Emily M. Lund
Claire Burgess
Andy J. Johnson *Editors*

Violence Against LGBTQ+ Persons

Research, Practice, and Advocacy

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ISBN 978-3-030-52611-5 ISBN 978-3-030-52612-2 (eBook)
https://doi.org/10.1007/978-3-030-52612-2

This Springer imprint is published by the registered company Springer Nature Switzerland AG
The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland

To my friends, family, collaborators, and mentors—thank you for your love, time, and support.

Emily M. Lund

To those who hope for a brighter day... we are with you, and we will stay with you.

Claire Burgess

TO ALL GOD'S CHILDREN.

Andy J. Johnson

Preface

Violence against LGBTQ+ persons is a pervasive and serious problem. As the violence unfolds within cultural contexts, it is infused with misunderstandings, stereotypes, and biases that serve to convince perpetrators of interpersonal and systemic violence that their prejudice, discrimination, and abuse are justified and acceptable. Some institutions have adopted discriminatory policies which limit the human rights of LGBTQ+ persons and contribute to the problem of violence against LGBTQ+ persons. Even in cases where treatment facilities have adopted policies that prohibit discrimination, misinformed persons may act in accordance with personal biases and prejudices as opposed to policy mandated inclusion and affirmation and in doing so, increase, rather than ameliorate, the suffering of LGBTQ+ survivors.

Traditional, evidence-based clinical practices remain essential but may not be sufficient due to the need to provide advocacy and tailored, culturally responsive intervention for an LGBTQ+ client. In addition, some LGBTQ+ survivors of violence may become involved in protests, campaigns, and nonviolent means of seeking sociocultural change to obtain human rights. Clinicians serving these clients or providing consultation to LGBTQ+ organizations may also need to be familiar with the dynamics of cultural and systematic change and social justice to provide effective consultation.

Violence Against LGBTQ+ Persons: Research, Practice, and Advocacy emphasizes the complex dynamics of violence against diverse LGBTQ+ persons. Rather than lumping all LGBTQ+ survivors into one falsely monolithic group, the present text analyzes unique aspects of violence against specific subpopulations of LGBTQ+ persons. A scientist-practitioner-advocacy model that draws from the transformative justice movement is used to educate mental health providers concerning the unique needs of LGBTQ+ survivors of interpersonal and structural violence in order to promote the use of truly effective, tailored, and culturally responsive treatment strategies. This approach recognizes that presentations of trauma following the experiences of bullying, interpersonal violence, sexual assault, and trafficking are deeply rooted in sociocultural systems of oppression and injustice. Furthermore, the dynamics of intimate partner violence and sexual assault that LGBTQ+ survivors experience have a foundational base of homophobia and transphobia differs from those seen in heterosexual cisgender survivors. Thus, this book seeks to better equip mental health professionals to address social contexts that contribute to the violence and the internalized forms of prejudice and oppression which exacerbate the trauma of the survivor in addition to learning

how to facilitate healing, empowerment, healthy relationships, and resilience at the intersection of sexual orientation, gender identity, gender expression, and diverse social locations.

A backbone to much of the present text is Meyer's (1995, 2003) *Minority Stress Theory*. The seminal theory provides a framework for understanding how experiences of discrimination and stigma can put an individual at risk for problematic health outcomes. Life stressors along with minority-specific stressors expose sexual and gender minority individuals to health concerns such as obesity, poor behavioral health, suicidality, and other physical and mental health effects. Additionally, coping strategies for minority individuals may be impaired due to poor access to care, limited availability of quality, tailored treatments, and reduced availability of competent service providers. Minority stress has given researchers increasing understanding of exactly how victimization exists on a spectrum and may occur at different levels. No theory has come further in helping epidemiologists, interventions, and the lay public fully understand the connection between minority stress and functioning than minority stress.

Minority stress provides a basis for understanding the structural dimensions of interpersonal violence, such as isolation from sources of support, taking money or other resources, depriving of necessities (right to housing, employment, medical care, food), suppressing conflict and resistance, closing off escape or transportation, and creating and enforcing rules for everyday conduct. Many of the chapters in the present volume detail how LGBTQ+ persons' victimization impact not only sexual and gender minority populations but also the overall sense of safety and well-being in the surrounding context.

Let this comprehensive volume serve as a "guide from the experts" to further: (1) best practices in working with LGBTQ+ persons who have experienced (or may later experience) trauma; (2) understanding of minority stress and coercive control concepts as applied to this population; and (3) critical thinking about ethics, stakeholders, and your position in an ever-changing landscape of power relations. Many of the chapters include an examination of the pervasive and traumatic impact of structures in place at different levels that may contribute to traumatic experiences.

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Acknowledgments

First and foremost, thank you to Claire Burgess and Andy Johnson for their collaboration, support, and friendship over the course of this editing process. I could not have asked for better coeditors in this journey and deeply appreciate their generosity with their time and expertise throughout this process. Thank you also to our team at Springer, especially Jennifer Hadley, Janet Kim, Sara Yanny-Tillar, and Shabib Shaikhand, for their time and assistance throughout this process.

I also owe a considerable debt of thanks to my friends, family, and colleagues for their support, kindness, and love throughout this process—thank you for understanding when this book had to take priority in my schedule and graciously accommodating and supporting me when it did. Thank you to my mentors, especially Erin Andrews, Rosemary Hughes, Michael Nadorff, Christina Nicolidias, and Timothy Slocum, for encouraging and supporting my research in the areas of social justice, diversity, intersectionality, and trauma and for always encouraging me to do work that addresses the "big questions," no matter how difficult they are. This book would not exist without your mentorship and support, and I am incredibly thankful for all you have done and continue to do for me.

Thank you also to Jared Schultz, Timothy Slocum, and Michael Nadorff for always being ready and willing to provide advice and guidance about academia and to Katie Thomas for always being willing to talk things through with me when I'm not quite sure what to do. You all are both dear friends and cherished colleagues, and I am lucky to have you in my life. Thank you to my parents, Jeff and Cathy, and my brother, Chris, for their unwavering support of me and my dreams. Finally, thank you to my LGBTQ+ friends and colleagues for providing support and community while also encouraging introspection and growth—I am truly lucky and grateful to have such wonderful role models and friends.

Emily M. Lund

Let me begin by saying a thank you to my collaborators, who invited me to join them in the journey of writing this text, Andy Johnson and Emily Lund. I consider the recommendation from my mentors to write, edit, and facilitate the interchange of scholarly ideas through this avenue to be a privilege, and hold it close to my heart. My Boston mentors at Fenway and the VA have woven incredibly novel, impressive research trajectories. I am honored

to be included in their work, and also consider it an honor that some of their work is featured here in this book. To my colleagues at work with whom I bounce ideas off but have not yet written alongside: you are a daily inspiration. I hope to collaborate with you someday soon and bring the spotlight on the more creative, or rambunctious, things we do at work.

To my University of Southern California mentors, John Monterosso and Jeremy Goldbach: your brilliance and unwavering support has made me reflect on the potential of human compassion. Thank you for supporting me in setting out as a fellow in this new territory—I did not imagine I would stay so active in writing. And last, to Liz: you are so gracious for allowing me to pursue this dream at an incredibly busy time in our lives. I cherish that, and I owe you *many* for it.

Claire Burgess

Jackson Katz and Ron Clark each helped me begin to realize the necessity of addressing violence against LGBTQ+ persons. Lydia X.Z. Brown and Emily Lund highlighted this need further when we worked together on a previous project. I was honored when Emily agreed to work together with me on the next edited volume. We considered several different options. Jennifer Hadley from Springer encouraged us to place top priority on violence against LGBTQ+ persons. Emily has been a wonderful colleague, encouraging me as we developed the vision for the book and taking steps to ensure the work would be consistently affirming. Claire Burgess graciously agreed to join our editorial team in the spring of 2019 when my research ground to a halt as I was grieving the loss of my younger brother to pancreatic cancer. Claire revived the work and put us back on track. The insight, dedication, and wisdom of Emily and Claire account for the strengths of *Violence Against LGBTQ+ Persons*. Responsibility for any limitations falls squarely on my shoulders. Many thanks to our chapter authors for the generous giving of their time and efforts in writing for us. Jennifer Hadley, Janet Kim, and Sara Yanny-Tillar from Springer provided valuable input at critical points along the way. Shabib Shaikh from the copyediting department was exceptional, even contacting us to offer assistance before we submitted the manuscript.

Debra Wingfield from the National Partnership to End Interpersonal Violence (NPEIV) demonstrated to me the advantages of using a coercive control model to understand how various forms of gender violence, ranging from internalized homophobia to microaggressions to interpersonal violence to violence under the guise of "therapy" to systemic injustices, affect not only the mental health but also the freedom of survivors in ways that can become internalized over time. Dynamics of coercive control at the individual, interpersonal, and sociocultural levels constrict the life movement, choices, and human rights of LGBTQ+ persons. Colleagues from OutFront Minnesota helped me to appreciate more fully the depth and range of human suffering caused by interpersonal and systemic violence. Cat Salonek, Emma McBride, Ashley Harp, Junior Avalos, and Roger Sanchez were especially instrumental in that regard. Wallace Swan has been a valuable mentor on policy issues affecting sexual and gender minority persons. Colleagues giving me greater

insight into the complex and diverse roles of religion, spirituality, and ethnicity in violence against LGBTQ+ persons have included the Rev. DeWayne Davis, Doug Federhart, Steve Robertson, David Coleman, and Austen Hartke, as well as the beloved community at All God's Children Church in Minneapolis.

It would not have been possible to complete this book without the work of my research assistants, J.J. Anderson-Gutiérrez and Laura Price, and my teaching assistants, Sarah Meckley, Barrette O'Keefe, and Miranda Robinson. The Bethel University Librarians labored diligently to provide access to information sources that were sometimes elusive and difficult to find.

Finally, I want to thank my wife, Carolyn Johnson, and my daughter, Briana Johnson, for their encouragement and unwavering support over the course of this project, even during the most difficult times and circumstances.

Andy J. Johnson

Contents

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Emily M. Lund, PhD, CRC (she/her/hers), is Assistant Professor of Counselor Education in the Department of Educational Studies in Psychology, Research Methodology, and Counseling at the University of Alabama in Tuscaloosa. She holds a PhD in rehabilitation counseling from Utah State University, a master's degree in educational psychology from Texas A&M University, and bachelor's degrees in psychology and social work from the University of Montana. She has worked with people with disabilities in their families in a variety of clinical and educational settings. Her primary research interests include interpersonal violence and trauma in people with disabilities; suicide and non-suicidal self-injury in people with disabilities; the experiences of counseling and psychology graduate students with disabilities; and LGBTQ+ issues, particularly as they intersect with disability. She has published and presented extensively on these topics and currently has over 80 peer-reviewed publications. In addition to this volume, she is an editor of the book, *Religion, Disability, and Interpersonal Violence* (2017), also published by Springer.

Claire Burgess, PhD (she/her/hers), is an Instructor at Harvard Medical School in Massachusetts and a clinical psychologist at the National Center for TeleMental Health at the Veterans Health Administration in Washington, DC. She serves as the LGBT Veteran Care Coordinator at VA Boston Healthcare System, where she connects veterans to care, and provides education locally to staff and trainees across disciplines. Dr. Burgess has expertise in assisting organizations with trauma-informed care considerations for transgender and gender diverse patients. Her passion lies in providing education to trainees, as she teaches nursing students and psychiatry residents topics such as cognitive behavioral therapy and LGBT health. Dr. Burgess has experience in research and intervention at the Fenway Institute and VA Boston Healthcare System, where she completed an LGBT Health Postdoctoral Fellowship. During her fellowship year, she led two national workgroups on transgender and intersex patient care within VA and is currently working on a third developing provider education on trauma-informed care of sexual minority veterans in healthcare settings. She received her MA and PhD in clinical psychology at the University of Southern California, where she was a graduate researcher in the Center for LGBT Health Equity.

Andy J. Johnson, PhD (he/him/his), teaches a variety of courses in the Department of Psychology at Bethel University in Saint Paul, Minnesota. His research interests center on the intersection of religion, ethnicity, national origin, immigration status, sexual orientation, gender identity, and ability/disability with interpersonal violence. A volume he edited, *Religion and Men's Violence Against Women*, and a volume he coedited with Ruth Nelson and Emily Lund, *Religion, Disability, and Interpersonal Violence*, are published by Springer.

Andy has served on the Board for the National Partnership to End Interpersonal Violence (NPEIV), where he was Co-Chair of Action Team 2: Training and Mentoring. A member of the Policy Committee for OutFront Minnesota, Andy has testified on the psychological research demonstrating the harmfulness and ineffectiveness of conversion therapy in support of efforts to ban conversion therapy in the state legislature.

He is current member of American Psychological Association (APA) Division 44: Society for the Psychology of Sexual Orientation and Gender Diversity, and a former Member-at-Large for APA Division 36: Society for the Psychology of Religion and Spirituality. Recently, Andy served as a member of the Olmstead Specialty Committee on Violence Against Persons with Disabilities for the State of Minnesota. He earned his MA and PhD in counseling psychology from the University of Notre Dame in Indiana.

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1 Queer Violence: Confronting Diverse Forms of Violence Against LGBTQ+ Persons and Communities

Emily M. Lund, Claire Burgess, and Andy J. Johnson

Abstract

This chapter introduces the topics of systemic and interpersonal violence against LGBTQ+ persons, a complex and multifaceted area that is marked by a variety of distinct but co-existing types of victimization. We describe this broad range of victimization, which spans from childhood to adulthood, covert to overt, and interpersonal to systematic, and discuss the cumulative effects of both acute and chronic victimization on the health and well-being of sexual and gender minority persons. We also highlight the importance of truly intersectional and culturally responsive care in working with LGBTQ+ clients who have experienced violence.

Violence is a complex and multifaceted concept, and members of the LGBTQ+ community (i.e., individuals who are non-heterosexual, non-cisgender, and/or intersex) have long been subject to increased rates of violence victimization in various forms (Katz-Wise & Hyde, 2012; Friedman et al., 2011). As detailed in the following chapters in this volume, violence against various communities under the LGBTQ+ umbrella is often both systematic—occurring at the level of social norms and political and public policy—and interpersonal, occurring at the level of the individual. This violence can be overt and explicit—up to and including homicide—and covert and subtle, such as microaggressions and invalidation (Nadal, Rivera, Corpus, & Sue, 2010). Although smaller-scale forms of aggression are often considered to be of relatively little concern by outsiders, researchers have found that they often have a considerable and damaging cumulative impact on recipients and lead to further feelings of isolation and decreased well-being (Galupo & Resnick, 2016).

Additionally, victimization of LGBTQ+ individuals often occurs across the lifespan and in a variety of forms and circumstances (Katz-Wise & Hyde, 2012; Friedman et al., 2011). Although the "It Gets Better" campaign sparked a popular anti-suicide and anti-bullying meme campaign aimed at LGBTQ+ youth (Gal, Shifman, & Kampf, 2016; Grzanka & Mann, 2014), the questions of if it gets better, how it gets better, and for whom it gets better remain open. Researchers have consistently found that LGBTQ+ individuals continue to experience violence victimization

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E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_1

at high rates into adulthood (Katz-Wise & Hyde, 2012; Friedman et al., 2011), and bullying victimization, contrary to its popular depiction as a phenomenon of childhood and adolescence, continues into post-secondary education and the workplace (Lund & Ross, 2017; Nielsen & Einarsen, 2012).

Overt and interpersonal violence victimization may take a number of different forms, including physical, sexual, and emotional maltreatment (Brown & Herman, 2015; Corliss, Cochran, & Mays, 2002). Additionally, violence and aggression may be perpetrated by a number of different types of perpetrators, including parents, intimate partners, peers, co-workers, and strangers (Brown & Herman, 2015; Corliss, Cochran, & Mays, 2002; Freedner, Freed, Yang, & Austin, 2002; Friedman et al., 2011; Galupo & Resnick, 2016). It may also occur in a single instance or be episodic or even nearly continuous in nature, occurring repeatedly or cyclically over time. A single individual may often experience multiple types of violence victimization across the lifespan or even at a single point in time, and these acute experiences of victimization may occur alongside chronic, systematic violence, potentially heightening the cumulative negative effects of both the acute and chronic trauma and stress (Gabrielli, Gill, Koester, & Borntrager, 2014).

Understanding and asking about the experience of multiple forms of victimization and marginalization is key to understanding the lived experiences of LGBTQ+ individuals. The chronic experience of both overt and covert discrimination, marginalization, and violence has been linked to a continual high level of psychological stress and distress among LGBTQ+ individuals. This chronic stress, termed "minority stress," has been linked to the higher rates of health problems, including depression and suicide among LGBTQ+ individuals (Michaels, Parent, & Torrey, 2016; Meyer, 2003; Plöderl et al., 2013). The minority stress model includes both proximal stress, such as internalized homophobia and the stress of identity concealment, related to systematic violence and marginalization, and distal stress, such as that related to overt and direct violence and discrimination (Michaels et al., 2016; Meyer, 2003).

Experiences of victimization as well as social circumstances and patterns of marginalization and discrimination may differ for different subpopulations of the LGBTQ+ community (Corliss et al., 2002; Brown & Herman, 2015; Heck, Flentje, & Cochran, 2013). For example, although both may experience considerable victimization and marginalization, the particular patterns of violence and discrimination experienced by gay men and lesbian women may differ, and it is important to understand the unique social history and context of each subpopulation (Heck et al., 2013). Similarly, transgender and cisgender clients may face unique social stressors and patterns of prejudice and discrimination, and thus it is important to consider a client's individual identity and circumstances rather than assuming that all people under the broad LGBTQ+ umbrella face the exact same challenges. Considering a client's individual identity may be further complicated by the fact that many individuals within the LGBTQ+ community may hold multiple gender and sexual minority identities (e.g., a client who identifies as both non-binary and bisexual or a client who identifies as asexual, homoromantic [lesbian], and transgender), creating a complex web of intersecting identities and potential areas for marginalization and discrimination (Gupta, 2017; Pinto, 2014). It is critical that the clinician carefully listens to and understands the individual's identity in its entirety and how that identity has influenced the experience of discrimination, victimization, and resilience.

Likewise, LGBTQ+ clients who hold other marginalized identities outside of realm of gender and sexuality, such as those who are also racial or ethnic minorities or who are disabled, may also have complex experiences of identity construction, discrimination, victimization, and resilience (Lightfoot & Williams, 2009; Lund & Johnson, 2015; O'Toole & Brown, 2002). Because these other aspects of their identities also result in social marginalization, multiple marginalized individuals may face additional,

cumulative minority stress, violence, and discrimination due both to the individual components of their identity (e.g., disability status alone, LGBTQ+ status alone, race or ethnicity alone) and the complex intersections between the multiple aspects of their identities and the surrounding environment (Brown, 2017; Levine & Breshears, 2019). Individuals who are members of multiple marginalized groups may face implicit and explicit pressure to choose a single aspect of their identity, a task that is both offensive and impossible due to the intersectional nature of both identity and access needs (Lightfoot & Williams, 2009; Lund, Johnson, & Nelson, 2017). When fulfilling this request proves impossible, these clients often receive substandard care (Lightfoot & Williams, 2009; Lund, Johnson, & Nelson, 2017; O'Toole & Brown, 2002). Thus, it is vital that clinicians take a fully intersectional approach in understanding and affirming each client's identity, needs, and experiences.

By understanding the lived experiences of each client, including their experiences of various types of interpersonal and systematic victimization and discrimination and the effects of those experiences, clinicians can better provide an affirming and validating therapeutic environment (Heck et al., 2013) in which clients can address and heal from the effects of violence and discrimination and develop strategies that allow them to cope and even thrive in the face of victimization, oppression, and marginalization. A deep and thorough understanding of the scope, nature, and effects of victimization faced by LGBTQ+ individuals provides the foundation on which both LGBTQ+ individuals and allies can continue to dismantle the systems of macro-, mezzo-, and micro-level oppression that perpetuate such violence and harm. The other chapters in this volume explore the concepts introduced here—the various forms of violence and discrimination experienced by LGBTQ+ individuals, the minority stress model, the importance of affirmation and intersectionality—in depth and with specific application to particular groups within the broader LGBTQ+ community.

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Concepts of Sexual Orientation and Gender Identity

2

Geoffrey L. Ream

Abstract

Violence against lesbian, gay, bisexual, transgender, queer, and other sexual/gender minority (LGBTQ+) persons may be encouraged or discouraged by ideologies about sexual orientation and gender identity. Current concepts of sexual orientation and gender identity may be grouped into three broad categories. One is based on empirical, psychological, and biological science, which have found that sexual orientation and gender identity are partially heritable, have no necessary connection to mental illness, and cannot be intentionally influenced by anything that happens after birth. Another category is modern progressive views, mostly grounded in constructivism and critical theory. These support accepting LGBTQ+ and other oppressed groups' authority about their own experiences and calling people what they want to be called. The third is conservative ideologies, which generally hold that LGBTQ+ persons are disordered and dangerous, especially to children, unless they take steps to either change their nature or play a role prescribed for it.

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On August 14, 2018, a grand jury delivered a report of the largest investigation ever by a government agency of child sexual abuse in the Roman Catholic Church. It described the experiences of over 1000 survivors. The church had already paid out hundreds of millions of dollars in child sexual abuse settlements, and this report promised to make the issue more expensive than ever (Goodstein & Otterman, 2018). Four days later, Bishop Morlino of Madison, WI, issued a letter to the faithful. In that letter, posted on the Madison Catholic Herald's website (Morlino, 2018) and quoted at length in some other Roman Catholic sources, he said that it was inappropriate to ideologically separate homosexuality from pedophilia and blame the church's child abuse problems on pedophilia. He implicated a "homosexual subculture" within the church's leadership and called for "vengeance" – from heaven, of course – against those who act upon the "intrinsically disordered" desire that is homosexuality, especially when they direct their attentions to young people.

If narrowly read, Morlino's letter was not trying to raise the long-debunked (see Herek, 2018) idea that same-sex attracted people are generally more likely to abuse children. He was calling out a specific cadre of men within the church's hierarchy whose secrecy norms around sexual indiscretion have often had the side effect of protecting child abusers. This was a known issue that Pope

E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_2

Francis was trying to manage administratively (Martel, 2019). Roman Catholic faithful, however, took matters into their own hands. Openly gay pastoral associate Antonio Aaron Bianco, who had played a critical role in revitalizing a San Diego Roman Catholic parish, started receiving harassing phone calls from blocked numbers. A stranger threw a punch at him after Mass, and his church office was vandalized with homophobic graffiti (Goodstein, 2018). LifeSite, a conservative Catholic website (which would later be refused an Apple News channel for "intolerance towards a specific group," see LifeSiteNews, 2019), posted personally identifying information about ("doxed") him. Bianco resigned for his and his family's safety (Goodstein, 2018).

The above does not sound like the sort of thing that ought to happen in modern America, where public opinions toward lesbian, gay, bisexual, transgender, queer, questioning, and other sexual/gender minority (LGBTQ+) persons have steadily improved over many years (Charlesworth & Banaji, 2019; Twenge, Sherman, & Wells, 2016) and same-sex marriage is becoming the law of the land (Chappell, 2015). However, in a social struggle, the progressive side is rarely the only one trying to make progress (Kendi, 2016; MacLean, 2017; M. White, 2006). The Roman Catholic Church and other promulgators of ideologies that empower violence against LGBTQ+ persons also work hard, believing that they are doing what is best for the society.

