuals may be at an even higher risk when compared to cisgender counterparts [18]. Forms of violence that are unique to TGNC individuals are largely a consequence of their greater visibility. Katz-Wise and Hyde note that "sexual orientation is often a hidden status, resulting in less victimization for those who are not visibly a sexual minority" [24]. In contrast, gender nonconforming individuals are more likely to be visibly "out" [25]—their visibility a consequence of the perceived discrepancies in secondary sex characteristics (voice, hair, build, etc.) and gender expression and presentation (makeup, hair, dress, etc.) that instigate violence. There are undoubtedly consequences associated with not conforming to historical notions of gender, such that conforming becomes a "strategy of survival" [26]. Gender nonconforming individuals and transgender individuals in the midst of transitioning are therefore especially at risk of experiencing gender-based violence.

Paradoxically, despite the higher prevalence of SGBV in the LGBTQ community, there is a greater likelihood that the violence goes unreported. Victims who identify as LGBTQ face additional barriers to reporting such crimes that heterosexual or cisgender victims do not face. Most prominently, there may be a reluctance to report due to fear of "outing" oneself to law enforcement, family, and/or friends, compounded with a fear of potential homophobia, biphobia, or transphobia [27]. For some individuals, being "out" may be a situation of life or death, should their support systems harbor anti-LGBTQ sentiments, or withdraw resources

and isolate the victim, inflicting further victimization. Therefore, clinicians have the potential to play an important role in screening for, identifying, and addressing SGBV experienced by LGBTQ patients.

Working with LGBTQ Clients Who Have Experienced SGBV

Historical Considerations

LGBTQ communities have a long history of maltreatment by healthcare providers, including being labeled as "disordered," attempts at "conversion" therapy, and refusal to be seen. Appropriately, LGBTQ individuals are often distrustful of healthcare providers. It is important for providers to take this into account when approaching LGBTQ clients, especially those with the additional trauma of SGBV. LGBTQ individuals are less likely to use primary care services, less likely to be forthcoming with their health care providers, and less likely to seek health care services when needed due to the history of discrimination [28, 29]. While this difference is documented nationally, the disparity is far greater in rural areas of the USA. Health care centers dedicated to LGBTQ populations, largely found in urban areas, have started to address these concerns, but there is significant work left to be done.

In the Room with LGBTQ Clients

Training in LGBTQ healthcare is not required by medical or mental health professionals in the USA. Because of a lack of training, many providers are unsure how best to approach LGBTQ clients, and especially those who are at high likelihood of having experienced SGBV. Starting with open-ended questions, which allow the client to bring in their chief concerns, can help provide a more comfortable space. Establishing the language a client would like the provider to use to refer to them is also important. Many transgender and nonbinary clients use names that differ from their legal names. Many of transgender people use traditional pronouns

(i.e., he/him or she/her) but some do not. Nonbinary clients may prefer gender neutral pronouns, the most common of which is they/them. Providers may find it nerve-wracking to ask about names and pronouns, but clients typically respond well to straightforward, earnest inquiries, often as simple as, "What name would you like me to call you?" or "What pronouns do you use?"

When taking a medical or mental health history with LGBTQ clients, the goal is to strike a balance between approaching the client as you would any other and asking about elements of the history that may be specific to this population. One straightforward method of history-taking is to go through the traditional categories/questions, asking LGBTQ-specific questions at appropriate times during the process. As an example, a physician who does not know much about transgender populations might believe it is important to know right away whether a patient has had any surgeries, but the more natural place in conversation to ask about past surgeries would be during the surgical history that is asked of all patients.

With questions about SGBV, LGBTQ clients may be particularly guarded when speaking with new providers, for a number of reasons. If the client suspects that the provider is uneducated about LGBTQ people, the client may worry that the provider will not understand the circumstances of the abuse (e.g., violence in a same-sex relationship) or will not have proper resources to offer them. It is also not uncommon for LGBTQ people with a history of SGBV as children to make (erroneous) connections between their abuse and their sexual orientation or gender identity. Men who identify as gay, for example, may have complicated feelings, often rooted in shame, about childhood abuse by male perpetrators. For example, perpetrators may have chosen them due to percieved sexuality or victims may have experienced some pleasure during these episodes, leading them to believe that they "asked for it," or may have a sense that their gay identities are a result of these early experiences. One way to help put clients more at ease when asking about SGBV is to be up front with them that it is common to have conflicted feelings about their experiences.

After a thorough history, medical providers proceed to a physical exam. Like the history-taking part of the session, the physical

exam can also be a vulnerable experience for LGBTQ people, particularly those with a history of SGBV. As with all clients, it is important to proceed slowly and to ask for consent before touching. Transgender and nonbinary clients, especially, may have complex relationships with their bodies. One approach that can help make the physical exam more comfortable for these clients is to ask about body parts and how they would prefer to have them named. Some transgender men, for example, refer to themselves as having a "front hole" rather than a vagina. Asking for and using the language a client prefers can make the experience of the physical exam less scary.

Mental Health in LGBTQ Populations

Minority stress theory describes the ways in which the everyday stress of living as a minority in society has a negative effect on wellbeing. Because of increased rates of societal stigma and discrimination, LGBTQ people have been shown to be at higher risk for certain mental illnesses, as well as suicidality, self-harm, and substance abuse. Substance abuse rates in LGB populations are typically reported as three times the general population and LGB people have two to three times the risk of suicide. Among transgender people, staggering statistics show that up to 76% have a history of suicidal ideation and up to 41% a history of suicide attempts.

Though the subject has not been well-studied, the consensus among many clinicians is that LGBTQ populations have elevated rates of posttraumatic stress disorder, including complex PTSD, stemming from their increased likelihood of having experienced SGBV. These illnesses can often make clients guarded, suspicious, and difficult to interact with. Providers who routinely remind themselves of the reasons for these behaviors often have an easier time working with traumatized clients.

It can be easy to become discouraged when faced with the glum statistics about mental health in LGBTQ populations. However, there is also evidence that LGBTQ people demonstrate remarkable resilience in the face of difficult odds. Specifically, experiences of social support, family acceptance, and community

connectedness have been identified as key promoters of resilience. Internal resilience factors such as individuals defining themselves, embracing their identities and oppression, taking pride in identity, and engaging in health-promoting behaviors and coping processes promote resilience against adversity. External activities such as finding empowering communities, seeking out connections in the LGBTQ community, and taking part in activism can also promote resilience in this population. Overall, as health professionals, while there are marked challenges for the LGBTQ population, the remarkable resilience and strength exemplified by this community can teach us all something about growing through adversity.

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