This chapter reviews concepts of sexual orientation and gender identity that are currently relevant to violence against LGBTQ+ persons. It covers the seminal, empirical, biological, and psychological studies that provided some of the first authoritative alternatives to traditional conservative anti-LGBTQ+ views (Bailey et al., 2016; Savin-Williams & Ream, 2007). It goes on to review the constructivist and critical sociological perspectives which underlie the modern norms of calling LGBTQ+ what they want to be called, respecting their authority to define their own experiences, and scrutinizing all generalizable knowledge about LGBTQ+ people for pro-oppressor biases (Diamond & Rosky, 2016; Jackson & Scott, 2010). Finally, it discusses conservative anti-LGBTQ+ ideologies that encourage violence against LGBTQ+ persons.

Empirical Science

Throughout much of the history of the social sciences, it was rare to find work that seriously questioned dominant ideologies about human sexuality (Jackson & Scott, 2010). This changed with the famous "Kinsey Report" (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953). By "describing a range of [human] sexuality without judgment," the Kinsey Report revolutionized society. It inspired Hugh Hefner to create *Playboy* (Abumrad, 2018). It also precipitated a change in thinking about same-sex sexual activity and several other taboo behaviors which, according to Kinsey's results, were far too common to be reasonably thought of as pathological. Alfred Kinsey himself was well-known to be bisexual and polyamorous, but his work could not be dismissed as self-justificatory theorizing because he had scientific survey data from a large sample to support his statements. Another influential contribution was Evelyn Hooker's (1957) famous finding that there was no significant correlation between male sexual orientation and expert-rated mental health. Science does not often foreground non-findings, but this one is noteworthy because Hooker should not have been able to find *any* gay men who were neither mentally ill nor criminals if society's ideologies about LGBTQ+ persons at the time had been correct. Since Hooker and Kinsey's time, empirical research has often been a leading voice in challenging dominant conservative anti-LGBTQ+ ideologies and exposing policies and practices that are harmful to LGBTQ+ persons.

The Biological Basis of Sexual Orientation and Gender Expression

Empirical science has firmly debunked the conservative anti-LGBTQ+ belief that being LGBTQ+ is associated with psychopathology which the environment either causes or allows

to express itself (Kinney, 2014). If sexual orientation and gender have any "causes" at all, they lie in biological processes that occur before birth. Androgen levels that are present in the mother's womb before a person is born affect several sexually dimorphic characteristics, including finger length ratio, various aspects of brain lateralization, sexual orientation, and gender. Research supporting this theory includes findings that gender differences in self-expression emerge very early in childhood, before environmental influences like parenting behaviors could have had any effect, and that gendered attributes are correlated with sexual orientation, which is a prerequisite to suggesting that gender and sexual orientation have the same biological underpinnings. Also, animal model studies found that directly manipulating prenatal hormone levels affects adulthood sexual behavior (Bailey et al., 2016). There is no single "gay gene" (Ganna et al., 2019), but heritability of sexual orientation is found to be about one-third, within the range of other complex behavioral traits (Bailey et al., 2016; Diamond & Rosky, 2016; Luoto, Krams, & Rantala, 2018). The consensus of these and other biological findings is that sexual orientation and gender are natural variations in human development and not part of some disease process. This invalidates conservative anti-LGBTQ+ ideologies predicated on the assumption that homosexuality and transgenderism are diseases that can be prevented (Dobson, 2001) or treated (Jones & Yarhouse, 2011). Conservative anti-LGBTQ+ ideologues assert that being LGBTQ+ is a problem because it is just "common sense" (Cameron & Cameron, 1998) or because being LGBTQ+ is so often correlated with problems (Mayer & McHugh, 2016). These are not scientifically valid arguments, which suggests that these talking points, even when they appear in scholarly journals, are aimed more at general readers than at scientists.

The Evolutionary Value of Traits Associated with Being LGBTQ+

Empirical science also debunks the conservative anti-LGBTQ+ assertion that there cannot possibly be a "gay gene" because it would have died out millennia ago (Dobson, 2001). That notion is based on the idea that same-sex oriented people are very unlikely to reproduce, which is simply not true. Many men who have sex with men are in stable relationships with women (M. R. Friedman et al., 2017) and identify as heterosexual (Savin-Williams & Ream, 2007). Also, women who are of reproductive age and not exclusively heterosexual are actually more sexually active with men than exclusively heterosexual women are, not less (Ela & Budnick, 2017). Far from describing how the gay gene should have died out, modern evolutionary science actually supports several theories for why biological traits associated with being LGBTQ+ persist and enhance the survival of the human species. A theory behind male homosexuality is that of the "gay uncle" who does not have children of his own and instead puts his time and resources into supporting family members' children (VanderLaan, Ren, & Vasey, 2013). A theory of women's bisexuality and sexual fluidity suggests that men are drawn to women being sexual with each other because this promoted bonding within the patriarchal and polygamous societies wherein most of the human race evolved (Luoto et al., 2018). It also enabled women to turn their attentions to each other rather than cuckolding the men to whom they belonged when those men were unavailable. The only sexual orientation category of women that would be unappealing to men would be those who have no interest in men at all, which may explain why exclusive attraction to women is currently less prevalent among women than bisexuality is (Apostolou, 2018). Evolutionary researchers generally agree that there is not one single evolutionary theory for all sexual orientation and gender diversity. Various sexual orientation and gender expressions, even

distinctions like "butch" vs. "femme," may have different evolutionary stories behind them and unique adaptive value for the species (Apostolou, 2018; Ela & Budnick, 2017; Luoto et al., 2018).

Multidimensionality of Sexual Orientation

Survey research confirms expectations based on biological, laboratory, and evolutionary science that there would be more gay men than bisexual men and more bisexual women than lesbians (Gates, 2011). It has also invalidated the conservative anti-LGBTQ+ epidemiological view that being LGBTQ+ is a condition that some people have and others do not. Modern surveys, improving on Kinsey's methods, ask separate questions about sexual attraction, dating, orientation identity, behavior, sex, and gender. They find that people who fit precisely into commonly understood sexuality and gender categories are the exception, not the norm (Laumann, Gagnon, & Michael, 2000; Savin-Williams, Joyner, & Rieger, 2012; Savin-Williams & Ream, 2007). Across surveys, 11% of American adults acknowledge some same-sex attraction, and 8.2% have engaged in same-sex behavior, but only 3.5% identify as lesbian, gay, or bisexual (Gates, 2011). This implies that the majority of people who experience same-sex attraction and/or engage in same-sex sexual behavior identify as straight, which sets the stage for investigating same-sex sexuality among straight-identified people (e.g., Ward, 2015).

Another key finding of surveys is that there are limits to survey research. Transgender, nonbinary, and other non-cisgender categories are too rare to reliably appear in surveys with sufficiently large subsamples for analysis (Gates, 2011). The many subcategories for sexual orientation specified in intricate multidimensional schemas like "The More Complicated Attraction Layer Cake," which addresses issues like how someone fits sex into the context of romance and whether attraction even depends on the object's gender (Rudd, 2017), are probably too small to emerge in even the largest population-representative surveys. Despite these limitations, it is still important to recognize the contributions of large-scale representative data, not least because these databases come from major government projects where politics have been an issue and including variables measuring sexual orientation and transgender identity was a hard-won accomplishment (Ream, 2019; Savin-Williams & Joyner, 2014; Twenge et al., 2016). If the census were to ask about sexual orientation and gender identity, this would create a treasure trove of freely available information for researchers and anyone else to analyze. However, the Census Bureau has declined to include these questions (Moreau, 2018).

Fluidity and Other Trajectories of Change in Sexual Orientation Identity

Empirical studies conducted either by conservative anti-LGBTQ+ ideologues or with their involvement find that, if one looks hard enough, one will be able to find at least a few people who say that sexual orientation change efforts (SOCE) and gender identity change efforts (GICE) worked for them (Jones & Yarhouse, 2011; Spitzer, 2003). Most LGBTQ+ persons do not have that experience, even though many have both engaged in therapy and wanted to change their sexual orientation or gender. Historically, researchers hesitated to look seriously into change in sexual orientation and gender identity because they knew that conservative anti-LGBTQ+ ideologues would take the findings and use them to support SOCE and GICE (Diamond & Rosky, 2016). Now, sexual orientation change efforts (SOCE) and gender identity change efforts (GICE) are rejected in theory and practice by probably all major scientific and human services organizations to which SOCE and GICE are relevant (Ashley, 2018). SOCE and GICE are also illegal in 18 US states plus a long list of localities (Taylor, 2019). The idea of intentional change in sexual orientation or gender is, at least at the present state of the art, so far beyond rehabilitation that researchers can investigate natural

change over time without worry that SOCE/GICE proponents could cause any real damage by trying to co-opt their findings (Diamond & Rosky, 2016). This is an important development, because it is becoming increasingly clear that there is more to the story of being LGBTQ+ than having been "born this way" (Ganna et al., 2019).

Latent class analysis of data from the National Longitudinal Study of Adolescent to Adult Health, the same longitudinal panel study that helped set the norm of dimensional operationalization of sexual orientation (see Savin-Williams & Ream, 2007), found three trajectories of sexual orientation identity development to be prevalent within the sample. One group, about half male and half female, were lesbian/gay/bisexual throughout adolescence and young adulthood. The other two groups, mostly female, were "heteroflexible" and "later bisexually identified." Latent class analysis of a different, females-only sample found that sexual fluidity itself is a stable sexual orientation category. It did not find support for the idea that fluidity is something that most women experience (Berona, Stepp, Hipwell, & Keenan, 2018). Other panel data studies found young men reporting sexual minority status in earlier waves but not in later waves. They might have been "mischievous responders" (Savin-Williams & Joyner, 2014), or they could have been involved in some experimentation or unwanted contact that caused them to question (Katz-Wise et al., 2017). Some of them might have felt genuine flushes of attraction toward same-age peers very early in adolescence, before those peers developed secondary sex characteristics. Fluidity is probably not the explanation for adolescents' inconsistent responses to sexual orientation questions across waves of panel data. Fluidity and other more complex identities may be more characteristic of adulthood, when people are past the adolescent need to achieve and maintain a fixed, stable identity (Better, 2014). The major sexual and gender identity change of adolescence is coming out as LGBTQ+ (Ott, Corliss, Wypij, Rosario, & Austin, 2011).

Bisexuality in Identity Politics and Public Health

In empirical science, the final authority on how a group of people are represented is the scientists. This has not always resulted in the most empowering conversation for bisexuals. Psychological and biological research have struggled with the question of whether bisexuality, in the sense of physiological arousal to both male and female erotic stimuli, even exists (Rieger et al., 2013). Conventional wisdom is that sexual orientation identity is healthiest when it is consistent with one's biological inclinations (e.g., Savin-Williams, 2001), so this inquiry raises issues with the validity of bisexual identity. Research from a public health paradigm often deals with the question of identity by not dealing with it, instead assigning categories like "men who have sex with men and women" (MSMW) that few people would probably choose for themselves (Wolff, Wells, Ventura-DiPersia, Renson, & Grov, 2017). Researchers do this because it allows them to study sexual risk behavior while being inclusive of people who would never identify as LGBTQ+ (Benoit, Pass, Randolph, Murray, & Downing Jr., 2012). Public health research is especially interested in MSMW in urban poor communities of color because they can be HIV "infection bridges" between high-risk "cores" of MSM (men who have sex with men) and women who would presumably not necessarily be at high risk except for their contact with MSMW (Friedman, Cooper, & Osborne, 2009). According to one count, the number of research articles describing bisexuality as an infection bridge outnumbered those addressing it as a legitimate identity category (Wolff et al., 2017). The mere existence of the "infection bridge" line of inquiry helps support the conservative anti-LGBTQ+ narrative within urban poor communities of color that HIV is an LGBTQ+ problem, one which may be addressed by – or provide a convenient reason for – fiercely oppressing people based on their sexual orientation and gender (Stanford, 2013).

Homophobia

One case in which scientific authority to define terms really served to empower LGBTQ+ people is the concept of homophobia. Homophobia is the idea that people with anti-LGBTQ+ prejudice, not LGBTQ+ people themselves, are the ones with a problem. The concept supposedly first emerged in George Weinberg's *Society and the Healthy Homosexual* (1972, p. 1), where Weinberg, who was heterosexual himself, said, "I would never consider a patient healthy unless he had overcome his prejudice against homosexuality." He went on to assert that "homosexuals" could be healthy and that the real mental health problem was society's prejudices. In later work, he called that prejudice "homophobia," defined as "The dread of being in close quarters with homosexuals – and in the case of homosexuals themselves, self-loathing" (quoted in Herek, 2017). One possible objection to the "-phobia" formulation is that, like homosexuality itself, homophobia cannot reasonably be called a mental illness if it is broadly prevalent among well-functioning members of the society (Colwell, 1999). Research finds that, while it might not be a mental illness, it is definitely a prejudice which, like other prejudices, causes people to make judgments that are automatic, intuitive, not necessarily based on conscious principled reasoning (Callender, 2015), and sometimes destructive. Terms other than homophobia have been tried over the years, e.g., homonegativity (Berg, Munthe-Kaas, & Ross, 2016), but "homophobia" has persisted.

Constructivism and Critical Theory

Alfred Kinsey (Kinsey et al., 1948; Kinsey et al., 1953) and Evelyn Hooker (Hooker, 1957) laid the foundation for a growing scientific consensus about LGBTQ+ persons, but scientific consensus is usually not enough to change policy, practice, and public opinion on politically charged issues. When the American Psychiatric Association (APA) finally removed homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1973 (Drescher, 2015), they did so because other intellectual and grassroots movements had forced the issue. These movements were part of a broader trend of social forces that drew attention to oppression and abuse that occurred under the auspices of psychiatry and which eventually dislodged psychiatry from its role as society's chief arbiter of psychological abnormality (Bayer, 1987). These forces established new norms for discourse about psychological issues, which included respecting people's authority about their own experiences, describing them in terms that their identity groups chose and which they find empowering, and scrutinizing research, theory, and all other generalizable knowledge for how it might even subtly serve the interests of oppression. These ideas are not fundamental to empirical science, but they are consistent with constructivist and critical intellectual traditions. It is constructivist and critical perspectives that frame modern progressive conceptualization of LGBTQ+ issues.

Depathologizing Homosexuality and Debunking Sexual Orientation Change Efforts (SOCE)

As of 1969, the year of the Stonewall riots, the authoritative psychiatric work on homosexuality was Irving Bieber's *Homosexuality: A Psychoanalytic Study of Male Homosexuals* (1962). He said "A homosexual is a person whose heterosexual function is crippled, like the legs of a polio victim" (quoted in Myers, 1981). According to his wife, he really thought he was helping people by suggesting that same-sex attracted men should receive treatment rather than punishment (National Public Radio, 2002), even though many of the available treatments involved apparent punishments like electric shocks. Psychologist Gerald Davison helped introduce orgasmic reconditioning (Abumrad, 2018). This was probably less unpleasant but still wholly ineffective (Conrad & Wincze, 1976). There was little hope during the Stonewall Era that the APA would change its ideas about homosexuality on its own. Even gay psychiatrists

thought they were hypocrites on some level for trying to support patients toward wellness when they were not well themselves (National Public Radio, 2002). The impetus to change came from LGBTQ+ activists who saw the stigma of mental illness as a major barrier to their rights and made depathologization of homosexuality a primary goal. They attended psychology and psychiatry conference presentations about conversion therapy, including one by Bieber in San Francisco in 1970. They were not there to debate politely with the speakers but to disrupt sessions and stop normal proceedings from going forward, just as the conversion therapists' ideologies stopped LGBTQ+ persons' normal lives from going forward. Activists also published notable conversion therapists' home addresses, putting conversion therapists in fear during their daily lives, just as conversion therapists' ideologies empowered law enforcement and other entities to put LGBTQ+ people in fear during their daily lives (Bayer, 1987; National Public Radio, 2002).

An exception to this demeanor was Charles Silverstein, then a Ph.D. student at Rutgers. Silverstein found Gerald Davison at a conference in New York and invited him to a workshop. At the workshop, Silverstein was one of three people presenting to a packed audience. Silverstein shared the following:

> To suggest that a person comes voluntarily to change his sexual orientation is to ignore the powerful environmental stress, oppression if you will, that has been telling him for years that he should change. To grow up in a family where the word homosexual was whispered, to play in the playground and hear the words faggot and queer, to go to church and hear of sin, and then to college and hear of illness, and finally to the counseling center that promises to cure, is hardly to create an environment of freedom and voluntary choice. What brings them into the counseling center is guilt, shame, and the loneliness that comes from their secret. If you really wish to help them freely choose, I suggest you first desensitize them to their guilt. After that let them choose. But not before. (Abumrad, 2018)

By listening to Silverstein's presentation, Davison accepted an LGBTQ+ person's authority to define his own experience. This helped guide Davison's own thinking around to the modern progressive idea that a clinician should not even entertain the idea of whether they could help someone change their sexual orientation, because that is the wrong question to ask. A clinician should consider it inappropriate to even try to help a client change their sexual orientation, because keeping that possibility alive contributes to the oppression of LGBTQ+ people (Abumrad, 2018). Silverstein went on to become the founding editor of the *Journal of Homosexuality* and win a lifetime achievement award from the American Psychological Foundation ("Gold medal award for life achievement in the practice of psychology: Charles Silverstein," 2011).

From Dysphoria to Diversity: Debunking Gender Identity Change Efforts (GICE)

David Reimer, born in 1965 as Bruce Reimer, one of a pair of twin brothers, was also assigned the name "Brenda" by his parents and "Joan" in case study reports. At 8 months of age, David lost his penis in a botched circumcision. Dr. John Money at the Johns Hopkins' Gender Identity Clinic persuaded David's parents to have him surgically reassigned as female and to raise him as a girl. Money's theory – consistent with social constructionist ideas that predominated at the time – was that gender comes from how someone is raised and taught and that it has no innate biological component. In David and his brother (called "John" in Money's writings), Money found the perfect twin study to illustrate his theory. Money wrote several research reports about the happy upbringing of "John/Joan" as a well-adjusted twin brother and sister pair. These writings gave the medical community all the evidence they needed to make it standard practice to surgically reassign babies as female if, like David's, their genitalia were damaged or if they did not fit the standard definitions for male or female (referred to as anatomical "intersex" conditions, see American Psychological Association, 2006). Physicians and families moved forward with these surgeries in full confidence that these children would be happy raised as girls (Colapinto, 2000).

According to later accounts that use David's own name and voice, he was never happy as Brenda. He was bullied at school (Associated Press, 2004) and also unhappy about office visits with Money, which involved genital examinations of the twins and rehearsed sex acts between them, ostensibly to support their healthy gender identity development. When David was 13, he told his parents that he would kill himself if he ever had to see Money again. When David was 14, his parents finally told him the full story. David set aside the name Brenda (modern trans persons sometimes use the term "dead name" to refer to a previous name that they held under a different gender which they associate with so many painful experiences), took on the name "David," and underwent female-to-male sex reassignment surgery. When *Rolling Stone* reporter John Colapinto broke David's story (2000), David's case again revolutionized medical practice, this time in the direction of not doing surgery until the child's true gender becomes apparent and the family can make an informed decision. In 2004, David, struggling under financial problems, depression, and a failing marriage, died by suicide (Associated Press, 2004). In that same year, a study of males born with cloacal exstrophy who were surgically assigned to female sex at birth appeared in the *New England Journal of Medicine* (Reiner & Gearhart, 2004). In firm repudiation of Money's theory, for which David had suffered so much, the majority of study subjects reported male gender.

David's experience illustrates how trans persons cannot be expected to see debates over GICE as a scholarly intellectual exercises when the outcomes materially affect their lives. J. Michael Bailey's (2003) *The Man Who Would Be Queen: The Science of Gender-Bending and Transsexualism* described two major categories of male transsexuals. One was "autogynephiles," or men sexually aroused by the thought of themselves as women. The other included men who were attracted to other men but were so feminine that they simply found it easier to present as women. The book, in modern parlance, was "tone-deaf," and it outraged transgender communities. Bailey's children were harassed online, and activists compelled his institution to conduct an (ultimately unsubstantiated) investigation of him (Dreger, 2008). A similar story involves Kenneth Zucker, head of the Gender Identity Service at Toronto's Centre for Addiction and Mental Health (CAMH). His clinic favored assessing "gender dysphoric" children intensively before any medical intervention to make sure that they would not regret the procedures. This approach drew ire from activists, who opposed any practice based on thinking about transgender identity as anything other than a naturally unfolding process. They accused Zucker (incorrectly) of practicing conversion therapy on his patients and persuaded CAMH to fire him in 2015 (Singal, 2016). These activists were arguably repudiating the "etic perspective" of empirical science, in which the researcher is an outside and impartial observer, and imposing the "emic perspective" connected with constructivist and critical thinking, in which a researcher is expected to represent a group from an insider's point of view and sometimes to suffer alongside them.

Our Modern, Progressive Conceptualization of Sexual Orientation and Gender

Conservative anti-LGBTQ+ psychoanalyst Irving Bieber's wife, complaining about her husband having been called a "motherf***er" at a Stonewall Era scientific meeting said, "This is not how you conduct a discourse" (National Public Radio, 2002). She may have been right about scientific discourses. However, what has arisen since the Stonewall Era is a different kind of discourse, one which does not depend so strongly on empirical science for its validity and is instead based on principles of constructivism and critical theory. In this discourse, authority over how to represent LGBTQ+ people rests with LGBTQ+ people themselves. Ideas that represent LGBTQ+ persons in a way that they would not choose to be represented and/or that contribute to their oppression are not only intellectually invalid, but morally questionable. Empirical science now no longer carries the burden of being the objective

arbiter of validity, because everything that is known about any complex social issue is acknowledged to have been filtered through the subjective experience of the observer and/or the person being observed (Ayala, 2017; Jackson & Scott, 2010). Empirical science is understood to be inherently limited by available technology and survey sample sizes and by the fact that it has been required to refute conservative anti-LGBTQ+ ideologies so often over the years that its priorities, to a significant degree, have been set by conservative anti-LGBTQ+ ideologues (Diamond & Rosky, 2016). Despite these limitations, empirical science is a welcome voice at the table. Conservative anti-LGBTQ+ work tends to be unwelcome, even when it appears in scholarly journals (e.g., Cameron & Cameron, 1998; Jones & Yarhouse, 2011; Mayer & McHugh, 2016; Regnerus, 2012), because it almost always advocates for ideas that contribute to LGBTQ+ oppression and/or co-opts LGBTQ+ persons' authority to define their own experiences.

Modern commonly used terms about sexual orientation and gender are as follows: *Gay* refers to a same-sex attracted man identified with a gay community. *Lesbian* as a term and social symbol has been hotly debated among lesbian, feminist, and women's rights thought leaders over the years (e.g., Zita, 1981), but it generally means a same-sex attracted woman identified with lesbian community. *Bisexual* refers to someone who has romantic and/or sexual attractions to people of more than one sex. Within the *gray-a* spectrum between asexual and *verisexual* (Galupo, Lomash, & Mitchell, 2017), there are *demisexuals* whose sexual attraction is conditional upon a strong romantic connection, *aromantics* who simply want no romantic connections, and *lithromantics*, who like sex and romance but do not want to personally participate in either, at least not in real life. *Intersex* refers to anyone born with genitalia that are not wholly male or female. *Transgender* refers to someone who identifies with and/or self-presents as the opposite gender along the male-female binary from the sex they were assigned at birth. Transgender persons may be *preoperative*, *postoperative*, or, if they never intend to get gender assignment surgery, *nonoperative*. *Transsexual* refers to someone born male or female who experiences gender dysphoria unless or until they can present as (respectively) female or male, engaging surgical intervention if necessary. A *transvestite* is usually a male who derives pleasure from dressing as a female. Because *transsexual* and *transvestite* used to refer to psychological diagnoses and still refer to binary gender, they are not used much. Someone who does not feel like they are male, female, or anything in between may be *nonbinary*, *agender*, or *genderqueer*. *Queer* was once a reappropriated term for all LGBTQ+ people, but it has since come to refer to specific ideological and intellectual alignments, e.g., "queer theory."

Conservative Anti-LGBTQ+ Ideologies

Conservative anti-LGBTQ+ ideologues often represent themselves as the voices of oppressed groups whose religious freedom is under attack. This is just one of many talking points generated by the conservative anti-LGBTQ+ ideology industry, which is a well-funded and well-coordinated worldwide movement that is very much on the offensive. The Global Philanthropy Project's *Religious Conservatism on the Global Stage: Threats and Challenges for LGBTI Rights* lists 14 US-based organizations with nongovernmental organization (NGO) status at the United Nations – most obtained it in the last 20 years – whose work includes promulgating conservative anti-LGBTQ+ ideologies. The same report also follows the work of one of the oldest and most prolific anti-LGBTQ+ organizations, the Roman Catholic Church (Peñas Defago, Morán Faúndes, & Vaggione, 2018). These organizations follow essentially the same core ideological formula that the American Religious Right did during the Culture Wars (Dobson, 2001; Herman, 1997; Kinney, 2014; Rosik, 2014) while tailoring their message to specific national, regional, and cultural audiences through "glocalization" (Peñas Defago et al., 2018). Conservative anti-LGBTQ+ ideologies are many and varied, and their promulgators readily disavow specific beliefs if they

think this will improve reception of their overall message. Their overall message has certain reliable common threads, though, along with culture-universal issues that it addresses and goals that it advances.

Raising the Specter of Child Sexual Abuse: While Covering up the Reality

Modern progressive concepts of LGBTQ+ issues are decades old, and the evolutionary history of LGBTQ+ persons encompasses millennia. Understanding conservative anti-LGBTQ+ views requires a perspective reaching back centuries, to the origins of theological documents currently held to be authoritative. It is sometimes said that these theological documents were written before egalitarian same-sex relationships were a known phenomenon, but this is a misunderstanding. The Byzantines, for example, acknowledged "adelphopoiesis," and Christian churches had ceremonies for it starting in the seventh century. The major difference between traditional and modern societies that affects conceptualization of LGBTQ+ issues is the status of women and children. In Byzantine society, women were carefully controlled commodities, and their movements were highly restricted. If men wanted to engage in pursuit and conquest of objects who did not have male secondary sex characteristics (i.e., beards) that would make them both sexually unappealing and social equals, then they had to pursue boys (Morris, 2016). A present-day equivalent would be the Afghani practice of *bacha bazi*, depicted in *The Kite Runner* (Hosseini, 2003). The Taliban is said to have banned *bacha bazi* under Sharia law, but the relatively lighter hand of American occupation has struggled to suppress it (Special Inspector General for Afghanistan Reconstruction, 2017).

Roman Catholicism often regards Saint John Chrysostom's (347–407 AD) pronouncement that men who have sex with men are "worse than murderers" to be the received wisdom of the early church. The statement could be dismissed as the product of a more ignorant time, but it is more useful to examine it in historical context. In Chrysostom's society, male students were expected to submit to their tutors' sexual attentions if they wanted the education that would allow them to advance in society. Chrysostom's own tutor had a bad reputation for pederasty and other immoral behavior. Society frowned upon pederasty, but not to the point of going too far out of their way to stop it, because that would have interfered with a key element of institutionalized patriarchy, which is that adult men of a certain standing may do whatever they want to the people over whom they have power. Chrysostom went on to become bishop of Constantinople, well-positioned to stop whatever had happened to him from happening to other people (Morris, 2016). His story resonates with that of John White, who wrote *Eros Defiled* (White, 1977) for InterVarsity Press, the publishing arm of evangelical college ministry InterVarsity Christian Fellowship. White begins his strongly condemnatory chapter about homosexuality with an account of his own unwanted sexual relationship with a Christian youth worker during his early teens. A related account might be that of Paul Cameron. A research psychologist by training, he began his career as a conservative anti-LGBTQ+ ideologue in 1982 by speaking out against an LGBTQ+ rights initiative in Lincoln, Nebraska, telling an apocryphal story of a local 4-year-old who was dragged into a public bathroom and castrated by a gay man. Cameron went on to spend a long career producing transparently flawed "research" supporting conservative anti-LGBTQ+ ideologies (e.g., Cameron, 1985). Eventually, in an interview, he mentioned his own unwanted sexual encounter at age 4 with an older boy (Southern Poverty Law Center, n.d.; Harkavy, 1996)

Anti-LGBTQ+ ideologues work diligently to connect LGBTQ+ people with child sexual abuse. Their concern for children resonates with a fundamental moral opprobrium against child sexual abuse that can be expected to exist in any society where children are sexually abused. The outcome that appears to concern them most deeply is not post-traumatic stress, but that children abused by (or even just exposed to) LGBTQ+ persons grow up to become LGBTQ+ themselves

(Cameron, 1985; Dobson, 2001; Regnerus, 2012). If there is any actual connection between abuse and being LGBTQ+, it is probably that abusers disproportionately focus on gender nonconforming children (Xu & Zheng, 2017), perceiving them to be easier targets because of their oppressed status under conservative anti-LGBTQ+ ideologies. Conservative anti-LGBTQ+ organizations' professed concern for children in their ideology cannot be reconciled with their regular failure to protect children in reality. The Roman Catholic Church (Martel, 2019), Orthodox Jewish communities (Otterman & Rivera, 2012), the Jehovah's Witnesses (Avery, 2019), and even the Boy Scouts (who were effectively a conservative anti-LGBTQ+ organization until their policy change in 2014, see Dockterman, 2019) historically dealt with child abuse administratively, as an internal matter, while hesitating to take measures like handing abusers over to the police that would have stopped them from abusing again. Both conservative LGBTQ+ organizations' messaging and their practice around LGBTQ+ persons and child sexual abuse do not serve the welfare of children but that of their organizations, leaders, and movements.

LGBTQ+ Persons Must Stay Within the Parameters of a Role Defined by Conservatives

In many contexts, LGBTQ+ persons are expected to stay hidden, i.e., "in the closet." This is probably especially noxious to transgendered persons, whose quality of life suffers if they have to "pass" as something other than their actual gender or if they have gender-confirming surgery withheld from them (e.g., Kuruvilla, 2019). Some conservative anti-LGBTQ+ contexts prefer for LGBTQ+ persons to hide, as it were, in plain sight. The following is from an essay by Michael Eric Dyson:

> One of the most painful scenarios of black church life is repeated Sunday after Sunday…A black minister will preach a sermon railing against sexual ills, especially homosexuality. At the close of the sermon, a soloist, who everybody knows is gay, will rise to perform a moving number…The soloist is, in effect, being asked to sign his theological death sentence…Ironically, the presence of his gay Christian body at the highest moment of worship also negates the preacher's attempt to censure his presence, to erase his body, to deny his legitimacy as a child of God. (Dyson, 1997, pp. 104–105)

If LGBTQ+ people play their part effectively, they become benign within a conservative anti-LGBTQ+ milieu (Quinn, Dickson-Gomez, & Kelly, 2016). Sometimes this even certifies them to play supportive roles in the lives of children, as in the case of the Samoan fa'afafine, who are a clearly demarcated third-gender group (VanderLaan et al., 2013; Vasey & VanderLaan, 2010). Where LGBTQ+ people cannot hide, because they were "outed" or cannot "pass" effectively or make themselves uniquely useful, they can at least play a role that seems to be necessary in many social contexts, which is a target for abuse. An example of this is the American child welfare system, where a classic study reports that about half of LGBTQ+ clients left for the *relative safety* of the streets at some point (Mallon, 1998). Where LGBTQ+ persons do not have to go out of their way to make themselves especially useful or visible, this empowers them and threatens conservative anti-LGBTQ+ ideologies. The advent of the straight-acting, straight-appearing "clone" as the self-presentation ideal for gay men, rather than the "fairy" or other options from earlier years, supposedly increased the level of threat that American society experienced from gay men, because people could no longer tell who was gay (Harris, 1997).

Playing their part effectively can also offer closeted persons compensations and opportunities that would be hard to obtain otherwise. According to Frédéric Martel's *In the Closet of the Vatican: Power*, *Homosexuality*, *Hypocrisy* (2019), which Pope Francis supposedly read and liked (Giangravè, 2019), the ranks of the Roman Catholic clergy are full of men who found redemption for their same-sex attractions and gender atypicality through full-time service to the church. The church, over the millennia that it has existed, has become a place where such men could hide in plain sight, like the soloist in

Dyson's essay. Martel (2019) describes episcopal entourages of attractive young men, vestments that explode the boundaries of male gender expression, and voracious patronage of male sex workers paid with collection plate money. To protect the subculture that Bishop Morlino called out in his letter (2018), the Vatican has kept up a rigorous and ruthless campaign of hypocritical anti-LGBTQ+ activism – employing political skills of high-level officials whose résumés include close working relationships with the Augusto Pinochet regime and the Medellín Cartel – and a strict *omertá* about clerical sexual indiscretion. This last has had, as aforementioned, the unfortunate side effect of protecting countless child abusers (Martel, 2019).

The price of closeted life is well-known to developmental psychology. Before Mel White came out of the closet, he was a ghostwriter for Jerry Falwell, Pat Robertson, Billy Graham, and other American Christian conservative anti-LGBTQ+ figures. Coming out forced him to change careers, but it also put an end to his painful struggle with a hypocritical double life where he could never have the experience of an authentically intimate relationship and grow from that (White, 1994). Many men of his generation chose to pay the price. The effect may be seen through the eyes of Francesco Mangiacapra, a high-class escort in Naples and Rome who was one of Martel's (2019) informants:

> Among priests…there are the ones who feel infallible and very strong in their position…Their desire is so repressed that they lose their sense of morality and any sense of humanity. They feel they're above the law. They aren't even afraid of AIDS!"…The second type…"They're priests who are very uncomfortable in their own skin. They're very attached to affection…they have a terrible need for tenderness. They're like children." These clients…often fall in love with their prostitute and want to "save him. (Martel, 2019, p. 146)

Closetedness regimes within the American Christian Right (Herman, 1997), the Black church (Stanford, 2013), the Roman Catholic Church (Martel, 2019), and traditional societies (Norman et al., 2016) are mainly concerned with the regulation of male desire and self-expression for the preservation of male-dominated power structures. They are little concerned with women's rights, needs, or desires except insofar as they affect men's (Herman, 1997; Martel, 2019); this is one way in which they offer women of all sexual orientations a relative degree of freedom.

SOCE and GICE are a Benign, Reliable Path to Redemption: For Anti-LGBTQ+ Ideologies

In 2004 and 2005 (respectively), 19-year-old Garrard Conley and 16-year-old Zach Stark went through residential programs run by Love in Action, an Evangelical Christian ministry that purported to be able to turn gay teenagers straight. At the time, unaccountable, profiteering residential facilities for adolescents were a growing national scandal (Government Printing Office, 2008). Conley's story is depicted in the 2018 film *Boy Erased* and Stark's story in *This Is What Love in Action Looks Like* (Fox, 2011). Their treatment did not feature the electric shocks or orgasmic reconditioning of earlier decades of SOCE (Streed, Anderson, Babits, & Ferguson, 2019). Instead, it involved intensive training for closeted life. Workers policed every mannerism and accoutrement, even classical music CD's (Fox, 2011). Participants also engaged in psychotherapy-like group sessions that required them to be entirely transparent and honest about themselves and also to accept a narrative about how their family dynamics led to their same-sex attractions – even if that narrative was a total lie (Abumrad, 2018). *Love in Action's* Director John Smid (the inspiration for Victor Sykes in *Boy Erased*, see Goldstein, 2018) left Love in Action in 2008, apologized for his involvement with SOCE in a 2010 blog post (Smid, 2010), and married his same-sex partner in 2014 (Phillips, 2014). Other SOCE practitioners who have become "ex-ex-gays" include McKrae Game of Hope for Wholeness (Ring, 2019), David Matheson of the Church of Jesus Christ of Latter-Day Saints (Compton, 2019), and John Paulk of Exodus International and Focus on the Family (Paulk, 2013). Michael Bussee and Gary Cooper, who helped found Exodus International in 1976,

left the organization to begin their life as a couple in 1979 (Bussee, 2013). Norman Goldwasser, a private practitioner who has published articles advocating for SOCE, was personally "outed" via a gay hookup app by Wayne Besen, of LGBTQ+ advocacy organization Truth Wins Out (Leanos Jr. & Sopelsa, 2018).

Across all methodologies and target populations past and present, SOCE and GICE have proven to be ineffective at their stated goals and potentially harmful to patients. A recent *New England Journal of Medicine* editorial asks why it is taking so long for these practices to be wholly abandoned (Streed et al., 2019). One possible answer to this is that the real goal of SOCE and GICE is not to change anyone's gender or sexual orientation. Rather, SOCE and GICE exist when and where they help uphold conservative anti-LGBTQ+ ideologies. Countries that are so homophobic and transphobic that they consider the death penalty for LGBTQ+ people (Peñas Defago et al., 2018) have little use for SOCE and GICE. Americans, however, tend to resist oppressive ideologies that cannot be convincingly couched in rhetoric that allows people to act on those ideologies and still be seen as good people (MacLean, 2017). Conservative anti-LGBTQ+ ideologies, in particular, tend not to be popular with Americans who think that acting on these ideologies amounts to oppressing people for something they cannot change. SOCE and GICE are necessary to marketing conservative anti-LGBTQ+ ideologies in America because they represent "hope" that LGBTQ+ people can change (Diamond & Rosky, 2016).

Conservative anti-LGBTQ+ ideologues find various ways to defend SOCE and GICE to the public. One is false balance or "bothsidesism," in which they offer a handful of flawed, biased empirical studies or just an ideological position and ask people to consider it as an equally valid counterpoint to the scientific consensus (e.g., Jones & Yarhouse, 2000). Another is through borrowing the language of constructivism and critical theory. A common refrain is to point out that many SOCE or GICE clients know what they are getting into and do it anyway. According to conservative anti-LGBTQ+ ideologues, what these clients learn in the work itself, and/or the social benefits of having gone through it, genuinely helps them function in ideologically conservative environments; therefore, SOCE and GICE should not be taken away from them (Jones & Yarhouse, 2011). A third defense of SOCE and GICE is by grounding arguments in scholarly and religious authorities other than science or the modern dominant discourse. Roman Catholic writers continue to theorize about sexual orientation and gender using their own philosophies and dogmas, not really taking scientific (or scriptural, see Cheng, 2011) challenges seriously (Kinney, 2014). They and other conservative anti-LGBTQ+ organizations might be embroiled in scandal, and many of their adherents might dismiss them as oppressive and out of touch, but they risk damaging their brand even further if they admit that they were ever wrong (Martel, 2019). A fourth defense is traditional values. The Black church developed its ideologies about LGBTQ+ issues in contexts where male strength had to be respected and where men who were not strong – and women who were not attached to men, nor viable to be such – risked being victims. A parent, pastor, teacher, or anyone else who did not police children's and youths' gender and sexuality was failing them (Stanford, 2013). Strictures like this exist in many conservative, traditional countries and cultures (Norman et al., 2016; Peñas Defago et al., 2018).

The Ultimate Moral Authorities Are Money and Power

The sixth-century Justinian Code called for spectacular executions of people convicted of homosexuality. This probably pleased the conservative masses and made them more likely to accept other things about the Code. It is unclear whether any such executions ever happened. The state instead pursued civil forfeiture, as in present-day American drug enforcement. The Justinian Code's conservative anti-LGBTQ+ provisions allowed the state to bankroll itself by charging wealthy people with homosexuality

and seizing their assets (Morris, 2016). The modern American political conservative establishment did not seriously take up anti-LGBTQ+ ideology until the late 1970s (M. White, 2006). America has always had vast, well-coordinated, and well-funded network of think tanks and other institutions dedicated to creating apologia for political conservative and libertarian causes (MacLean, 2017), but the Civil Rights Era had brought it to a crossroads by diminishing the political appeal of racism. Fortunately – for them – the convergence of social forces like the AIDS epidemic and generational guilt about "latchkey kids" made it the right moment to try the time-honored formula of anti-LGBTQ+ ideologies (Hall, 2013; Twenge, Sherman, & Wells, 2015; White, 2006). As the LGBTQ+ rights movement has come to dominate many fronts in the American Culture Wars, conservative anti-LGBTQ+ organizations have maintained their relevance and their business model by turning their efforts abroad. A popular refrain there is that it is not the anti-LGBTQ+ ideologues who are the American colonizers but rather the LGBTQ+ activists born in those countries, who are pushing back against levels of persecution that did not exist before American organizations got involved (Peñas Defago et al., 2018).

Conclusions and Implications for Violence Against LGBTQ+ Persons

The major families of concepts about LGBTQ+ issues reviewed in this chapter – empirical, scientific, constructivist/critical, and conservative anti-LGBTQ+ – may be understood in terms of competing end goals. In a perfect world from the perspective of empirical science and constructivist/critical theory, LGBTQ+ persons would be called what they wanted to be called, according to labels that their communities had chosen for them. All generalizable knowledge about gender and sexuality would be scrutinized for how it might help serve the interests of oppression, even subtly or unintentionally. People might study sexual orientation and gender identity from a place of benign interest, the way they study birth order or handedness, but there would be no political urgency. Society would not go beyond concerns of consent and public health in putting limits on sexuality and gender, understanding this to interfere with well-being (Hammack, Frost, & Hughes, 2019). The boundaries of identities and expressions respected under the auspices of sexual and gender diversity would expand to include mostly heterosexuals (Savin-Williams, 2017), bromantics (Anderson & McCormack, 2014), people who just like to call themselves "queer" (Better, 2014; Hammack et al., 2019), people who are into leather (Better, 2014), demisexuals, femboys, drag kings, eunuchs, people with unwanted experiences, people with no experience, and almost anyone and everyone, until the distinction of sexual/gender minority becomes meaningless.

Conservative anti-LGBTQ+ ideologues have their own vision for a perfect world, rooted in antiquity. Conservative anti-LGBTQ+ ideologies support male strength and entitlement in societies where these things are seen as necessary to personal safety and the social order (Stanford, 2013). They provide an empowering source of moral authority against child sexual abuse in contexts that are not willing to contravene traditional patriarchal ideologies to the extent of taking effective measures against child sexual abuse (Martel, 2019; Morris, 2016; Peñas Defago et al., 2018). In conservative anti-LGBTQ+ ideologues' perfect world, men of a certain standing may do what they want, while religious figures and other ideologues loyal to them say whatever they must to sell the public on the idea. Details like the death penalty, SOCE/GICE, and women's rights, desires, identities, and most other things about women are left up to the locality (Peñas Defago et al., 2018); only feminist ideology is fiercely oppressed (Herman, 1997). An example of their perfect world would be the Roman Catholic Church's stance against condoms, taken under Pope John Paul II. It has caused unnumbered AIDS deaths, unwanted pregnancies, and other suffering worldwide that disproportionately burdens LGBTQ+ people and heterosexual women. It was articulated by 12 powerful men, many of them in the closet and all of them under a vow of chastity (Martel, 2019).

This chapter has covered many society-wide struggles over conceptualization of LGBTQ+ people, and the last thing that must be said about them is that they are all still active fronts. Ibram Kendi observed, in the preface to the paperback edition of his seminal work on racism, "Dual and dueling forces" and that "racist progress has consistently followed racial progress" (Kendi, 2016, p. x); conservative anti-LGBTQ+ ideologies may similarly advance as well as retreat. Japan's Supreme Court in 2019 upheld a law forbidding transgender persons to change their names on government-issued identity documents unless they first have gender-confirming surgery. Many US states also require this (Allen, 2019). In 2016, conservative apologia journal *The New Atlantis* critically reviewed a broad swath of empirical research about LGBTQ+ issues. The authors predictably determined all evidence against all conservative anti-LGBTQ+ positions to be insufficient (Mayer & McHugh, 2016; Valdiserri, Holtgrave, Poteat, & Beyrer, 2019). One of the authors was the psychiatrist who closed Johns Hopkins' Gender Identity Clinic in 1979 (Shrier, 2019). Also in 2016, *Supergirl* star Jeremy Jordan went public with his struggle to get his 17-year-old cousin Sarah released from a "pray away the gay" facility (Williams, 2016). In 2017, 20/20 episode "A Boy Named Lucas" (2017) profiled religious youth homes where SOCE is one of the many services offered "with a Bible and sometimes a belt"; in 2019, a grand jury indicted the Texas couple who ran one of the homes for child trafficking (Assunção, 2019). Conservative anti-LGBTQ+ ideologues continue to prosecute, under the cover of concern for children and youth, an agenda that endangers children and youth, which ironically – and conveniently, for them – makes social environments more receptive to anti-LGBTQ+ agendas. The task of those who wish to stop violence against LGBTQ+ persons is to somehow break the cycle, calling out the positive effects of modern progressive ideas and the negative effects of conservative anti-LGBTQ+ ideas, while working to make society a place where everyone's identity and boundaries are respected.

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Internalized Homophobia and Transphobia

3

Lauren L. McLean

Abstract

Cultural narratives of our society surrounding gender identity and sexuality can provide a rigid narrative of these constructs leading to homophobia and transphobia toward individuals who identify outside of these constructs. This book chapter will explore how cultural narratives create homophobia and transphobia as well as how these phobias affect individuals within the LGBTQ+ community. Mental health practitioners need to be aware of the pervasive discrimination, prejudice, and violence toward LGBTQ+ persons as these acts can create clinical issues that present common problems for child, adolescent, and adult clients, their families, and their partners. Mental health practitioners may hold internalized biases and benefit from recognizing these biases and bracketing values so that they can more effectively work with, and be an ally for, LGBTQ+ clients. Furthermore, educators in the field of mental health can work to create affirming classroom settings and effectively prepare students to work with the LGBTQ+ community. This chapter will address these issues within the mental health community as well as strategies for clinicians to help clients heal from homophobia and transphobia.

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Social worlds drive the way people perceive themselves and their lives resulting in narratives, which are stories about ourselves and the meaning that we make behind events that occur in our lives. Aspects of a person's culture, social lives, and the historical period in which they exist affect their personal narratives and narrative possibilities. When the narratives between a person's social worlds and who they are clash, it can threaten their sense of self, creating interpersonal and intrapersonal conflict, as changing a life narrative undermines their sense of who they are, where they come from, and where they are going. As a result, mental health professionals need to be aware of historical, cultural, and social narratives that shape not only their own worldview but also their clients' worldviews and the power and privilege that lie beneath those views.

Gender is one ongoing narrative process that helps people to define who they are. People learn to read others' gender by learning which traits culturally signify genders. Thereby, people learn rules that lead to classifying individuals with a wide range of gender presentations into only two types of genders (male and female). Gender is so pervasive in society that assumptions are made that gender is genetic rather than a social construct that is constantly created, recreated, and redefined (Lorber, 1994). People are assigned a sex category at birth based on genitalia and outer appearance, which tends to become synonymous with gender and, moreover, sexual orientation.

E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_3

Assumptions are made that can put people into one of two binary gender and sexual orientation categories, and people operate under the assumption that there are rules and attributes for deciding gender and sexuality that mainly rely on culturally established norms to understand, attribute, and display gender and sexuality (Lucal, 1999). From then on, things like names, manner of dress, who people love, who people are attracted to, and uses of other gender markers are aligned with this assigned sex category. Displays of gender are also used to lead others to make decisions about what gender and sexual orientation someone is through things like hair, clothing, and makeup. The signs and signals that a person provides to notify others that they identity with a certain gender (and assumed sexual orientation) are so ubiquitous that people fail to notice them unless something is missing or does not conform to how society perceives a certain gender to look and act. Almost every aspect of individuals' lives revolves around gender including interactions with children, puberty, parenting styles, teaching styles, work, division of labor, allocation of goods and services, values, music, art, stories, games, achievements, relationships, sexual expression, and so on, which often helps people to establish order and organization within their own narrative. These gender and sexuality norms are then enforced by subtle sanctions of gender inappropriate behavior by society or a more overt and formal punishment (or threat of punishment) by those in society or in a position of authority (Lorber, 1994), which can stem from homophobia and transphobia.

Gender and sexual inequality have different constructs and different influential causes at any given historical moment. Because gender is a social construct, there may be differences in someone's sex, gender, self-identity, presented identity, perceived identity, and sexual orientation. A person who does not establish a traditional gendered appearance, or sexual and romantic preference, faces challenges to their identity and status, as it is difficult to avoid being labeled as a desired gender because people categorize others as a specific gender regardless of their feelings about such labels. Those whose gender does not match their biological sex can experience a problem of not living up to the prototype of their gender set up by society and may encounter problems with preserving their gender identity to the outside world (West & Zimmerman, 1987), which, again, can be influenced by homophobia and transphobia.

Additionally, members of society recognize that their behaviors, mannerisms, looks, relationships, and so forth are subject to scrutiny and comment, both positive and negative. Therefore, people act around the fact that they are subject to accountability of how they look and how they might be characterized and begin to internalize the messages that they receive about themselves from those around them. If these internalized messages are negative, members of the LGBTQ+ community may begin to experience disempowerment, disenfranchisement, and mental health issues. Add to this the manifestation of inequality, prejudice, and discrimination that can arise from being part of diverse intersecting identities, such as race, gender, and sexual orientation, and an individual may encounter further disempowerment, disenfranchisement, and mental health disorders (Risman, 2004). For LGBTQ+ clients who receive contradictory narratives of aspects of themselves, like sexual attraction and behavior and gender identity and expression, that can arise from homophobia and transphobia, they may experience an impeding of their overall sense of self and identity development (Mair, 2010). Therefore, it is important to explore the impact of internalized homophobia and transphobia on the mental health of the LGBTQ+ community and what mental health professionals can do to address this issue.

Internalized Homophobia and Transphobia Defined

Homophobia can be defined as an irrational fear of, aversion to, or discrimination against homosexuality or homosexual individuals or a dislike and irrational hatred that is strong and unreasonable against those that identify as gay (Homophobia, 2018). Much like homophobia,

transphobia is an irrational fear of, intense hatred toward, aversion to, or discrimination against transgender people (Transphobia, 2018). Internalized homophobia, also known as internalized homonegativity, occurs when a sexual minority person has negative feelings and homophobic attitudes (either overt or covert) toward themselves and others who are sexual minorities as a result of social bias and outward homophobia toward them (Szymanski, Kashubeck-West, & Meyer, 2008). As those within the LGBTQ+ community continue to receive outward negative messages against them, they begin to internalize those messages to accept and endorse this sexual stigma as part of their value system and self-concept. This leads to beliefs that they deserve to be, or should be, stigmatized for being a sexual minority (Herek, Gillis, & Cogan, 2009). Internalized homophobia is a type of homophobia that occurs within an LGBTQ+ individual that is often associated with self-loathing and self-hatred leading to controlling what they do, what they say, and how they express themselves, particularly to avoid discrimination (Newcomb & Mustanski, 2010). Internalized transphobia refers to the same feelings and processes as internalized homophobia; however, these feelings and processes are regarding the individual being transgender. Many individuals experiencing internalized homophobia and transphobia may not be aware that they are experiencing this phenomenon or that it is influenced by social processes and narratives. They simply know that they hate part of themselves and are ashamed of it.

Effects of Internalized Homophobia

The effects of homophobia and transphobia stemming from societal, cultural, and institutional norms that are non-affirming for LGBTQ+ individuals are far reaching. There is a higher prevalence of mental disorders caused by excessive social stressors related to stigma and prejudice, a phenomenon that is also known as minority stress, which is disproportionately more prevalent within the LGBTQ+ population (Meyer, 2003). Minority stress can stem from objective outside events and situations, such as a hate crime, internal processes, subjective perceptions, and a person's evaluation of the situation or a combination of external and internal factors. External heterosexism from sociocultural norms, prejudicial events, and discriminatory situations may develop into internalized homophobia for many individuals. Indeed, more experiences of heterosexist discrimination were related to higher levels of internalized homophobia, which, in turn, is related to greater psychological distress (Szymanski, Dunn, & Ikizler, 2014. Individuals may internalize negative messages about being part of the LGBTQ+ community and are psychologically more vulnerable when experiencing heterosexist discrimination (Szymanski & Mikorski, 2016). Furthermore, victimization is related to greater instances of internalized homophobia, as victimization increases individuals' feelings of shame and discomfort with themselves as sexual minorities (Puckett, Newcomb, Garofalo, & Mustanski, 2016). In addition, if an individual is more self-critical, ruminates, is self-blaming, is coping with multiple minority stressors, and is less connected to the sexual minority community, they are at greater risk for internalized homophobia and psychological distress (Puckett, Levitt, Horne, & Hayes-Skelton, 2015; Szymanski et al., 2014).

Other factors, such as difficulty talking about stressors and life difficulties and self-esteem that is derived from one's social groups, can impact the development of internalized homophobia (Mason, Lewis, Winstead, & Derlega, 2015). For gay men, internalized homophobia can be a mediating factor between childhood physical abuse, depression, and PTSD symptoms as well as contributing to gender role conflict (Gold, Feinstein, Skidmore, & Marx, 2011; Szymanski & Mikorski, 2016). With regard to PTSD symptoms in particular, internalized homophobia can increase the severity of symptoms by creating more withdrawal behaviors, such as isolating, in order to avoid feelings of shame about themselves (Straub, McConnell, & Messman-Moore, 2018). Internalized homophobia can also increase anxiety, depression, more HIV risk behaviors, less relationship satisfaction, and intimacy issues

(Thies, Starks, Denmakr, & Rosenthal, 2016). As internalized homophobia creates more depression and shame and depression and shame, in turn, create more relationship issues, it can affect gay men's commitment levels, and it could potentially lead to more sex partners (DeLonga et al., 2011; Greene & Britton, 2015). These relationship problems were both for those not in relationships and those that are in relationships and are independent of "outness" and how connected individuals are to the community (Frost & Meyer, 2009).

In addition, relational aggression and relational victimization can be common in gay male relationships, and gay men who report higher levels of relational aggression also tend to report higher levels of relational victimization and higher levels of internalized homophobia. This may lead to gay men "outing" other gay men representing a potential defensive response stemming from this internalized homophobia. It appears that the disproportionate use of relational aggression to negatively critique, judge, and police sexual and gender expression represents common stress coping mechanisms of self-belittling and identification with those that victimize the LGBTQ+ community (Kelley & Robertson, 2008).

If an individual identifies as a member of more than one minority group, this can lead to additional stress and trauma due to discrimination and prejudice toward each minority identity; individuals can also experience interactional stress and trauma as a function of the intersection of multiple minority identities. In addition, those that identify with a cultural group that is non-affirming of LGBTQ+ identities may feel pressure to keep their sexual behavior and sexual identity separate by maintaining a heterosexual façade to avoid the possibility of a homophobic response from their communities. This can include avoiding affiliation with gay communities to obtain social support (Amola & Grimmett, 2015; Barnes & Meyer, 2012). These chronic experiences of structural, cultural, and interpersonal stressors in themselves are likely to contribute to negative mental and sexual health outcomes. Other factors, such as maladaptive coping strategies and poor, or unavailable, social support, can either directly contribute to outcomes or influence the process (Ching, Sharon, Chen, So, & Williams, 2018).

Effects of Internalized Transphobia

Discrimination in the transgender community contributes to mental health challenges at all levels. The five most frequently reported reasons for discrimination include gender identity and/or expression, masculine and feminine appearance, sexual orientation, sex, and age. The more individuals experience discrimination and internalized transphobia, the more likely they are to experience PTSD symptoms, nonsuicidal self-injury, suicide attempts, depression, substance abuse, and risky sexual behaviors (Brumer-Perez, Hatzenbuehler, Oldenburg, & Bockting, 2015; Jackman, Edgar, Ling, Honig, & Bockting, 2018; McNeil, Ellis, & Eccles, 2017; Operario, Yan, Reisner, Iwamoto, & Nemoto, 2014; Reisner et al., 2016; Tebbe & Moradi, 2016; Testa et al., 2017; Zimmerman et al., 2015). For gender minority youth, there is an increased risk of experiencing bullying and harassment, which increases risk of alcohol use, marijuana use, and illicit drug use (Reisner, Greytak, Parsons, & Ybarra, 2015).

Factors such as beliefs and thoughts concerning their ability to control their situation and environment, level of community danger, expectations of rejection, self-stigma, rumination, and prejudicial events are all associated with psychological distress (Fernie, Wright, Caselli, Nikcevic, & Spada, 2017; Timmins, Rimes, & Rahman, 2017). Those who experience discrimination due to being transgender may find limited access to adequate general and transgender-specific healthcare services, both of which impact overall mental health and well-being, particularly if these individuals reside in a rural area. Some individuals will avoid the healthcare system altogether (Hughto, Pachankis, & Reisner, 2018). Transgender individuals that are attempting to access services may experience refusal of treatment by providers due to the personal bias of the provider, the provider's lack of knowledge and/or

experience, and provider discomfort with providing transgender care. Individuals seeking services often find that they have to provide broader education about transgender persons and their needs to medical providers (Smith et al., 2018). Discrimination due to being transgender can lead to internalized transphobia, greater general stress, greater rates of depression, and elevated rates of suicidal ideations and attempts (Hoy-Ellis & Fredrikson-Goldsen, 2017). As individuals disclose their gender identity, and throughout the transition process, they can experience losses of relationships, and they may experience grief and decreased support because of those losses. There is also an increased challenge of maintaining any intimate relationships that predated transition. Individuals who are transgender may also have difficulty navigating the process of disclosing to others that they are transgender (Smith et al., 2018). Some transgender individuals may even isolate with peers for fear of putting them at risk by being associated with someone who is transgender out in public.

In addition to navigating relationships, transgender individuals may also struggle in the workplace as well as maintaining employment due to either being fired and/or denied employment as a result of transphobic bias and pressure to conform to gender binary norms in the workplace (Mizock & Hopwood, 2018). Work-related transphobia can include lack of social support, workplace gender policing, personal safety threats, acquisition and barriers to advancement, intersectional discrimination, stigma, and lack of inclusive policies. Consequences for transphobia can include loss of pay, status, and job benefits that are associated with demotion, the inability to gain employment, and the lack of appropriate policy and procedures to protect transgender individuals in the workplace. For those that experience microaggressions, stigma, and harassment, the risk of psychological distress is greater (Mizock et al., 2018). Due to loss of employment, or a reduction in hours, individuals can face lack of access to healthcare, and they may experience challenges with obtaining legal counsel and protection against discrimination. In addition, there are continued difficulties with securing a living wage despite the transgender individual's skill level, education, or willingness and/or ability to work. This lack of livable wages can affect housing stability and accessing gender-affirming care. While not every trans person desires to have gender-affirming surgery, lack of access to expensive gender-affirming surgeries may make some individuals more susceptible to visual detection as being transgender, thereby increasing the risk of transphobia and discrimination and creating a continued cycle of workplace discrimination due to transphobia, difficulty maintaining employment, and lack of transgender care.

Implications and Strategies for Mental Health Professionals

A minority identity can augment or weaken the impact of stress depending on the person's identity. A minority identity does not always have to be a negative as it can also be a source of strength depending on factors such as affiliation, support, and coping mechanisms. Therefore, interventions for internalized homophobia and transphobia can be broken down into two main categories, which are subjective interventions and objective interventions. Subjective interventions will focus on the individual and their way of evaluating their condition and coping with stress and adversity. Objective interventions aim to alter the stress-inducing environment and reduce exposure to that stress.

Mental health professionals should have competencies and comfort in discussing sex and sexual feelings with a client, particularly same-sex sexual behaviors. Throughout any treatment with clients from the LGBTQ+ community, professionals should adhere to professional guidelines already established in the field, such as the Guidelines for Psychological Practice with Transgender and Gender Nonconforming Clients, which suggests assessing clinician cultural backgrounds, addressing identity intersectionality, challenging assumptions, building rapport and acknowledging differences, assessing client strengths and resilience, and providing a variety of affirming resources (Chang & Singh, 2016).

Professionals should take care to avoid placing the burden of education on the client, overasserting power, overemphasizing a client's sexual or gender identity, avoiding discussing the client's identity, pathologizing the client, making broad generalizations, or attempting to "fix" the client's sexual or gender identity (Mizock & Lundquist, 2016). Ensuring one has an affirming practice includes certifying that one has had the proper training to offer culturally competent services, marketing to the LGBTQ+ community, having LGBTQ+ office staff, having affirming materials in the waiting room or on your website, addressing transgender and gender nonconforming clients by preferred names and pronouns, and avoiding hetero- and cisgender-normative assumptions and language when interacting with clients. Other recommendations for affirmative mental health treatment include displaying a rainbow flag or Safe Zone signs, having single-stall gender-neutral bathrooms, having clients identify themselves rather than making assumptions, showing willingness to discuss homophobia, transphobia, discrimination, and prejudice with clients, validating fears, and collaborating with the client on their specific goals (Hinrichs & Donaldson, 2017; Porter et al., 2016).

Professionals can help to address internalized homophobia by normalizing same-sex activity in order to reduce feelings of guilt and shame that might contribute to psychological distress and risk-taking behavior. With regard to internalized transphobia, mental health professionals should also realize that the differences in transgender individuals who have and have not completed transition, the length of time since completion, and the degree to which individuals are satisfied with their transition process (and visible expressions of gender) may be important in understanding risk and resiliency for transgender individuals (Glynn et al., 2016). Mental health professionals should also be aware of the collaboration between disciplines (psychological, medical, adjunctive, etc.) to provide transgender care and the different aspects of the transition process. This process can include voice and communication therapy, hair removal, breast binding or padding, genital tucking or a prosthesis, padding of the hips and buttocks, changes in name and gender markers on identity documents, hormone treatment, surgery, and other treatments and behaviors. Each individual who identifies as transgender may choose certain methods of transitioning and decline others based on their individual resources and preferences; therefore, the transition process may look different for each client. Supportive therapy during the transition process can include helping a client identity any unsafe situations in the environment, understanding the benefits and risks of self-disclosure, exploring reactions of loved ones, understanding the intersection of identities, developing healthy coping strategies, identifying support systems, managing expectations, assessing for the presence of internalized transphobia, and the like (Leibowitz & de Vries, 2016; Selvaggi & Giordano, 2014).

Mental health professionals should consider how treatment is useful in helping LGBTQ+ individuals, whose identities intersect with another minority status, to confront intersectional oppressive and traumatic experiences to build a new sense of self-efficacy. Professionals should keep in mind that mental health treatment in general is adapted from Western and heteronormative approaches and treatment may need to be altered to modify and incorporate cultural beliefs, values, and norms. One example would be to integrate indigenous healing practices, at the comfort level of the client and the competency of the clinician, into treatment. Mental health providers should also be aware of the intersection of class, sexual orientation, and gender. Professionals might help clients prioritize affirming care and treatment and help clients access resources to reduce homophobia and transphobia, work discrimination, and housing discrimination. Professionals can also explore the impact of financial challenges on other areas of a client's life, learn more about career counseling, educate themselves on risks for workplace discrimination and legal protections, and become more self-aware to dispel stereotypes and false beliefs.

Due to the implications of social, community, and institutional effects on how LGBTQ+ individuals view themselves and their mental health

and well-being, there is a need for fewer social constraints with the LGBTQ+ community in order to foster self-esteem. Support and connectedness to other LGBTQ+ individuals, talking with someone who shares a minority status about sexual identity issues, forming new "families," or having a sense of belonging to the LGBTQ+ community, either in person or online, may decrease the likelihood of the psychological effects of internalized homophobia and transphobia (Barr, Budge, & Adelson, 2016; Mason et al., 2015; Salfas, Rendina, & Parsons, 2018; Smith et al., 2018). In addition, having a sense of meaning in life mobilizes individuals actively to confront the situational stressors of a non-affirming environment, and it can help individuals make positive reinterpretations when processing the prejudicial and discriminatory experience (Szymanski & Mikorski, 2016).

With LGBTQ+ clients, it may help to normalize the experience of discriminatory events, the internalized homophobia that can result, and for the association of those events on psychological distress to be discussed in order to improve self-esteem. For transgender individuals, the gender transition process may help to affirm social identification of their individual gender identity, thereby alleviating some mental health symptoms (Smith et al., 2018). In addition, it may help LGBTQ+ clients identify barriers to resiliency, cultivate a sense of hope for the future, embrace their self-worth, and engage in social activism. Counselors should assess and process how a client's gender and sexual orientation label may have evolved throughout his or her life and what experiences contributed to any changes in these identities. In addition, mental health professionals should foster clients' positive self-encouragement, help them identify a source of strength, help them evaluate the nature of their inner dialogue, support critical examination of societal messages, and help clients develop alternative and affirming messages about themselves (Herrick et al., 2013; Singh, Hays, & Watson, 2011).

For mental health professionals who are working with clients with religious faith, it is important to determine the client's level of religious coping. Religious coping is the process by which people draw on religious beliefs and practices to understand and cope with life stressors (Bourn, Frantell, & Miles, 2018). Religion for clients in the LGBTQ+ community can be either positive or negative, and internalized homophobia can have an impact on how clients use religion to cope. Non-affirming religious faiths can be associated with higher internalized homophobia, feeling unsafe, and feeling unaccepted, and LGBTQ+ individuals who are raised in non-affirming religions may acquire and believe the negative beliefs and messages that the religion sends (Barnes & Meyer, 2012; Smith et al., 2018). For those that see religion as a positive, it can serve as a protective factor against some, but not all, relations between minority stress and mental health (Bourn et al., 2018); however, those that view religion as a negative influence in their lives can experience higher levels of psychological distress. There are some cultural and religious practices that can serve as a protective factor, for example, those that believe in two-spirit individuals in tribes that honor two-spirit identities, but recognize that there are some LGBTQ+ individuals who may choose to give up all religious beliefs or practices and there are those who will opt for more affirming settings, which can also help to lower internalized homophobia. Those who opt to attend affirming religions may do so because it helps to provide them with continued personal meaning and it fosters community connectedness. Conversely, if a client chooses to stay in a non-affirming religious environment, they may need assistance to develop and employ a variety of strategies to cope. Nevertheless, client's exposure to religious beliefs and environments should be explored as well as their response to that environment.

Specific therapeutic strategies for treating internalized homophobia and transphobia can include cognitive behavioral therapy combined with minority stress models and skills-focused coping (Reisner et al., 2016). Cognitive interventions that directly address negative beliefs, negative schemas, and criticism about the self and one's sexual orientation and gender identity, combined with behavioral interventions to decrease negative coping strategies, may be help-

ful. More adaptive coping strategies that can be incorporated can be the client's ability to be open, use social supports, emotionally process experiences, develop the ability to view thoughts and feelings as events rather than truths, retain a sense of optimism, solve financial problems, and use public resources, legal support, and counseling (Kaysen et al., 2014; Mizock & Mueser, 2014; Puckett, Mereish, Levitt, Horne, & Hayes-Skelton, 2018). Psychoeducation on the effects of homophobia and transphobia can raise awareness of the distress caused by internalizing these messages and beliefs. In addition, case management and advocacy can facilitate access to resources and reduce homophobia and transphobia. In addition, the application of dialectical behavioral therapy case conceptualization and skills training that is tailored to the LGBTQ+ community can assist with the goal of helping mental health professionals develop practical approaches for promoting the psychological health and well-being of LGBTQ+ clients (Sloan, Berke, & Shipherd, 2017).

For children and adolescents, schools can benefit LGBTQ+ youth by developing relational aggression interventions, similar to other antibullying programs, which incorporate more sexual and gender minority diversity and specifically target those experiences by LGBTQ+ youth. These interventions can incorporate a discussion on internalized homophobia and transphobia, the use of relational aggression as a coping mechanism, minority stress, and the impact on LGBTQ+ students. Professionals in the schools can support the use of gender minority stress perspectives in designing early interventions aimed at addressing the negative health consequences of bullying and harassment. One example of one such intervention is AFFIRM, which is a cognitive behavioral coping skills group intervention for transgender youth (Austin, Craig, & D'Souza, 2018). Other interventions can include safe spaces where LGBTQ+ youth can receive support from staff or teachers, gay-straight alliance groups, curricula that address the health and well-being concerns of the LGBTQ+ community, and school policies that prohibit discrimination and harassment (Hatchel & Marx, 2018; Ryan, Legate, Weinstein, & Rahman, 2017). Interventions can also focus not only on individual student support but also family interventions to facilitate gender and sexual orientation identity development. Family interventions that assist with helping families develop supportive environments for their children may help promote resiliency against the development of internalized homophobia (Legate, Weinstein, Ryan, DeHaan, & Ryan, 2018; Trub, Quinlan, Starks, & Rosenthal, 2017). As parents may struggle with the identity of their child, there will be a need for multiple treatment modalities that target parental coaching and education, parent support groups, and child and family therapy (Malpas, 2011).

When working with families, mental health professionals should address the issue presented by the couple or the family without blaming the clients for the impact of discrimination and internalized homophobia and transphobia. Therapeutic models such as feminist therapy or narrative therapy may be useful when working with couples and families because they directly address the system from a social, cultural, and political perspective. These therapies can also help examine the intersections of multiple identities, critically evaluate discriminatory experiences, and develop resilience that is often already present in these families (Giammattei, 2015).

In the realm of research and training, there is a need to assess for gender in research outside of the male/female binary. There is also a need for mental health resources to begin to focus on interventions to understand how treatments work for those within the LGBTQ+ community, whether current assessments reflect inclusive language, whether current assessments are appropriate for the LGBTQ+ population, as well as how microaggressions can occur in mental health interventions (Budge, Israel, & Merrill, 2017). In addition, there is a need to improve educational and training resources for mental health professionals to become more aware of LGBTQ+ issues and to be more competent in this area. Professional development workshops can be created and promoted to help mental health professionals build their knowledge and awareness of mental health issues in the LGBTQ+ population (Couture,

2017). Supervisors can help trainees to advocate for their own learning needs involving LGBTQ+ issues, and any training clinics, or agencies, should have clear policies about homophobia and transphobia and any other discrimination based upon gender identity and expression (Gates & Sniatecki, 2016).

The level of discrimination that those in the LGBTQ+ community experience, along with the psychological effects it produces, shows the importance of social changes to improve the societal contexts in which sexual minorities are living in order to decrease the likelihood of individuals experiencing victimization. There need to be more policies to protect against discrimination and victimization. Professionals can provide training to organizations on workers' rights and discuss appropriate coworker conduct, make sure employees are aware of the policies, and ensure that employees are aware of the steps outlined should they have a concern about discrimination as employees should feel comfortable making a complaint without fear of retaliation (Gates & Sniatecki, 2016). Policy change is needed to more adequately protect the rights of LGBTQ+ employees as well as to ensure the enforcement of preexisting laws or company policies. Inclusion of LGBTQ+-specific resources and antidiscrimination policies may contribute to a more supportive climate and better access toward services (Paceley, Goffnett, & Gandy-Guedes, 2017). Legislative and policy prevention initiatives should challenge heteronormativity and sexual stigma within institutions, social environments, and family settings (Lorenzetti, Wells, Logie, & Callaghan, 2017). Furthermore, mental health professionals can consult with LGBTQ+ individuals or groups in the community, and with other local professionals, to determine the needs for various services and what services currently exist in the community (Heck, Croot, & Robohm, 2015).

Conclusion

The society, culture, and historical time period in which we live shape who we are, our values and beliefs, and the meaning that we derive from our lives. The social and cultural constructs of gender, and the actions and behaviors of that gender, are so pervasive and ingrained in the fabric of our society that we often do not give them a second thought. It is only when something does not conform to societal expectations that we begin to notice. For some, this can create feelings of discomfort, prejudice, discrimination, homophobia, and transphobia, which can also be experienced at a broader societal level through varying levels of institutional discrimination. Those within the LGBTQ+ community that are on the receiving end of homophobia and transphobia discrimination can begin to believe those negative messages about themselves and internalize them in a process known as internalized homophobia and internalized transphobia. In turn, this internalization can create varying levels of psychological distress and maladaptive coping strategies, particularly for those with intersecting minority identities.

Interventions to counteract that internalization should follow a two-prong approach of working with the individual and working to establish broader societal and institutional changes. Mental health professionals should ensure that they are engaging in LGBTQ+ affirmative care and establishing a safe space for LGBTQ+ clients. Individual interventions can include exploring the client's identity, experiences, and concerns, working to counteract negative messages that can inhibit self-esteem and personal development, helping clients to establish more adaptive coping strategies, and helping clients to connect with community resources. Incorporating a variety of theories and strategies, such as CBT, DBT, narrative, and feminist theory, which are adapted to the needs of the LGBTQ+ client, can prove beneficial. In addition, focusing on the already established strengths of the individual, couple, and/or family unit can help to foster resiliency. On a broader level, interventions should focus on, and be modified for, LGBTQ+-specific experiences and concerns, establishing and strengthening LGBTQ+ social bonds and a sense of community, engaging in more LGBTQ+ affirmative research and training, and working to challenge discriminatory policies in order to establish antidiscriminatory policies. Overall, there is a great

need for LGBTQ+ affirmative care by mental health professionals as overt and covert messages of prejudice, discrimination, and hate can subtlety erode at an individual's mental health and well-being over time. Mental health professionals can serve a great role in providing this care, within the individual, community, and society, to counteract those messages, advocate for the LGBTQ+ community, and work toward the improved mental health and well-being of the clients we serve.

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4 How Teachers Can Reduce Bullying of Sexual and Gender Diverse Students

Peter S. Theodore and Adam Stoker

Abstract

Bullying of sexual and gender diverse youth (SGDY) in our school systems occurs at alarming rates and is associated with mental health and academic concerns including depression, anxiety, suicidality, lower perceived safety and community at school, increased truancy, and poorer grades. Given the prevalence and negative impact of bullying on SGDY, educators must play an important role in preventing bullying and intervening effectively upon witnessing bullying. This chapter will highlight many effective strategies teachers can adopt to help prevent and respond effectively to bullying of SGDY. Methods for creating classroom environments that are safe and affirming of sexual and gender diversity, such as reducing heterosexist and cisgender bias, fostering prosocial and collaborative learning environments, facilitating school connectedness through group-based and service-learning activities supportive of LGBTQ persons, and adopting teaching materials (e.g., textbooks, lessons, vignettes) inclusive of affirming LGBTQ content, will be described. How teachers can serve as role models and support systems for their sexual and gender diverse students (e.g., serving as faculty sponsors of Genders and Sexualities Alliances (GSAs), being knowledgeable of LGBTQ community resources when appropriate, intervening effectively when bullying of SGDY occurs) will also be described.

LGBT-related bullying occurs at alarming rates and impacts students who self-identify or are perceived to be lesbian, gay, bisexual, transgender**,** or otherwise sexually or gender diverse (SGD). Acts range from using biased language in the form of homophobic or transphobic slurs to intentionally isolating or rejecting SGD students, to threatening or committing acts of physical aggression against SGD students. Recent findings revealed that over half of SGD students report feeling "unsafe" at their schools, with many avoiding gender-segregated spaces at school**,** such as bathrooms, and approximately one third of SGD students reporting physical harassment and assault (Kosciw, Greytak, Clark, & Truong, 2018). The impact of a hostile school climate: SGD students experiencing bullying report higher rates of mental health concerns (e.g., depression, anxiety, trauma**,** and suicidality), behavioral health disparities (e.g.,

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E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_4

substance use and sexual risk behaviors), and poorer academic outcomes—disengagement, truancy, lower grades**,** and less desire to pursue college (Aragon 2014; Saewyc & Homma, 2017; for additional information, see Burgess et al.'s chapter in the present text).

Research examining best practices to reduce and prevent LGBT-related bullying has yielded mixed outcomes with some strategies proving more effective than others. The most promising intervention strategies focus on mobilizing support and advocacy of sexual and gender diverse youth (SGDY) through peer/bystander intervention and teaching styles grounded in socio-emotional learning strategies designed to build empathy; engage students in collaborative, group-based learning; enhance problem-solving; and foster sense of belonging and community for *all* students—inclusive of SGDY (Logis & Rodkin, 2015; Rodkin, Espelage, & Hanish, 2015; Thornberg & Wänström, 2018). The remainder of this chapter will describe empirically supported teacher characteristics and practices that reduce LGBTQ-related bullying, foster socio-emotional learning, and enhance SGD student success.

Creating Community, Engagement, Visibility, and Safety

One of the first steps teachers can take to decrease sexual- and gender-related bullying is to create a culture of inclusion and a sense of community in their schools. School connectedness, marked by mutual respect, affirmation, and celebration of diversity across peers, teachers, and staff, facilitates a sense of belonging and safety that translates to academic success (Saewyc & Homma, 2017). School connectedness has been found to be particularly effective at decreasing rates of depression and suicidality in sexual and gender diverse students, as it protects against the damaging effects of bullying.

Saewyc and Homma (2017) found various mechanisms through which educators can foster school connectedness. In their academic curriculum, teachers can formulate activities that foster prosocial skills such as leadership, conflict resolution, emotion regulation, stress management, and empathic attunement. They can plan group-based classroom activities requiring teamwork and execution of leadership skills and service-based learning opportunities (e.g., volunteerism and reflection papers) that foster prosocial skill development. In addition, teachers can create visibility for sexual and gender diversity by encouraging service to LGBT-affirming or HIV/AIDS community-based organizations in their service-learning activities (Saewyc & Homma, 2017). These service-learning opportunities can engender SGD student school connectedness and yield valuable insights among all students on issues that disproportionately affect SGD populations, thus increasing compassion, understanding, and support.

Teachers can also turn their classrooms into safe spaces for SGDY by incorporating intentional classroom management and teaching techniques. For example, teachers can actively involve students in the development of behavioral rules that are designed to facilitate comfort and respect in the classroom, as research has found that students in classrooms wherein they are more involved in decision-making surrounding rules and consequences in the classroom tend to behave better (Lewis, 2001). The involvement of students in the creation of these rules can create a sense of ownership that may be beneficial in increasing compliance to said rules. The classroom discussions wherein these rules are discussed and formulated can also serve as a powerful time to address and talk specifically about bullying, its types, and its negative effects. It also is a time where teachers can demonstrate to their SGD students their intentions to welcome and affirm all forms of sexual and gender diversity and for their classrooms to serve as safe spaces for all students.

Teachers demonstrating their own intention to welcome sexual and gender diversity in their classroom can demonstrate to students that diverse and complex views are welcomed in their classroom. Hand and Levinson (2012) argue that discussions on difficult and controversial topics should be part of the educational process and that

the teacher should facilitate the discussions in such a way that diverse views are welcomed. Students need to understand the complexity of the issues being discussed, and teachers should be clear in communicating to students that these issues are complicated and that they [the teachers] may not know the answers.

Accordingly, we argue that teachers who make their classrooms places where these diverse views about social justice and current events (including but not limited to views about sexual and gender diversity) can be discussed and debated respectfully further create safety, inclusiveness, and connectedness. By creating classrooms where contrasting and alternative views are welcomed and examined, teachers can model and shape respectful discussion and debate and openness to competing ideas and perspectives. Encouraging discussions of power, privilege, and oppression that inform critical thought and reinforcing respectful exchanges of ideas create a classroom climate more likely to recognize, celebrate, and affirm diversity of all forms.

Creating SGDY-Affirming Classrooms

Visual Cues in the Classroom Pennell (2016a, 2016b, 2017) highlights the importance of training teachers to recognize and challenge heteronormativity in the classroom and learn how to make their physical classrooms welcoming and more affirming spaces. Specifically, Pennell (2016a, 2016b) recommends teachers engage in a *heteronormativity scavenger hunt* wherein one explores their physical space (i.e., their classroom or school building) for overt and implicit signs of heterosexism with the intention of eliminating such signs when possible in order to create safe and welcoming settings for sexual and gender diverse students and their families. Teachers should review posters hanging around the classroom or throughout the school and examine the degree to which they primarily, if not exclusively, depict heterosexual and cisgender individuals and couples. They may also find that promotional materials for activities such as school dances do not adequately represent sexual and gender diversity. When possible, efforts should be made to provide greater balance of images that are inclusive of same-sex couples and queer or gender non-binary persons.

Teachers should scan their classrooms for the absence or presence of LGBTQ-affirming symbols that reflect that they affirm sexual and gender diversity and their classroom is a safe space for SGDY. One way that teachers can demonstrate their support for diversity is by hanging posters, signs, and images in the classroom that demonstrate sexual and gender diversity. Teachers can also display "Safe Zone" stickers on their doors or wear "OUT for safe schools" badges while making sure to inform students and other faculty about what these signs mean. Displaying pride flags in their classrooms in addition to flags honoring other cultures and nationalities is a visual demonstration of acceptance of gender and sexual diversity, which is an important part of creating safety and openness to sexual and gender diversity (Mulcahy, Dalton, Kolbert, & Crothers, 2016). Teachers can also save and display pamphlets containing information about campus-based or community-based resources such as LGBTQ pride centers and service agencies.

Visual Cues Throughout the School Teachers may take initiative to investigate the physical structures of their school and, when appropriate, advocate for spaces that are sensitive to the needs of gender non-binary students. For example, all-gender restrooms should be available for gender diverse students and should be located in safe areas of the school where students are less likely to be physically or verbally harassed for their sexuality or gender expression. Research has found that sexual and gender diverse students often feel unsafe in gendered spaces such as public restrooms (Kosciw, Greytak, Palmer,, & Boesen, 2014). Increasing access to all-gender restrooms and making sure these restrooms are in areas when SGDY will feel safe to use them can help combat this sense of unsafety.

Creating LGBTQ-Inclusive Curriculum

Teachers should review their teaching materials to evaluate inclusion of sexual and gender diversity. For example, teachers should review their textbooks to ensure that they are representative of sexual and gender minorities and include sexual and gender diverse characters in their academic vignettes.

Teachers can promote and support diversity and inclusiveness in their classrooms through the dissemination of *queer cultural capital* (Pennell, 2016a, 2016b). Drawing on *queer theory*, Pennell (2016a, 2016b) developed the premise of *queer cultural capital* in a manner which views education as a bridge toward social justice and empowerment. It describes teachers as a conduit who transmit information about queer communities from a strengths-based perspective. Dissemination of queer cultural capital can occur through discussion of positive historical figures, current events, and referencing or creating class assignments linked to LGBT-affirming books, textbooks, movies, and documentaries.

Dissemination of queer cultural capital may be of particular benefit to SGD students who come from non-affirming homes or religions. These students who may not have been taught about sexual and gender diverse historical figures or who may be told at home that they will not be successful in life due to their sexual orientation or gender expression may benefit from recognizing queer figures who made an impact in society. Queer knowledge can help them remain focused on their own strengths and accomplishments and continue pushing forward despite the opposition they may be facing at home.

There are many elements of queer cultural capital that can be beneficial to process in the classroom. First, a focus on resilience as demonstrated by maintaining hope and celebrating pride amidst ongoing oppression and adversity can help sexual and gender diverse students stay resilient despite bullying, harassment, or problems at home. In addition, teachers can discuss how accomplished sexual and gender diverse communities have historically been at deriving support from one another when society was not accepting. Helping students to recognize that they can build a sense of community or a "chosen" family can help SGD students combat isolation, marginalization, and potential rejection from their family of origin.

Teachers foster affirmation in students by helping the students in their schools to understand the rich history behind reclaiming previously pejorative symbols and terms. For example, the term queer has been historically used in a derogatory way to refer to a sexual or gender diverse individual; however, in recent years, sexual and gender diverse communities have begun embracing and using this term affirmatively. Similarly, a pink inverted triangle was historically used (most notable in the concentration camps during World War II) to identify and punish homosexual individuals. Sexual and gender diverse individuals currently use this symbol to represent power and resilience and to commemorate the historical injustices the community has endured.

Curricula are often largely absent of any mention of LGBT history, events, notable figures, and accomplishments. A national survey of school principals revealed as little as 4% reported that students in their schools were taught about LGBT issues (GLSEN & Harris Interactive, 2008). Despite increasing sociopolitical support and recognition of sexual and gender diversity in society, textbooks and classroom materials that are inclusive of sexual and gender diversity remain quite limited in selection with little gain over time (Kosciw et al., 2014). When included, there is little attention given to ensuring that the information is affirming and includes positive representations. For example, Kosciw et al. (2018) found that only 20% of sexual and gender diverse students reported that sexual and gender diverse people or LGBT history or events were positively represented in their curricula and 18% noted exposure to negative content related to sexual and gender diversity. This exposure is particularly problematic when considering that many SGDY are growing up in households or ascribe to religions that do not affirm their sexual or gender identity and are, therefore, bombarded with nega-

tive content. How can a SGDY develop a positive self-identity when a significant part of their identity is continuously presented in a negative light?

For many SGDY, seeing themselves positively represented in the school curriculum can have a significant impact on their emotional well-being and subsequent school engagement, attendance, and academic achievement. For non-SGDY, learning about LGBT history, figures, and events may foster a desire to serve as advocates and allies and to intervene to prevent homophobic bullying and harassment of peers when observed (Palmer, Kosciw, Greytak, & Boesen, 2017). SGDY can begin to develop a sense of resilience and connection to their community as they learn about such events as the Stonewall riots in 1969 when LGBT people in New York fought back against the antigay police force and demanded that there be establishments where sexual and gender diverse people could be open about their identity. They can learn about self-advocacy as they are taught about the Mattachine Society and other early gay rights advocacy groups. They can recognize the progress that society has made toward equal rights and the importance of civic engagement as they are taught about the former "Don't ask, Don't tell" policy in the military and the federal legalization of marriage after the Supreme Court of the United States ruled that the Defense of Marriage Act was unconstitutional.

SGDY may begin to understand that their sexual or gender identity is a normal aspect of human sexuality and gender while also learning of the dynamic and empowering efforts that resulted in the depathologizing and removal of homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and more recent depathologizing of transgender and other gender diverse persons through the removal of gender identity disorder from the DSM.

SGDY develop an understanding of their own power as sexual and gender diverse individuals as they learn of important civil rights activists such as Marsha P. Johnson, Sylvia Rivera, and Harvey Milk or scholars such as Alan Turing, Oscar Wilde, Audre Lorde, James Baldwin, or Keith Haring. SGDY may begin to connect and feel pride with their community as they learn about more recent celebrities and public figures who have propagated change by being openly proud of their sexuality and gender diversity (e.g., Laverne Cox, Michael Sam, RuPaul, Ellen DeGeneres).

It is also important that SGDY are taught about LGBT health. For example, teachers should educate students about sexual orientation, gender identity, sexual health, and health disparities through an affirming and non-cisnormative or non-heterocentric lens. Sexual health education should include information regarding safer-sex practices for SGD people. Gender should not be discussed through a binary lens, and students should be taught about health disparities that disproportionately affect sexual and gender diverse populations, as this can increase the health and safety of SGDY and compassion among non-SGDY. In non-health-related classes such as math, science, or technology, teachers can integrate sexual and gender diversity in their curriculum simply through including sexual and gender diverse individuals or couples into their vignettes, word problems, or class examples. Additionally, when doing school projects such as presentations, teachers should encourage rather than discourage or prohibit discussions on sexual and gender diverse people or topics. For example, a teacher in a religious school may not be able to use the example of an openly gay couple in a vignette, but they can use androgynous names in their vignettes without indicating a gender and leave interpretation up to the students. A teacher may not be able to sponsor a GSA at their school, but they can open up their classroom as a safe place for all students during free periods such as before or after school and during lunch and/or recess, periods when bullying is more likely to occur. In addition, a teacher who is prohibited from openly discussing sexual and gender diversity in the classroom can nevertheless intervene when SGD-related bullying occurs. Teachers should strive to demonstrate in whatever way possible that they are safe and affirming, that their classrooms are safe spaces, and that bullying will not be tolerated.

Genders and Sexualities Alliances (GSAs) and Civic Engagement

Outside the classroom, teachers can also play important roles in responding to sexual- and gender-related bullying. Teachers can sponsor, participate in, or help to form a GSA at their school. Originally called Gay-Straight Alliances, the name Genders and Sexualities Alliances evolved to be more inclusive of gender diversity. GSAs are student clubs sponsored by a faculty advisor that serve as a forum for students to engage in discussion of sexual and gender minority (SGM) issues (e.g., forms of homophobia, biphobia, and transphobia) and other intersecting forms of oppression and to advocate for the rights of SGMs (Chong, Yoshikawa, Poteat, & Calzo, 2019; Palmer et al., 2017; Poteat et al., 2018; Poteat, Calzo, & Yoshikawa, 2018; Poteat, Heck, Yoshikawa, & Calzo, 2017). Significant research has quantified the benefits of GSAs, as detailed in Burgess et al. (2020) in the present text.

GSAs are a particularly meaningful space for school-age children who may be questioning or hiding their sexual orientation or gender identity. These groups are considered some of the most vulnerable as they are least likely to reach out for support, yet they may derive benefit from simply attending a school with a GSA. Additionally, SGDY who are not yet ready to disclose their sexual orientation may still attend GSA activities and derive support and social connection as a straight ally, as research has found that between 25 and 50% of participants in GSAs identify as straight allies (Poteat et al. 2018, b, 2019).

In addition to the benefits derived from institutional-level support and the ability to participate in a GSA without "outing" oneself, SGDY can gain validation, affirmation, and visibility through their participation in GSAs. Through engagement within the community, familiarity with sociopolitical issues, and the ability to challenge oppression and fight for social justice, SGDY and allies can develop a strong sense of empowerment at GSAs through increased self-efficacy (Zimmerman, Israel, Schilz & Checkoway; Poteat et al. 2018, b, 2019). Consistent attendance at meetings, adoption of leadership roles, and assumption of responsibilities have all been found to be significant predictors of this increased self-efficacy (Poteat et al. 2018, b, 2019). In turn, self-efficacy has been found to facilitate a sense of commitment to social justice such that these students are less likely to standby when they witness sexual-, gender-, and racial-based bullying and more likely to engage in discussions about issues affecting sexual and gender diverse individuals (Chong et al., 2019.

Greater GSA involvement has been found to be associated with greater civic engagement and activism in general. The collective conscience and social action that develops through the discussion and debate of ideas that occurs in GSAs empowers students to engage in activism for GSMs as well as other oppressed communities (Chong et al., 2019. Furthermore, the understanding that students gain from understanding intersectionality of identities may empower them to advocate for those most oppressed within their communities (e.g., transgender people of color). Additional findings support the association between GSA involvement and civic engagement across other social justice issues, mediated by a sense of agency (Poteat et al., 2018); prosocial values and beliefs developed through engagement in GSA promote efficacy to effect change toward social equality such that they are willing and choose to fight for equality across multiple systems of oppression.

In addition to the improved civic engagement that is engendered through GSA involvement, both SGDY and heterosexual youth in these alliances report improved mental health, including decreased odds of suicidal ideation and attempts and decreased substance abuse (Poteat et al., 2017). Furthermore, GSAs can be a valuable resource for knowledge and information, particularly when the advisor is familiar with the unique issues affecting sexual and gender diverse individuals. For example, in Chong et al.'s (2019) study involving 33 GSAs at various high schools, students who reported gaining the most information and resources from their GSA reported more frequent discussions on substance abuse, mental health, sexual health, transgender topics, health disparities, and risk and protective factors, relevant

for SGDY (Chong et al., 2019; Poteat et al., 2017; Poteat, Calzo, Yoshikawa, Miller, et al., 2018).

Teachers as Advocates, Supporters, and Mentors

Teachers have the unique opportunity to guide and influence students at different stages of their development. Depending on the age and developmental level of the student, teachers work daily with students who are navigating various developmental challenges, exploring and discovering their identities, interacting with peers, striving to develop a sense of belonging and acceptance, and negotiating struggles associated with conformity, individuality, rejection, and fear of isolation.

The typical developmental life stress faced by virtually all youth can be particularly difficult for SGD students when coupled with their marginalized identity. Consider, for example, a student who is striving to develop their spiritual identity in a religion wherein homosexuality is considered sinful while simultaneously beginning to recognize they are attracted to their own gender. Consider also the complex and intense stress that a young closeted transgender girl who was born and presents as male has when she accepts that she is psychologically female and wishes to present as such, but is known in her social circles as male.

When coupled with increased incidence of bullying and absence of peer social support or sense of belonging, the negative health effects of this stress for SGDY can be significant. In these cases, the teachers have the opportunity and the responsibility to help their SGDY feel safe and welcome. In fact, the American Psychological Association and National Association of School Psychologists (2015) assert that it is the responsibility of teachers and other school personnel to support SGDY and protect them from homophobic and transphobic victimization.

Developing Trust Teachers have the opportunity to mentor students through difficult adolescent transitions such as disclosing their identity or experiences of stigma. However, to do so, students must first be able to trust that they are a safe and supportive person. Trust is often developed as students gradually disclose information of increasing relevance to their sexual or gender identity. For example, students may initially start by disclosing general thoughts and general ideas about sexuality and gender identity. As their confidence in the teacher develops, this can shift to more personal disclosures in the form of artwork, stories, other creative endeavors, and personal conversations (Mulcahy et al., 2016).

Through slowly disclosing information of increasing relevance to their teachers, students evaluate teachers' listening skills and openness to ideas that challenge social convention and heteronormative ideas. Students are simultaneously able to gauge their teacher's own level of comfort with student's own style of self-expression and ability to disclose unconventional aspects of themselves. Accordingly, the initial interaction between a SGDY and faculty mentor is critical in establishing trust and connection (Mulcahy et al., 2016).

Mentorship Qualities In addition to the trust necessary in this mentor/mentee relationship, Mulcahy et al. (2016) found that there are specific qualities that SGDY often seek in a mentor. One quality that students found important was their mentor's sexual or gender identity. Students often look to see if their mentor is a sexual or gender diverse individual or, if they are not, students evaluate signs of progressive thinking and affirmation of sexual and gender diversity.

Students also often look at sponsorship and active involvement in clubs promoting sexual and gender diversity and other diversity initiatives on school campuses when considering whether to confide in a mentor. They may gauge support for all forms of diversity (including race, gender, style of dress or expression, style of music, political views, and thoughts about current events). Students may also determine faculty support of diversity by listening to their conversations with other faculty and students. They may screen faculty comments for indications that they endorse stereotypical gender roles, hegemony, or hetero-

sexist humor and jokes (Mulcahy et al., 2016). Faculty members should self-monitor their speech and behaviors inside and outside of the classroom, especially when students are present, as even if a faculty member is talking privately with another faculty member, students may be listening and attending to their conversation.

Mulcahy et al. (2016) also found that SGDY students may look at faculty members' behaviors toward students that are open and out on campus. For example, if a faculty member celebrates and affirms the accomplishment of students who are out on campus, SGDY are more likely to recognize them as a safe person and seek mentorship from them. Educators can also show their support for SGDY's professional and personal development by encouraging post-secondary education and career pursuits, particularly in the form of providing information to SGDY students on progressive and affirming colleges, and supporting and affirming career goals across disciplines.

In addition to these direct demonstrations of support, faculty mentors can provide a safe place for SGDY by opening up their classroom during "free periods" such as before and after school and during lunch. These time periods can be especially problematic for some students as they are periods of unsupervised peer interactions which can translate to increased likelihood of bullying, victimization, and relational interaction for vulnerable populations including SGDY (Mulcahy et al., 2016).

Benefits of Mentorship to SGDY The benefits of mentorship may include increased self-acceptance, self-awareness, and identity integration which can be particularly beneficial for students from non-affirming religions or non-affirming households. Other benefits may include an increased sense of school safety and belonging and decreased loneliness and isolation, all of which may contribute to increased academic success. Strong mentorship may also increase SGDY students' self-efficacy, leading to an increased desire to pursue college education. As students become aware of colleges that are affirming of sexual and gender diversity, they are likely to feel a greater sense of hope and excitement about their professional futures. Supportive faculty mentor relationships also promote greater self-acceptance and understanding in students. This can contribute to more authentic relationships with peers, increased involvement in school activities, and the skills necessary to obtain leadership positions in school clubs (Mulcahy et al., 2016).

Teachers as Leaders/Role Models

As leaders in the schools, teachers must employ a variety of strategies to model and shape prosocial behaviors and peer dynamics among students and to decrease bullying in the schools. One such strategy is for teachers to remain attuned to social hierarches and peer dynamics while in the classroom. This can be accomplished through monitoring patterns of participation and communication style among students. Teachers can then help increase engagement of the quieter and more passive students while teaching and modeling more collaborative styles of communication for those who tend to be more aggressive or outspoken (Logis & Rodkin, 2015).

Research has found that teacher's level of attunement to social dynamics corresponds to prosocial classroom climate including less acceptance of aggression, an increased sense of belonging, and a willingness to protect peers against bullying (Hamm, Farmer, Dadisman, Gravelle, & Murray, 2011; Neal, Cappella, Wagner, & Atkins, 2011). Accordingly, when teachers are aware of social cliques and hierarchies, they can balance the placement of those students who are aggressive, extroverted, or outspoken with those who may be more shy, introverted, or quieter. Teachers can use this knowledge of student social dynamics to organize their classroom in such a way that they are able to foster prosocial development. Through creating seating charts that are mindful of student social dynamics, teachers are able to foster healthy and positive interactions between circles of friends, thus making their classroom safer for all students (Mikami, Boucher, & Humphreys, 2005).

In addition to the way that they organize their classrooms, teachers should strive to integrate

group activities into their lesson plans. Group learning activities encourage collaborative thinking and cooperation (Mikami et al., 2005). When coupled with mindful placement of students in the classroom, teachers can encourage positive communication between various social groups and hierarchies and foster positive communication between the various social circles.

Additionally, in order to be effective leaders and role models for SGDY, teachers must be mindful of sexual- and gender-related microaggressions. Microaggressions refer to heteronormative assumptions and heterosexist biases that support and sustain power dynamics based upon binary notions of gender and sexuality and that privilege masculinity over femininity, cisgender over transgender/gender diverse persons, and heterosexuality over all forms of non-heterosexuality (Palmer et al., 2017). Through a heteronormative lens, heterosexuality and binary expressions of gender that align with one's biological sex (masculine, cisgender, heterosexual boys and feminine, cisgender, heterosexual girls) are viewed as "healthy" and "normal," while anyone who does not fit these rigid categories is viewed as "unhealthy."

It is important for educators to recognize that these microaggressions are often not conscious or intentional. They can come in the form of using gendered language such as he/him/his or she/her/hers while not also including non-binary pronounces such as zi/hir/hirs or they/them/theirs. They can come in the form of not representing gender and sexual diversity in posters hung in the classroom, assignments, or vignettes. They also may present themselves in one-on-one conversations where communication occurs through a gender-binary or heterocentric lens.

Accordingly, teachers can monitor their speech to ensure that they are representing gender and sexual diversity, as well as monitoring the language of their students. Since microaggressions are frequently unintentional, the first step in eliminating them is recognizing when they are occurring. As teachers monitor their own speech for sexual- and gender-related microaggressions, they can set the example and help their students to do the same, thus creating a safer and more inclusive school climate.

Intervening When Witnessing SGD-Related Bullying

In addition to modeling prosocial behaviors and inclusive language, teachers can serve as models of victimization intervention for students. Research has found that students are more likely to intervene when witnessing sexual- and gender-related language and harassment when they have witnessed an educator do the same (Wernick, Kulick, & Inglehart, 2013). The impact of modeling highlights the importance of educators being willing to intervene both to address the problem directly and show students how they too should behave when witnessing bullying. There is danger in inaction, as it inadvertently condones bullying and thus effectively dissuading victims and bystanders from reporting bullying when it does occur (Kosciw et al., 2018).

Despite the prevalence of sexual- and gender-related bullying in schools, it appears that only about 50% of teachers are directly addressing the problem. In 1 study of nearly 300 teachers, approximately half of them reported "never" discussing homophobic language in their classrooms, and less than half reported intervening consistently when witnessing homophobic bullying (Poteat et al., 2019). Unfortunately, training on bullying prevention appears to be severely lacking. Only about half of teachers and school personnel report receiving training on anti-bullying policies. Furthermore, educators report feeling the least comfortable or prepared to intervene when witnessing homophobic bullying (Bradshaw, Waasdorp, O'Brennan, & Gulemetova, 2011). Without proper training and support, educators are less likely to intervene due to a decreased sense of self-efficacy, not necessarily due to not caring. From a student's perspective, however, the reason for a teacher's inaction is irrelevant. The damage is the same regardless of the teacher's reason for inaction, with students likely to no longer feel safe or supported around that teacher.

Self-efficacy, or the belief in one's ability to intervene effectively, was found by Poteat et al. (2019) to explain both the consistency of immediate intervention against homophobic language

and more general discussion of homophobic language and harassment. They also found that this sense of self-efficacy increases when teachers perceive support among their colleagues.

Furthermore, perceived support and a culture among teachers where intervening against sexual- and gender-related bullying (or bullying in general) is the norm have been associated with more consistent intervention when hearing sexual- and gender-related bullying as well as increased discussion on homophobic language in the classroom (Poteat et al., 2019). Social factors and the influence of peer norms operate at the teacher level as well as the student level: if teachers have shared values and it is the norm in the school to openly discuss sexual- and gender-related bullying and harassment and to intervene when it occurs, teachers are more likely to do so as they will have the support and encouragement of their peers. Collaborative support is likely to engender more widespread intervention, consultation, and problem-solving, learning from failed attempts to intervene, and sharing ideas for fostering language in the classroom that is inclusive of sexual and gender diversity (Poteat et al., 2019). Institutional support and trainings may serve to foster this collaborative support and enhance teacher's self-efficacy when intervening in bullying situations.

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5

Violence Against Sexual and Gender Minority Youth: Social Interventions of the Twenty-First Century

Claire Burgess, Cary L. Klemmer, Micha Martin, and Ankur Srivastava

Abstract

Victimization of sexual and gender minority youth (SGMY; lesbian, gay, bisexual, transgender, and gender diverse youth) has gained substantial national attention (Russell et al., 2011; Toomey et al., 2010). A number of studies find that SGMY are more likely to experience violent victimization than their peers (Burton et al., 2013; Fedewa & Ahn, 2011; Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012). In schools, obligatory learning environments for youth, victimization may come not only from other students but from teachers that may perpetuate or ignore bullying in their students. Victimization can be particularly isolating in rural environments or in environments in which affirmative role models are not present (De Pedro, Lynch, & Esqueda, 2018). In this chapter, we review the SGMY victimization literature and reflect on possible points of intervention. Specifically, we suggest that resilience and post-stressor growth may be best fostered through targeting minority stress experiences from a variety of intervention points (e.g., family, school, counseling). Improvements to behavioral health, given these interventions, will be examined.

Background and Introduction

Much attention in recent decades has been given to violence and hate crimes against sexual and gender minority youth (abbreviated as "SGMY"; sexual minority youth, abbreviated as "SMY"). In school settings, SGMY face bullying victimization, which can be described as a form of aggression involving repeated exposure to negative acts intended to inflict injury or discomfort and conveying a power imbalance between individuals (Olweus, 1993). Further, in recent years, much research has been dedicated to understanding *cyberbullying*, which refers to the intentional, repeated harm toward another through any electronic device (Hinduja & Patchin, 2010).

What is unique about SGMY is that in school and community settings, they experience bully-

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E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_5

ing at a substantially higher rate than their heterosexual, cisgender peers. Victimization estimates range from 75 to 98% for verbal victimization, 76 to 86% for relational victimization, 55 to 71% for electronic victimization, and 22 to 38% for physical bullying victimization (Abreu & Kenny, 2018; Birkett, Espelage, & Koenig, 2009; Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012; Rivers & Noret, 2008; Sterzing, 2012). These rates of victimization fall in contrast to national rates for their heterosexual and cisgender counterparts, which range from 10 to 20% of all youth being perpetrators or victims for in-person victimization (Institute of Medicine, 2011; Nansel et al., 2001; Nansel, Craig, Overpeck, Saluja, & Ruan, 2004) and 5 to 40% for cyberbullying (Aboujaoude, Savage, Starcevic, & Salame, 2015; Kowalski & Limber, 2007; Rice et al., 2015; Wang, Iannotti, & Nansel, 2009).

Minority Stress: Health Impact of Violence on SGMY

One way to conceive of the impact violence has on SGMY is through minority stress theory (MST; Meyer, 2003; as applied to transgender and gender diverse individuals, Hendricks & Testa, 2012). MST has been widely used to explain the health disparities found between sexual minority (Alessi, Martin, Gyamerah, & Meyer, 2013; Goldbach, Schrager, Dunlap, & Holloway, 2015; Goldbach, Tanner-Smith, Bagwell, & Dunlap, 2014), gender minority individuals (Gamarel, Reisner, Laurenceau, Nemoto, & Operario, 2014; Hendricks & Testa, 2012; Reisner, Greytak, Parsons, & Ybarra, 2015), and their heterosexual, cisgender counterparts. MST argues that the presence of stigma, prejudice, and discrimination creates unique stress experiences for minority individuals and is correlated with behavioral health consequences (Alessi et al., 2013; Goldbach et al., 2014; Goldbach et al., 2015). The behavioral health sequelae include both proximal (e.g., expectations of rejections, concealment, and internalized homophobia) and distal stressors (prejudice events and experiences of discrimination and violence) (Goldbach & Gibbs, 2017; Rosario, Schrimshaw, Hunter, & Gwadz, 2002). Although MST was initially proposed to explain unique health outcomes among sexual minority individuals, MST has been applied to gender minority populations as well to explain experiences of transgender-related discrimination and stigma associated with behavioral health outcomes, like substance use, depression, and PTSD (Gamarel et al., 2014; Reisner et al., 2015).

The present chapter focuses on interventions for hate crimes, bullying, and other forms of violence against SGMY. SGMY may develop negative cognitions about themselves and may be more likely to perceive intolerance and rejection from their environments, given settings in which hostile, bullying behaviors exist (in SMY, see Burton, Marshal, Chisolm, Sucato, & Friedman, 2013). These stressors are remarkable for the toll they leave on both perpetrator and victim, diminished self-esteem, increased depression, and increased suicidal ideation, with cyberbullying demonstrating a greater impact toward depression and suicidal ideation than traditional bullying in some studies (Hinduja & Patchin, 2010; Turner, Exum, Brame, & Holt, 2013).

In addition to its association with suicidality and depression in several studies (Burton et al., 2013; Russell, Franz, & Driscoll, 2001; Shields, Whitaker, Glassman, Franks, & Howard, 2012), bullying victimization is also associated with externalizing outcomes (Williams et al., 2009), risky behaviors (Bontempo & D'Augelli, 2002), and substance use (Goldbach et al., 2014). Victimization due to being perceived as a minority identity is the most critical mechanism related to increased substance use in SMY: in a meta-analysis, general victimization toward sexual minority youth demonstrated the greatest effect size relationship to substance use (Goldbach et al., 2014).

Informing Intervention: A Review of School Climate

Long studied, school climate is indicative of the overall quality and character of school life (Cohen, Mccabe, & Michelli, 2009). School cli-

mate is broader than the experience of one individual student: it is the aggregate of many individual's perceptions of the school setting that include parents, teachers, administrators, students, and staff (McGuire, Anderson, Toomey, & Russell, 2010; Toomey, McGuire, & Russell, 2012). Thus, school climates reflect the norms, values, goals, interpersonal relationships, teaching/learning practices, and organizational structure of a school (Thapa, Cohen, Guffey, & Higgins-D'Alessandro, 2013).

Given school climate can be indicative of positive outcomes for SGMY, it an important target for interventionists interested in improving the lives of adolescents. Schools are an important intervention context for SGMY that can shape developmental outcomes, yet often present challenges and risk for violence and negative mental health outcomes (Kosciw, Greytak, Giga, Villenas, & Danischewski, 2016; Kosciw, Greytak, Zongrone, Clark, & Truong, 2018). Students' feelings of safety are foundational to a positive school climate (Thapa et al., 2013).

Deficiencies in safety and safety policy may negatively impact students' ability to thrive in school and are predictive of students' overall likelihood to encounter violence; literature has implicated the role that a negative school climate plays in contributing to elevated rates of school violence and negative mental health outcomes of students (Benbenishty & Astor, 2005; Benbenishty, Astor, & Roziner, 2018; Coulter & Rankin, 2017; Thapa et al., 2013). Both sexual and gender minority youth are at risk to skip school from fear of victimization (Friedman et al., 2011; Garofalo, Wolf, Kessel, Palfrey, & DuRant, 1998). In Friedman et al.'s (2011) meta-analysis, researchers found sexual minority youth were more likely to report victimization at school and skip school out of fear than non-sexual minority youth.

Though research demonstrates the heightened degree to which SGMY encounter violence in schools, are truant to perhaps avoid violence or aggression, and report negative perceptions of school climate relative to heterosexual, cisgender peers (Clark et al., 2014; Day & Russell, 2018; Toomey et al., 2012), few evidence-based interventions correlate with positive school climates for SGMY (Day & Russell, 2018; Kosciw et al., 2016; Kosciw et al., 2018; Russell, Day, Ioverno, & Toomey, 2016; Wernick, Kulick, & Chin, 2017).

Best Practices for Preventing Violence in School Settings

The current dialogue on how to best foster positive school climate for sexual and gender minority adolescents suggests a number of important factors that schools can implement to improve safety, reduce violence, and lead to improved behavioral health. In one of the first research studies of rural transgender and gender diverse youth (TGDY), De Pedro, Lynch, and Esqueda (2018) highlighted several policies and milestones schools can implement, supportive of SGMY. These included (1) school-based support groups and clubs specific to SGMY students such as gay-straight alliances ("GSAs") (Seelman, Forge, Walls, & Bridges, 2015), (2) teacher and peer intervention in incidence of bullying and school violence (Wernick, Kulick, & Inglehart, 2013), (3) promotion and implementation of enumerated anti-bullying and school violence policies that provide direct and immediate protection to students and institutional legitimacy and power to educators and other advocates to enforce the enumerated policies regarding gender identity and sexual orientation (Russell et al., 2016), (4) depiction of SGMY and their experiences in classroom curriculum across content areas (De Pedro, Jackson, Campbell, Gilley, & Ciarelli, 2016), and (5) availability of LGBTQ-specific resources on campus such as access to SGMY affirmative sexual and mental health counseling (Kosciw et al., 2018).

The impact of the above-listed school climate-related factors on improving the safety and well-being of SGMY students overall is not fully understood, indicating a need for further research in this area. Research has shown that while both teacher and peer intervention in correcting homophobic harassment is impactful, this type of intervention may be quite rare (Wernick et al., 2013). In fact, educators have been shown to be the source of gender-oppressive language, which

may dampen supportive intervention from other sources (Dessel, Kulick, Wernick, & Sullivan, 2017). Recent research has demonstrated that only a minority of schools systematically implement the five factors mentioned above to promote positive school climate for SGMY students, in part due to the political context involved in the implementation of the sexual and gender minority-specific policies (Green, Willging, Ramos, Shattuck, & Gunderson, 2018). The widespread lack of implementation may obfuscate current knowledge on the impact that these factors have on the education, violence, and mental health outcomes of SGMY. In the next sections of this chapter, we will examine the literature, programs and policies showcasing these five factors in action.

Gay-Straight Alliances GSAs have been documented to contribute to overall positive school climate for SGMY, though the results are somewhat mixed and more research is needed (Gower et al., 2018; Hazel, Walls, & Pomerantz, 2018; Seelman et al., 2015). GSAs provide students access to supportive and safe adults (Kosciw et al., 2018) and promote increased self-esteem (Russell, Ryan, Toomey, Diaz, & Sanchez, 2011). However, research has also shown that the presence of a GSA alone does not contribute to improved climate for all SGMY students in schools. In fact, one study demonstrated that GSAs were not associated with improved connectedness to school for SGMY (Seelman et al., 2015). This study showed that, instead, other, co-occurring characteristics of schools where a GSA was present (i.e., their size, activity, visibility, financial support, and adult involvement) and individual's participation in those GSAs explained improved perceptions of school climate among SGMY (Seelman et al., 2015). This research suggests that GSAs with strong support and capacity are likely to be the most effective supports for SGMY.

However, GSAs may not provide shelter from violent victimization for SGMY. A study of rural schools in California found that SGMY in rural schools reported less safety when their school had a GSA (De Pedro et al., 2018). Those schools embedded in communities that offered limited access to basic LGBTQ-focused resources and support such as LGBTQ community centers, social services, and housed a non-affirming populace may lead SGMY to feel less safe. Furthermore, it may be that GSAs are formed by SGMY in response to a discriminatory environment, explaining this result. Ultimately, more research is needed on the impact of GSAs on SGMY's experiences, especially longitudinally and in the context of an ever-changing sociopolitical environment.

In conclusion, multiple intervention targets and supports may be necessary in schools as well as the broader community to develop salubrious environments for SGMY. Successful anti-bullying policies in schools that have support groups demonstrate lower rates of SGMY victimization and suicide attempts (Goodenow, Szalacha, & Westheimer, 2006, for SMY).

Supportive Adults and Peers One consistent buffer in the SGMY violence literature is the presence of supportive others. Minority stress theory posits that supportive others, such as peers, parents, and other adults, likely provide a strong moderating impact on the negative effects of environmental and internalized chronic stress (Hendricks & Testa, 2012; Marshall, Yarber, Sherwood-Laughlin, Gray, & Estell, 2015; Meyer, 2003; Simons, Schrager, Clark, Belzer, & Olson, 2013). For SGMY with supportive adults in school and home contexts, higher levels of father and teacher emotional support are associated with lower levels of emotional and behavioral problems of youth both cross-sectionally and over time (Yeung & Leadbeater, 2010). In this study, students' reports of teacher support reduced the negative impact of relational victimization on emotional and behavioral problems in students. In the study of rural California schools, intervention by adults and peers toward harassment was found to have the strongest explanatory impact on SGMY's positive perceptions of safety in their rural schools (De Pedro et al., 2018). Specifically, they found having supportive adults who know the needs and experiences of SGMY

may lead to an improved sense of safety among rural, school-going SGMY.

On the other hand, when adults in youth contexts mislabel or ignore SGMY, they may perpetuate subtle microaggressions in the educational setting. Educational staff may be modeling to other students and their peers that a lack of response to these individuals is acceptable. A key intervention point is the way in which a teacher responds when marginalization occurs in a social environment and responding in a way that empowers and values LGBTQ experiences (Alessi et al., 2013). Importantly, supportive adults (and peers) who respond supportively beget more supportive adults and peers in the context of schools. Wernick et al. (2013) found that peer and teacher intervention in sexual and gender minority-based bullying increased the likelihood that students would intervene in bullying victimization. These results indicate the role that students themselves have in improving school quality for SGMY and suggest a local target for preventionists' efforts.

Policy Evidence is promising that with explicit and comprehensive polices in schools, SGMY youth can be protected from violence. School policies that explicitly protect students from violence and harassment based upon their gender identity or sexual orientation, either perceived or actual, are conducive to SGMY positive health and decreases in violence (Russell et al., 2016). The Gay, Lesbian, and Straight Education Network (GLSEN) showed that SGMY in schools with comprehensive protective policies toward minorities were less likely to experience hateful speech, were more likely to report that staff were supportive in intervening in incidences of verbal and physical violence, and were more likely to report greater connectedness to adults in schools (Kosciw et al., 2018). The effects of affirmative policies are far reaching: in schools where transgender and gender diverse students felt more safe accessing bathrooms that matched their gender identity, they reported increased self-esteem and stronger academic achievement (Wernick et al., 2017). In sum, interventionists may find it effective to focus on promoting comprehensive policies that name and protect access to needed resources, such as access to bathrooms that match the gender identity of students (Bender-Baird, 2016).

A recent national report of the GLSEN on school climate revealed that, although a majority of schools in the country do have at least one supportive policy protective of SGMY students, only 12.6% of the national SGMY sample was aware that these policies exist (Kosciw et al., 2018). Problematically, this study demonstrated that most students (90%) were unaware of any policy or guideline that explicitly supported transgender and gender diverse students. A gap in awareness of the implementation of these policies illustrates that policies in and of themselves may not offer protection to students without stakeholder solutions and infrastructure to act on protective measures (Orr & Baum, 2015).

Curriculum On a broader level, schools may be environments for inclusive learning, which can normalize sexual and gender minority individuals, experiences, and identities. GLSEN's national report documents estimates of the prevalence and impact of inclusive curricular resources on the school climate for SGMY. About one fifth of SGMY report being taught positive representations of LGBTQ people, history, and/or events in their schools, with a similar proportion reporting that they had been explicitly taught negative content on LGBTQ people (Kosciw et al., 2018). Despite a seemingly diffuse connection to violence intervention, these findings are consequential: students in schools with positive representations and access to SGMY-specific resources such as comprehensive sexual health education attentive to human sexual and gender diversity are more connected to their schools, experience less verbal and physical victimization, and performed better on their coursework than those students who did not report similar representation and resources in their schools. Therefore, advocacies that incorporate positive representations of SGMY people in school curricula and ensure that the needs of SGMY are

addressed through LGBTQ content accessible through school support personnel (e.g., school counselors and school social workers) are meaningful interventions that likely will promote positive school climates for SGMY (Marshall et al., 2015).

Intervention Research on Gender Minority Youth

Transgender identities may be less visible, as they may be mistaken for sexual minorities by society (Beza, 2017). Early studies were consistently criticized for "grouping" TGDY into single samples with SMY (Collier, Van Beusekom, Bos, & Sandfort, 2013; Lee, Matthews, McCullen, & Melvin, 2014; Marshall et al., 2017). Grouping TGDY with SMY prevents a full understanding of how gender identities may be related to victimization and behavioral health outcomes (Bosse & Chiodo, 2016; Collier et al., 2013; Kuper, Nussbaum, & Mustanski, 2012). In addition, grouping TGDY with SMY (i.e., LGBTQ) may obscure important characteristics and needs of TGDY, for example, gender-based discrimination, violence, family rejection, and hate crimes (Bradford, Reisner, Honnold, & Xavier, 2013; Gamarel et al., 2014; Klein & Golub, 2016; Stotzer, 2008). Though a body of literature does exist examining important school climate and school violence-related factors of SGMY as a whole, this research mixes gender identity and sexual orientation by combining these students into one group and considering their experiences as identical (Frohard-Dourlent, 2016; Frohard-Dourlent, Dobson, Clark, Doull, & Saewyc, 2017). TGDY have developmental trajectories unique and separate from those of their sexual minority peers (Marshall, 2017; The GenIUSS Group, 2014), and studies examining the school-based experiences focused on transgender students are lacking in sample size and representativeness (Day & Russell, 2018; Green et al., 2018; J. G. Kosciw et al., 2016; Kosciw et al., 2018; McGuire et al., 2010). Studies attentive to subgroup differences (i.e., transfeminine, transmasculine, and nonbinary gender identities as well as sexual orientation) are absent from existing literature and are needed (Toomey, Syvertsen, & Shramko, 2018). Hence, by examining sexual minority and gender minority populations separately, data specific to transgender and gender diverse people may imply that the percentage of youth that experience bullying, violence, and poor academic performance is higher than it would be for SMY alone.

To improve understanding of transgender individual's experiences and stressors, Testa, Habarth, Peta, Balsam, and Bockting (2015) worked with an exclusively gender-nonconforming sample to develop a measure of gender minority stress, the Gender Minority Stress and Resilience Measure (GMSRM). Testa et al. (2015, 2017) examined negative experiences associated with gender identity and their implications for individual's expectations of facing rejection or victimization in the future and internalization of transphobia. For instance, a major study of sexual and gender minority youth (Toomey, Ryan, Diaz, Card, & Russell, 2010) sampled only 21 gender minority youth out of a sample of 245. The study's hallmark finding was that gender nonconformity is related to experiences of victimization due to being perceived as SGMY which is then related to depression and negatively related to young adult life satisfaction. While aspects of gender identity such as gender expression may be relevant to sexual minority individuals as seen in Toomey et al.'s research, aspects of gender identity are difficult to pull apart for the purposes of measurement.

In school settings, research on TGDY individuals shows that they have a higher risk of victimization, which is correlated with absenteeism (Snapp, Hoenig, Fields, & Russell, 2015), which may, problematically, be linked to the "school to prison pipeline" for this population. Statistics find that 63% of individuals who identify as transgender in high school receive lower grades

than their peers and feel unsafe in the academic environment (McCann, Keogh, Doyle, & Coyne, 2017). This population additional reported a 59% absenteeism rate.

Intervening in Healthcare Settings: SGMY Affirmative Therapy

SGMY are a minority that face oppression not shared with family members or peers. Sexual and gender minority youth are unique in that, while most minority identities like culture and ethnicity may be shared with their family and peer group, sexual and gender minority youth do not necessarily have this benefit (Crisp & McCave, 2007). While social and cultural knowledge may be passed from parents to youth who share minority identities, this is lacking for SGMY and can lead to feelings of separateness and isolation. Gandy, McCarter, and Portwood (2013) explain that SGMY are at increased risk of verbal and physical victimization and may not be in a family context that understands the steps necessary to protect their child from violence.

The community would benefit from empirically supported treatments for SGMY trauma and violence victimization (Craig, 2013; Horn, Kosciw, & Russell, 2009). Current programming is general and may not address the specific stressors that SGMY face (Meyer, Dietrich, & Schwartz, 2008). Additionally, broad programming may not result in improvements in mental health (Galliher, Rostosky, & Hughes, 2004). Current programs that use a minority stress theory framework have been found to be effective at treating the mental health of SMY (Craig, 2013). Thus, minority stress-adapted treatments may be useful in reducing bullying or alleviating the poor social and mental health outcomes associated with bullying.

One approach that has had some support is affirmative therapy techniques in counseling, which have been shown to be successful in reducing risk of violence when working with minority youth. This approach may be effective because of its focus on affirming and legitimizing a youth's experience, which contrasts with their experiences in environments outside of therapy. One example of an empirically supported affirmative treatment is gay affirmative practice (GAP), an approach based on cognitive behavior therapy that also incorporates resiliency and strength-based methods (Crisp & McCave, 2007). This treatment focuses on supporting the youth to work through stressful situations even if the context of the stressors cannot be changed (Craig, Austin, & Alessi, 2013). Part of the treatment involves provider affirmation that some of a youth's concerns are not generated via dysfunctional cognitions, but through navigating risky or unsupportive contexts.

According to Gandy et al. (2013), one limitation of affirmative approaches is that an inexperienced provider may dismiss a youth's concerns as a sign of dysfunctional thinking. For instance, some SGMY may think "if I come out my family, they will kick me out of the house and I will become homeless," which may be a realistic concern. A provider who does not understand the family context or risks involved in a youth disclosing their sexual or gender identity may interpret this type of thinking as distorted and provide inadequate feedback. The literature suggests that instead of attempting to work with the client to replace this thought to instead approach it with prompting questions such as "is it helpful to hold on to this belief?" (Craig et al., 2013). Some of the issues that seem unrealistic may be reality to TGDY (and may not apply to other minorities). The strengths of affirmative treatments are that they provide culturally competent, sensitive approaches to working with the unique stressors SGMY face.

Additional empirical findings suggest that the knowledge and attitude of service providers has a direct impact on sexual and gender minority youth. Cultural competence and a provider's ability to separate their personal beliefs and assumptions are imperative for collaborative work to take place between the client and the clinician (Bowers & Bieschke, 2005; Shelton & Delgado-Romero, 2011).

As youth age, they may experience barriers in receiving healthcare. Some common barriers to

care that transgender and gender diverse individual's face are the availability of appropriate services in both medical and behavioral health settings. Finding culturally competent providers that offer affirmative care can be challenging, as negative past experiences may deter transgender individuals from further seeking services (Lombardi, 2001; Pazos, 1999). Behavioral health providers working with this population should be aware that the path to the providers' office may not have been easy and clients may be hesitant and skeptical of the therapeutic relationship. Social workers play a key role while working with transgender and gender diverse individuals as surgical procedures that gender diverse people seek often require documentation from a behavioral health provider.

Conclusions: Resilience and Post-stressor Growth

Resilience is an essential component of the minority stress model that is thought to moderate the impact of minority stress on SGMY adolescents. It is thought that increased levels of resilience can protect against the negative impact of sexual minority stress on mental and physical health outcomes (Meyer, 2003). As for research on TGDY, resilience is also thought to be an essential factor that can be targeted by preventionists to improve the behavioral health of this group. Resilience in the form of pride in one's gender identity and connectedness to in-group members is thought to be important in disrupting the negative impact of gender minority stress on TGDY's behavioral health (Testa et al., 2015). Parental support serves to bolster growth of a positive attitude toward gender identity in multiple studies (Simons et al., 2013; Wilson, Chen, Arayasirikul, Raymond, & McFarland, 2016).

Gender minority adolescents grow unique resilience strategies as they navigate the development of their authentic selves in environments that expect their confirmation to gender identity and expression norms (Singh, Meng, & Hansen, 2014). For example, in the face of violent and traumatic experiences, TGDY may build resilience by means of using individual, social, and cultural variables that allow at-risk individuals not only to overcome hardships but to succeed (Mizock & Lewis, 2008). Singh interviewed TGDY across the Southern United States to better understand their resilience strategies, with particular attention to TGDY of color (Singh, 2013; Singh et al., 2014; Singh & McKleroy, 2011). Singh has found that these youth, due to experiences of overt and covert racism and transprejudice, utilize the following strategies of resilience:

1) evolving, simultaneous self-definitions of racial/ethnic and gender identity (e.g., pride in identification as black and transgender),
2) awareness of adultism (i.e., that adults hold power over youth, and may not understand transgender individual's experiences leading the youth to search out supportive organizations and individuals to support their needs),
3) finding one's place in the LGBTQ community (e.g., finding friends and support in other LGBTQ youth through, for example, LGBTQ centers),
4) using of social media to affirm one's identity, and
5) self-advocacy in the educational system. (Singh, 2013)

Elsewhere, Singh et al. (2014) have identified major threats to these youth's resilience, which include challenges in accessing affirmative healthcare, experiencing emotional and social isolation, employment discrimination, possessing limited financial resources, and encountering pervasive gender policing. This research demonstrates that preventionists hoping to improve the behavioral health of TGDY can focus on bolstering these youth's coping strategies and removing the barriers to their development. This not only requires individual-level intervention with TGDY to ensure they are resilient in the face of violence but also necessitates structural change toward greater acceptance of gender diversity, limiting pervasive gender policing and preventing violence targeted at transgender and gender diverse individuals all together (Jauk, 2013). A related

study by Grossman, D'augelli, and Frank (2011) with 55 TGDY, majority of whom had experienced verbal or physical abuse, found that selected aspects of resilience (sense of personal mastery, self-esteem, perceived social support, and emotion-oriented coping) accounted for 40–55% of variance in relation to mental health symptomology and internalizing and externalizing problems.

Though a preponderance of literature exists documenting the negative stressors TGDY face, literature documenting transgender resilience is needed to adequately illustrate the way in which resilience emerges among TGDY, as well as the ways in which it protects from the negative impact of stigma based on gender identity and expression (Stieglitz, 2010).

Future Directions

Future research studies could improve their measurement of victimization as a minority stressor, given its association with poor behavioral health outcomes. Past studies of gay-related stressors have failed to examine key gay-stress variables, such as witnessing gay-related victimization (see Russell et al., 2001). Little is known about sexual minority youth under the age of 14, because many are unaware of their same-sex attraction or do not self-identify as a sexual minority until early or mid-adolescence (Floyd & Bakeman, 2006).

There is a need for research explaining the mechanisms (such as victimization) by which sexual minority youth are affected by adverse health outcomes (U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [HHS ODPHP], 2019; Institute of Medicine, 2011). Researchers, such as Burton et al. (2013) and Goldbach et al. (2014), have begun examining victimization as a mechanism through which adverse health outcomes occur. Decreasing victimization is the first step to suicide prevention and decreasing the incidence of dangerous health outcomes (Russell et al., 2001). The explanatory variables of sexual minority youth mental health and health outcome disparities have only just begun to be explored (Burton et al., 2013), and there are little known buffers against victimization (Nesmith, Burton, & Cosgrove, 1999). Prevention will be a priority in the coming years addressing substance use and depression that follows from victimization within this population.

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6

The Serpent and the Dove: A Spiritual and Political Formation of Nonviolence and Direct Action in the LGBTQI Community

Haven Herrin

Abstract

Soulforce has, since our start in 1998, practiced what we call relentless, nonviolent resistance in our organizing to end the religious and political oppression of lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) people. Starting out in the 1990s, we analyzed the powerful sources driving the most toxic and violent messages against LGBTQI people, and the data overwhelmingly at that time pointed to Christian broadcasters like Pat Robertson and Jerry Falwell and global Christian denominations like the United Methodist Church and the Catholic Church as the architects, funders, and promoters of the gravest physical and spiritual violence launched against the LGBTQI community. The faces and structures have changed since our early days, but the operating premise remains the same: Christianity co-opted by systems like white supremacy, capitalism, and colonization to advance a racial, economic, and patriarchal agenda. This is an ideological system Soulforce defines as Christian Supremacy.

Addressing Christian Supremacy and practicing relentless, nonviolent resistance form the bookends of our theory of change in pursuit of collective liberation for LGBTQI and all who are targeted by weaponized Christianity.

Our Origin Story

Soulforce has, since our start in 1998, practiced what we call relentless, nonviolent resistance in our organizing to end the religious and political oppression of lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) people. Starting out in the 1990s, we analyzed the powerful sources driving the most toxic and violent messages against LGBTQI people, and the data overwhelmingly at that time pointed to Christian broadcasters like Pat Robertson and Jerry Falwell and global Christian denominations like the United Methodist Church and the Catholic Church as the architects, funders, and promoters of the gravest physical and spiritual violence launched against the LGBTQI community.

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E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_6

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Nice Will Not Save Us

Most schools of nonviolent resistance formed around iconic practitioners who dismantled systems of colonization, racialized violence, and labor exploitation. As a consequence, we cannot be surprised that white supremacy created a warped version of Nonviolence to disrupt and divide those of us working for collective liberation.[1]

We have continually strived to disentangle ourselves from the white supremacist, and some might also say capitalist, versions of Nonviolence so that our work and witness are not misunderstood, accidentally promoting or practicing oppressive values or losing out on collaboration with activists for whom "nonviolence" has become a dirty word, a tool of shame and repression.

Soulforce was called once again to discern what nonviolent activism means to our organization in 2014 when the #BlackLivesMatter movement coalesced. Calls from the Right were loud and insistent that the movement was not but ought to practice Nonviolence. By all accounts the activists were organizing in a nonviolent—or perhaps "not-violent" so as to not press such labels upon organizers without their consent—manner, but the Right wielded, with some success in curtailing sympathy toward the work, some classically frustrating clichés within the body of thought and praxis that surrounds nonviolent activism.

Some examples of these discourses are:

1. Assessing the comfort of those in power who uphold and benefit from the system of white supremacy in order to determine whether Black Lives Matter activism qualified as "Nonviolent"
2. Using false peace and (*some* people's) security as the measure of oppressed activists' Nonviolence
3. Using calls to Nonviolence as a constraint on what tactics that #BlackLivesMatter activists can use and still be considered worthy of justice
4. Implying that whether #BlackLivesMatter received the stamp of Nonviolence from the Powers That Be was determinant of their moral worth and full humanity and therefore the merits of their demands[2]

At Soulforce, we felt: *Let's make damn sure that is not our expression, perceived or real, of nonviolent activism*. Observing calls to Nonviolence used as a weapon of white supremacy in this way demanded that we stoutly clarify that our practice centers the most marginalized and that all else—our ethics, our practice, and our *why*—flows from that stance. Since 2014, we have increasingly challenged ourselves to revisit and reclaim what we mean by nonviolent resistance: why we aspire to it, how we measure our integrity and success, where we direct our efforts, why we choose it, and what it looks like.

As an organization that has intentionally transitioned to avowedly center People of Color and Trans/Gender Non-Conforming/Non-Binary (TGNCNB) People, we did not want to be people of a false peace, flirting with docility and gentleness as a means of exercising privilege and maintaining a blessing from the Powers That Be.

In our nonviolent practice, if we were going to be "nice," according to the measures of those in power, we were going to be nice because that's what was in our hearts, or felt good to our souls, or was a tactical means to our ends. We are not here to placate the oppressor or evince the belief that being deemed Nice will save us, especially the most vulnerable among us.

[1] Haven Herrin and D.J. Hudson, *Nice Will Not Save Us*, Vol. I (Abilene, TX: Soulforce, 2019), paragraph 3. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[2] Ibid, paragraph 7. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

Soulforce's original tagline was "Relentless Nonviolent Resistance." Today it is "Sabotage Christian Supremacy."

The word sabotage comes from the French word *sabot*, meaning the heavy work boot that workers wore as they noisily stomped through their factories, using collectivized labor disputes to gum up the gears of the industrial revolution that was eating workers alive. The word retains the essence of The People who, lacking conventional political and institutional power, work to find creative leverage with their bodies and collective weight to tip the balance in favor of the many over the few and privileged. It underscores using one's power for the good of the collective. And it also retains the flavor of intentional subtlety—the implication that one must be scrupulous about what is public and what is private when one is up against forces with far greater resources and weapons at their disposal. The lesson: There is no shame or duplicity in fighting for liberation through means that protect your body and spirit.

That's why Soulforce feels great about the use of the word *sabotage*.

For some, the evolution of our tagline is a logical progression of the exact same principle—staunch commitment to challenging oppression—applied to the changing backdrop of the Religious Right's spiritual and physical violence toward marginalized groups, including but not limited to lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) people. Examples of violence that are moralized, financed, and promoted specifically from within the Religious Right include the lack of employment protections for LGBTQI people at the federal level, federal and state laws allowing for "conscientious objection" to adequate and competent healthcare for LGBTQI people, violence against immigrants at the US border in the name of "law and order," and climate crisis denial.

As the Right has ramped up its violence and shamelessness, we would say it is fair, even morally required, to put our stake in the ground at being fervently, aggressively, and publicly committed to dismantling those violent systems.

For others, the transition from the first to the second tagline is rocky and uncomfortable, if not an outright betrayal of what some people understood our essential attitude to be.

I understand why the word *sabotage* might demand a bit of consideration. It is aggressive. There's very little strategic dissembling diplomacy about it. But in workshops, when we itemize the actual harm of Christian Supremacy—further examples include white nationalist shootings, violent invasions of our sanctuaries from the Tree of Life Temple to the Pulse Nightclub, and an administration that would bureaucratize the legal and biological reality of TGNCNB people out of existence—we usually arrive at an agreement that such violence is worthy of a forceful, tactical takedown.

What is this surface dissonance, then, between those who prefer the "nicer" seeming tagline and those who resonate with the more aggressive tone of the latter? Insofar as both camps are answering a call within their spirits or conscience to respond to ills of our social and political reality in a principled way, neither is more valid than the other. But the supposed tussle between Nice vs. Aggressive is instructive; it reveals the need to define what we mean by nonviolent resistance, examine our orientation toward aggression and power, and, perhaps most importantly, articulate why we might choose to engage in nonviolent resistance in the first place.

The offering here for healthcare providers and other support professionals is that anger can be healthy in activism when it indicates a sense of self-protection and empowerment. Aggression can be a useful and reasoned response toward systems, institutions, ideas, and figureheads. When that aggression devolves into internalized rancor and stewing, rather than focusing outward on systems change, that is when we would ask a comrade in our action to take a break and reflect.

Niceness or "good behavior" is a strategy, not a moral imperative. From this principle, we DERIVE THE POLITICS, ETHICS, AND PRACTICE OF OUR nonviolent activism. Answering our spirits' (or ethics') call to responsive action in whichever way best liberates us and our people is a

self-protective measure that indicates self-worth, compassion, and optimism.

Nonviolent Activism

Soulforce engages in a practice of resistance that centers those of us on the margins to free ourselves and our opposition from violence inflicted upon our bodies and spirits. That could, of course, describe the activism of many groups who do not formally subscribe to nonviolent activism per se.

> We *choose* to strive toward a nonviolent form of resistance. In our nonviolent activism, the why and the how are intrinsically bound. Process matters because we are primarily seeking healing and transformation in the journey of activism itself. Our gaze is as much internal, if not more so, toward our own souls and community, as external toward circumstances we want to change. **Practicing nonviolence means**, for us, to cultivate a spiritual orientation toward survival *and* thriving that invokes strategically effective action that seeks personal transformation and an end to systemic violence, based in rigorous ethics that value the body, the spirit, and the collective.[3]

If that feels mushy, it's because this is an ethical practice not a rote set of directives. However, in an attempt to describe the benchmarks of that spiritual orientation, here are our most enduring positions:

1. We work to get as many of our oppressed people out alive as we can.
2. My job in seeking liberation is to heal and transform myself; it is not my job to redeem my oppressor.
3. We, the oppressed, dictate the terms of our liberation. Oppressors are welcome to join in the process of transforming themselves and the world.
4. Our work targets structures, not people, but the more responsibility someone possesses within a system of violence, the more we will challenge them to transform.[4]

Tactically speaking, this is our rubric for the what and the how:

1. First, we recognize that suffering is taking place and that it is perpetuated by disparities in power, wealth, and access.
2. Second, we deeply experience, or connect in solidarity, to this reality of suffering. We learn, research, practice empathy, strategize, and build alliances.
3. Third, because we cannot un-know, we must act. For our souls to remain whole (because we care about such things), and for our bodies to survive, we are called to remedy the situation. This action can be individual or communal, spiritual or physical, internal or external, or some mixture of these.
4. Fourth, we pursue our twofold aims—healing and reclaiming our spirits in the face of oppression and changing the ideologies and structures that hold oppression in place—using a variety of tactics that flow from our ethics.
5. Fifth, *if* we engage in direct action, we use our skills in research, strategy, solidarity, protest, and negotiation to set the terms of our liberation.[5]

If we undertake any activity that fits into and feeds that framework—self-care, prayer, education, research, lobbying, direct action, and more—we are engaging in nonviolent activism, according to our understanding.

There are many iconic practitioners of nonviolent resistance who lived and struggled for justice well before Soulforce came along with our constructions of the "17 Step Journey Towards Nonviolence," "Five Vows," and other structures to give shape to the spirit of our nonviolent practice: Dorothy Day, Václav Havel, Cesar Chavez, Mahatma Gandhi, and Dr. Martin Luther King Jr., to name a few.[6]

[3]Ibid, paragraph 93. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[4]Ibid, paragraph 94. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[5]Haven Herrin and D.J. Hudson, *Nice Will Not Save Us*, Vol. II (Abilene, TX: Soulforce, 2019), paragraph 22. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[6]The website Waging Nonviolence (www.wagingnonviolence.org) offers a trove of biographies and commentary on nonviolent activism.

But there are infinitely more daily practitioners of nonviolent resistance who slowed down the means of production, held back information, took care of their kindred to build up fortitude, made the gears of power grind with more friction, and refused to let their spirits be dominated. This too is nonviolent practice, waged at the most intimate and granular levels that allowed bodies and souls to survive until today.[7]

Direct Action and Civil Disobedience

It is useful at this point to make the distinction between the wide field of nonviolent activism and direct action in specific. The former contains all the philosophy, preparation, research, pressure tactics, strategy, *and* direct action, should the work come to that.

Direct action—composed of more physical and public actions, either in-person or online, such as marches, sit-ins, street theater, boycotts, and petitions—is frequently conflated with nonviolent struggle writ large because the more kinetic activities are noticeable and newsworthy, thus becoming the part that stands in for the whole.

Direct action is just one possible element of the nonviolent activist's process, and even this can vary widely:

> "I am a lesbian, and since moving to Florida in 1992, I have been an activist for LGBTQ rights. In 2010, I was able to join other Soulforce members at a national conference of the Presbyterian Church (USA) in Minneapolis, where the issue of ordaining LGBT individuals as pastors was on the agenda. After a planning meeting of our group, we entered the conference hall, and interrupted the normal proceedings by surrounding the stage and beginning to sing. (I think we sang *O Lord, Hear Our Prayer*.) We were politely but firmly asked to leave, and when we didn't, first the security guards and then the police were called. We were given the option of leaving, to avoid arrest. Some of us (more than a dozen, including me) refused to leave and were arrested. We were escorted in a line to a couple of police cars parked outside the building, where we were issued tickets. It was the proudest moment of my life." – Eunice Fisher[8]

> "My first participation with Soulforce occurred across the street from Thomas Road Baptist Church where we staged a same-sex marriage ceremony then carried banners down a street in Lynchburg. Meeting Mel and Gary brought personal liberation to life; 'You can do this' was a nourishing message that has never left my heart. They proved that honesty was possible. After the suicide of my gay first cousin when we were 23 and 24, I battled approach-avoidance issues of self-denial, fear, isolation and desperation to find anything positive about my sexual orientation. When I walked into Mel and Gary's home, I saw that a beautiful, expansive relationship was possible.[9] I read *Stranger at the Gate* and gained the courage to give it to the lady I had married three years after Billy's death. I had thought that my only hope or choice for survival would be in a heterosexual marriage." – Jim Best[10]

These first-person stories are both held within the embrace of nonviolent activism, but they played out very differently. Eunice committed to breaking a trespass law to make a visible point.[11] Jim's experience in Lynchburg reads as more internal, centered on both the healing nature of the ceremony *and* the salve of realizing a different, more joyful way of living his authentic life was possible. Jim and Eunice both participated in nonviolent direct action, but only Eunice's action in Florida was more outward and confrontational, whereas Jim's action focused on healing and community in a more internal setting.

[7] Herrin and Hudson, *Nice Will Not Save Us*, Vol. II, paragraph 80. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[8] Eunice Fisher. Haven Herrin and D.J. Hudson, *Nice Will Not Save Us*, Vol. II, paragraph 64. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[9] Mel White and Gary Nixon are the Founders of Soulforce. The "Return to Lynchburg" direct action (October 25–27, 2002) included a blessing of the Founders' new home across the street from Jerry Falwell's Thomas Road Baptist Church, a vigil in front of Thomas Road Baptist Church, and a same-sex marriage celebration.

[10] Jim Best. Herrin and Hudson, *Nice Will Not Save Us,* Vol. II, paragraph 65. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[11] As a 501(c)3, we do not condone illegal activity. As a matter of historical record, we use Eunice Fisher's story to demonstrate the breadth of possible direct actions and encourage options that do not incite police engagement.

As a non-profit, we do not advocate for any illegal activity. We speak of civil disobedience as a matter of a historical record—because we must discuss it in order to fully explore the history of nonviolent practice, dispel certain myths, and examine the logic of various tactics and their motivation—and as a matter of preparation so that activists can cultivate skills in de-escalation and police interaction. The choice to engage or not engage police is heavily mediated by who you are, class, race, language, citizenship, and gender, and other identities influence that interaction. These social positionings can dictate how the police view your direct action—as nonviolent direct action, an intentional act of civil disobedience, or a violent rebellion. As such, we need to understand the dynamics of policing and what civil disobedience is in order to properly navigate these things.

Nonviolent and Violent

Nonviolence is a difficult word to work with because the word itself suggests that Violence is its opposite. But the truth is not so tidy. *Not-violent* more accurately defines the opposite of violence: passive, not forward-leaning or constructive, and an absence.

But we live in four dimensions, operating within complex systems while conducting activism that is a process over time. Trying to simply act in a manner that is the opposite of violence actually centers the oppressor because it proposes that the most salient question is "To whom or what were you violent toward today?". Instead, we believe we are better served by examining and holding accountable the ideologies, institutions, and individuals who are perpetuating violence. This shift in language and framework accomplishes something tactically vital: We need to shift the focus from the oppressor to the oppressed if we are to dismantle violent structures.

Nonviolent activism has whole bodies of theory and praxis behind it; therefore, it is less about the finite act—*was this snapshot in time violent or not-violent?*—and more about the evolving and transforming process of being in the stream of nonviolent activism:

> "Mel and I were spending a week together in D.C. preparing for the very first Soulforce direct action with the Roman Catholic Church [RCC]. It was fall of 2000 and the U.S. Conference of Catholic Bishops [USCCB] was coming up in November. In the infancy of Soulforce, I learned the goal of Soulforce work by listening to Mel's answer to a simple question. Rhonda Smith of the Washington Blade asked Mel, 'What is the goal of Soulforce work?'
>
> I immediately thought about an apology from the Pope. Or, perhaps that wasn't going to happen, but I imagined that the USCCB would at least welcome their LGBT 'children' back into the fold of the church. Or, they might make some kind of statement that contradicted the official position of the RCC which stated that homosexuals were 'objectively disordered' and that our relationships are 'intrinsically evil.'
>
> Or maybe the goal was to get a lot of media coverage to leverage the power of public opinion, embarrass the RCC into treating LGBT more humanely. Or maybe it was to at least show the more progressive Catholics that they had allies in this struggle for equality.
>
> But nope…Mel didn't list any of those things as the first goal of Soulforce. He spoke powerfully and succinctly: 'The first goal of Soulforce and all of the actions that we do is the transformation of the people doing the work!'" – Bill Carpenter[12]

Soulforce's working definition of violence is *that which removes someone's agency and self-sovereignty.*[13] What this means in application is that a punch or sharp word does not carry the same threat or meaning from every Body. When an institution like Focus on the Family denies the legitimacy of LGBTQI families, for example, it does not carry the same moral weight or responsibility as if I were to personally defame the Dobson family. I don't have the same wealth, broadcasting power, or social capital. I don't individually have the capacity to harm his family, whereas Focus on the Family's teachings have indeed caused suicide, destroyed families, and created the ideological ecosystem that enables legal, spiritual, and physical violence against LGBTQI people:

[12] Bill Carpenter. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[13] Herrin and Hudson, *Nice Will Not Save Us*, Vol. I, paragraph 77. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

> "I have seen the ways bad theology kills: emotionally, physically, spiritually. I've seen the ways that institutions used religion to hide the truth of queer people's belovedness and wholeness and beauty, and that breaks my heart."[14] -*Caitlyn J. Stout, Spring Arbor University graduate, activist, current Vanderbilt Divinity School student*

In short, not all forms of violence are the same, because we do not all possess equal weight, resources, and positioning. In this way, we always, always include a power analysis—an assessment of the person or institution, oppressor or oppressed, and their access to power, protections, and cultural narratives of moral authority.[15] This leaves a lot of interesting gray area for debate about what constitutes violence, acceptable violence, not-violence, and nonviolence wherein we have to take responsibility for our ethics and principles. How you balance survival versus ethical purity is a deeply personal matter, not dogma.

The answers are not clear-cut, and to suggest there are absolutes here is one way that white supremacist values infect our nonviolent practice.

Embodied Perspective and Context

Because direct action is often so very public, the question of how it is received is always urgent. One person's experience of peaceful, nonviolent resistance might be another's experience of violence. We are all, including the media and police, projecting and receiving different messages when participating in or witnessing a direct action based on who we are and what we have been taught about power, class, race, property, bodies, aggression, and peace[16]:

> "At the General Conference [GC] in Fort Worth in 2008, Soulforce did not plan a large-scale disruptive witness. By then, two long-time Affirmation members, Steven Webster and Jim Dietrich, were well-trained Soulforcers, who represented Soulforce to our movement.[17] Steven Webster, myself and Troy Plummer constituted a negotiation team with the United Methodist bishops about any disruptive actions that might emerge. We met with GC leaders and, with Jen Ihlo, communicated with police about potential acts of civil disobedience. Though Soulforce as an organization had no plans to disrupt, their presence at GCs laid the foundation for our movement to take up the mantle of collective action. Once again, Soulforce's history of determined training and action lent us the credibility to put us at the tables of power. Steven and I were chosen for the negotiating team because of our experience with nonviolent disruptive action, the tools for which Soulforce had given us.
> …
> People in our movement don't necessarily like Love Prevails for the same reasons they didn't like Soulforce back in the day.[18] We make them nervous. We ruin their plans. Though a number of our team are consummate long-term insiders of the movement, we are considered outsiders by mainstream gay Methodists. We thank Soulforce for standing with us in the last four years to inspire, cajole and train us. Some of the best moments we may claim as a movement at this General Conference will be a result of Soulforce's outside agitation, experience, preparedness, creativity and willingness to take risks. We continue to need Soulforce's experience in strategy and nonviolent resistance. We need alliances and collaboration to broaden our vision for what is possible and to give us strength. – Dr. Julie Todd[19]

Even within a movement that presumably shares similar goals—in this case organizers within LGBTQI and allied Methodists—there is internecine conflict. Some are willing to wait longer than others for justice. Some are *able* to wait longer for justice because the sting of oppression

[14] Caitlyn Stout. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[15] Herrin and Hudson, *Nice Will Not Save Us*, Vol. I, paragraph 83. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[16] Herrin and Hudson, *Nice Will Not Save Us*, Vol. II, paragraph 72. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[17] Affirmation is an organization for United Methodist Gay, Lesbian, Bisexual, Transgender, and Queer concerns. www.umaffirm.org

[18] Love Prevails is an organization of LGBTQI and allied United Methodists that launched out of the organizing around the pastoral trial of Rev. Amy DeLong. They have an orientation toward direct action, so Soulforce and Love Prevails have a long history of affinity and partnership. (https://loveprevailsumc.com/)

[19] Dr. Julie Todd, *On Soulforce* (2016). Reprinted with permission from the author

is not as sharp or grinding. Some believe in diplomacy with words, and some people believe in the healing and reconciling power of action.

Our social positions, access to privilege, and the weight of oppression we carry in our bodies dispose people differently toward the option of direct action. No matter where you identify within these metrics and more, it is important to know that power and power imbalances are usually operating along the fissures of divergent perspectives. Who you are and how the world treats you and receives you may significantly shape the emotional and intellectual relationship you have to the field of nonviolent activism.

Why Nonviolent Activism

When Soulforce formed in 1998, we chose then, and continue to choose now, a nonviolent form of activism for four primary reasons.

First, and most importantly, we wanted to heal ourselves in the process of resistance. We needed soul reclamation. We needed to embody for ourselves the love, protection, and advocacy that had been denied to us by our families, schools, political leaders, and spiritual keepers. Sticking up for oneself by joining in a community of activists, perhaps undertaking some small act of witness that asserts boundaries and self-worth, is like being the parent or teacher or pastor we perhaps wish had known but did not:

> "One memory I will never forget is about Kara's singing while in jail in Washington, DC. Ken and I were in a separate cell than Kara.[20] But, neither of us could sleep even with those stainless steel slab beds because Kara could be heard from the other wing singing Christian hymns all night long. Her singing made the thawed-out baloney sandwiches we collected to squish into pillows comfortable." – Mike Perez[21]

Choosing a loving, transformative path of activism heals ourselves and possibly our adversaries; bringing hate and ire instead of joy to the work might eat away at our own spirits, making the work of our liberation a heavy drudgery that deadens our souls:

> "Active love creates a force in the world that overthrows tyrants and defeats injustice. 'Soul force' is born in the hearts of [those] who put love into action, who choose to challenge injustice by embodying the principles of relentless non-violent resistance. When we are willing to put ourselves on the line to help end suffering and injustice, our lives are given new meaning and new power." – Mel White[22]

Second, we needed a style of activism that matched the tone and culture of right-wing Christian spaces which we were challenging. Perhaps if we led with loving courage, graciousness, and thoughtfulness, we would pluck the cultural strings of hospitality and compassion theoretically so deeply embedded in these fraught religious environments, thereby making ourselves coherent and calling our adversaries into the best versions of themselves:

> "I think Soulforce is important and unique in its size and ability to address homo/bi/trans-phobia from WITHIN faith communities…speaking their language to more effectively call in/out to create change. I believe Soulforce does so with an intersectional lens and utilizing our powerful stories as a liberational tool. Soulforce saved my life and taught me about activism.[23] I wouldn't be here and doing the organizing I am without Soulforce.
> Soulforce saves lives and empowers people to confront injustice.
> I remembered the 2006 Ride coming to my AOG [Assemblies of God] Bible College and them blocking the doors. I hated that action for a number

[20] Kara Speltz is a founding member of Soulforce and served on the staff for many years.

[21] Mike Perez's statement on the Soulforce civil disobedience during the meeting of the US Conference of Catholic Bishops in Washington, DC (November 10–14, 2002). This action led to the "Trial of the DC Three" in January 2003. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[22] Mel White, *Soulforce: 1999–2006* (Austin, TX: Soulforce, 2006), 5. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[23] Kimberlé Crenshaw coined the term "intersectionality" in 1989. In her words, "Intersectionality is a lens through which you can see where power comes and collides, where it interlocks and intersects. It's not simply that there's a race problem here, a gender problem here, and a class or LBGTQ problem there. Many times that framework erases what happens to people who are subject to all of these things." https://www.law.columbia.edu/pt-br/news/2017/06/kimberle-crenshaw-intersectionality

> of years as a closeted queer student trying to get into my buildings for class, scared to death of being found out. But later, after seeing what they endured blocking doors and knowing they were risking arrest, [I knew] they believed so much in my right to move freely on campus…So I decided we should block the doors.
> We did a die-in outside as the two of them and a security guard came to watch with big eyes. I read names and stats of people who had killed themselves or been murdered. One was my friend, Tommy who killed himself because he couldn't reconcile his sexuality and beliefs. My fellow Riders fell to the sidewalk in tears holding lilies with bloody red AOG hand prints wrapped around them. We ran out of room one way and had to send people further down. When we ran out of people to represent names, I quietly tapped each one, thanked them, and asked them to put a sign back on and get in line. We sang to lift our spirits as a few of us gathered the flowers and hand prints, placed them on the "Blood is on your Hands" poster and "Come and Talk to Us, George Wood" poster.[24] I gave a few flowers to the men who came outside, then set the rest on the rock (there is one at every AOG college) that read: 'For I know that my redeemer lives.'"[25] – A.L. Genaro

The third reason focuses on efficacy. Tactically, nonviolent activism was and is smart for us. If we carry out our work with an attitude of interpersonal malevolence—where it's about animosity I feel for a particular human rather than the system—then our battle remains at the level of interpersonal strife instead of rising to the level of critically examining and challenging the structures, policies, institutions, systems, and ideologies that beset us. As much as it might have *felt* like it was about Jerry Falwell when he was alive and saying hateful things on television to raise money off our backs, nonviolent resistance helps us remember to pull up out of the personalized rancor to focus on healing ourselves as we create meaningful structural and ideological change.

Moreover, if we bring weapons, verbal or material, to the fight, our adversaries will always outdo us. Those in power will always have bigger media access, bigger guns, and bigger bank accounts…and more permission to use them. If our organizing becomes about the "take down" and the brute submission of our adversary, rather than transformation and reclamation, we will not win.

We must also consider harm reduction in our work. Gender, race, class, ability, nationality, and other identities among our comrades are reasons being targeted by different kinds and degrees of violence. The more conventionally violent we make our own activism, the more dangerous it is for the more marginalized to be involved in our activism.[26]

Finally, we had read about the successes of nonviolent activism. India is no longer under direct English colonial rule. Farm workers did achieve more dignity in the fields of California. As a moral calling or simply an expedient methodology, people have used nonviolent means to transform their struggles and advance liberation.[27] We have also quantifiably cultivated its fruits in 20 years of organizing:

> "I was in the courtroom when Judge Mildred Edwards, herself a Catholic, rendered her decision. She told the 3 that she had to convict them but that she would do something she had not done in 15 years on the bench – dispense with a sentence. 'Terrible violence was done to you when the body of Christ was denied to you. You are in solidarity with all victims of violence. I am terribly sorry for what happened to you. As a member of the Church, I ask you to forgive our Church. There is no way I am going to order you away from the Hyatt. You can engage in peaceful demonstration as long as it is law abiding. Go in Peace.'
> It was a Soulforce moment. When Judge Edwards finished her words of healing, hope, and encouragement, we sat near tears in awe, stunned silence, and I think I can say reverence. Judge Edwards radiated unconditional love, acceptance, understanding, compassion, goodness, and wisdom. I'm not sure how I define God, but I think the spirit of God was in that courtroom and we all felt it. For

[24] George Wood is the Chairman of the World Assemblies of God Fellowship.

[25] A.L. Genaro. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[26] Herrin and Hudson, *Nice Will Not Save Us*, Vol. II, paragraph 144. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[27] In my studies of practitioners and history of nonviolence, I have often referenced Michael Nagler's book *In the Footsteps of Gandhi: Conversations with Spiritual Social Activists* (Berkeley: Parallax Press, 1990).

> the first time in a long time I felt I was in church… It was a redeeming moment that gave meaning to all our suffering and makes all we do worthwhile." – Cris Elkins[28]

I take the time to tease out here the *why* of our choice to practice nonviolent resistance because *why* defines and illuminates the ethics and objectives of the activist. Behind-the-scenes reasoning and motivation are the critical points I will return to again and again in the following sections. I will raise up for examination the nuances in discourse and praxis taking place in the broader US culture regarding nonviolent activism right now that are useful for healthcare workers, social workers, religious leaders, and others who are involved in the care and support of LGBTQI people.

Mythology

We need to be honest about deeply politicized agendas projected onto the concept of nonviolent resistance: the stories told about it, the co-optation of it, the oversimplification of it. I must also be honest about the messiness and diversity of how personal ego, ethics, and identities in the categories of race, class, gender, and others inform an individual's *why* and *how* of nonviolent activism. This honesty can help care providers be more curious and make fewer assumptions about nonviolent activism and those who choose to participate.

Nonviolent activism, as a concept set on a pedestal and surrounded by pedagogy and think tanks and mastheads, carries a lot of baggage. Some speak of it like a religion, as if Nonviolence were a codified doctrine. It can become a form of pious idolatry, a description of style distorted into as an end unto itself. To be fair, this happens in the hands of both the oppressed and the oppressor.

Some equate nonviolent activism with being nice or making everyone, especially the oppressor, feel comfortable or safe because they see the word *nonviolence* and think it must mean the absence of violence…a utopian ideal that is only possible if we don't account for the systems at play, seen, and unseen and the history that brings us to this moment. This demand for perfect absence of violence becomes a moral measuring stick often placed up against the oppressed but rarely those in power.[29]

This idolatrous assessment of virtue, in turn, leads to many assumptions about who the nonviolent activist is (or should be) and why they do what they do. Some of that mythology gets internalized and expressed, thus fulfilling prophecy.

When we teach people about nonviolent activism, there's a section of our workshop called Merit Badge Activism, where we lightheartedly caution folks against certain kinds of motivations that tend to distort the activism that flows from them.[30]

The first is the Clean Hands Badge—engaging in activism in order to purify oneself through very public suffering or demonstrate how righteous one already is. This motivation can derail the work because it actually de-emphasizes the work in favor of a very personal agenda to attain moral superiority or admiration.

The second badge is the Avenger, the person who is there to work out a personal vendetta or get their licks in on whatever human, institution, or ideology that has harmed them. Revenge limits what is possible by constraining the work to an interpersonal tit-for-tat rather than steering our efforts toward personal transformation and systems change. This badge tends to be affixed to folks who think all nonviolent activism is public

[28] Cris Elkins at the Soulforce protest at the US Conference of Catholic Bishops annually from 2000 to 2004 in Washington, DC, at a time when "intrinsically evil" was the prevailing rhetoric regarding LGBTQI people in the Roman Catholic Church. Haven Herrin, *20 Years of Spiritual Justice: Soulforce 1998 to 2018* (Abilene, TX: Soulforce, 2018), 28. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[29] This idea is examined in Soulforce's "Refreshing Nonviolence" video course. Haven Herrin, *Refreshing Nonviolence* (Abilene, TX: Soulforce, 2019), //soulforce.org/refreshingnonviolence. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[30] "Merit Badge Activism" is examined in *Nice Will Not Save Us*, Vol. I, paragraphs 112–119. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

aggressive direct actions and civil disobedience, which is a common misunderstanding.

The third badge is the Badass Merit Badge, awarded to the person who has come there to show how grand they are with bravado and swagger. Often, they are more focused on praise and admiration among their own organizing team than the actual issue, individualizing the process to the detriment of the collective.

The final one is the New Civil Rights Badge, given out to imagined people who were not in fact descendants of the Civil Rights Movement but want to feel a part of that for psychological or spiritual reasons. Perhaps they feel more comfortable in their boldness because they are borrowing from a known and beloved lineage, whereas their current efforts for LGBTQI justice are still derided and trivialized.

These badges of course say as much about how society warps and instrumentalizes the definition of nonviolent activism as much as it says about any individual's reason for taking part.

At the individual level, these motivations might indicate that people have something that is in need of healing. It might be a toxic idea they were told over and over about their supremacy, or it might be internalized shame about their lack of power and other poisonous ideas they have been forced to drink over and over again.

These badges also indicate understandable reactions to the projections made onto nonviolent activism, such as:

> Our work needs to be the most docile, pure, and thus morally righteous game out there or it's worthless.
> Nonviolent activists are out there to agitate for agitation's sake and get their ego in the limelight.
> Aggressive activists are spiteful and petty rather than simply using whatever means they have to express very valid grievances.
> The false, whitewashed story of the gentle lamb version of Dr. Martin Luther King, Jr. and his comrades, made more palatable and laudable by distance, is the only valid form of activism.[31]

Without getting too far into the weeds of judgments and hierarchies, I will simply say that some motivations serve the work of seeking liberation better than others and that your *why* matters because it will inform the strength, cohesion, and vision of your organizing. Activists have a significant challenge in drowning out the noise of projections, reductive narratives in the media, and gentrified stories about who Gandhi, King, and other leaders were in order to get to a place of deep discernment about who they want to be in their activism, why, and to what end.

Living into the Gray

In a workshop I give on Nonviolent Activism and Direct Action, I have an exercise where I hand out three cards of different colors, one set to each person. One color signifies Violent, one Not-Violent, and one Nonviolent. I then read out different scenarios where actions are taking place in response to stimuli, such as choosing to march when a harmful law is passed or using physical force to protect a child. The exercise is designed to test the limits of what we individually define as violence and demonstrate that right vs. wrong does not neatly align with violent vs. nonviolent, or even not-violent.

In this exercise, the room is rarely unanimous that using physical force to protect a child is violent, and out of those who do define it as violent are often quick to make the distinction that it's not the same as other kinds of violence. This exercise teaches us a few important lessons. First, we cannot conflate nonviolent with absolute moral or political righteousness. Something can be contextually right without being squarely nonviolent. Second, we should not try to explain all tactics within the framework of Nonviolent vs. Violent. There are some scenarios, like protecting a child in imminent danger, which such a line of questioning is dangerously intellectualized. Finally, there is a lot

[31] I reference the following online articles as evidence for this statement on Gandhi and King:

Michael Harriot, "From Most Hated to American Hero: The Whitewashing of Martin Luther King, Jr.," www.theroot.com (April 2018)

Dara T. Mathis, "King's Message of Nonviolence Has Been Distorted," www.theatlantic.com (April 2018)

of subjectivity in the definitions of violent, nonviolent, and not-violent.

In our experience of practicing nonviolence for 20 years, the notion of "nonviolent" functions better as an adverb or adjective than as a noun. There are an infinite number of reasonable and effective ways to resist oppression and transform power. *Nonviolently* is one of them. This orientation takes us out of the realm of dogma and absolutes, away from the place where throwing a punch vs. saving a child's life is even a valid question.

When we start to canonize Nonviolence, we begin to seat judges and gatekeepers who hand out gold stars and demerits, as if there is one definitive idea of what violent or nonviolent is. Doing so erases context and perspective and prioritizes "nice" above survival.

When the stress is on *Nonviolence* rather than *resistance*, the questions that are put to our work, because nonviolence is so often conflated with niceness or passivity on the part of the oppressed, lean toward "Were you kind to your adversary?" rather than "How many people did you get free from oppression today?" Emphasizing the resistance work itself maintains our focus on the urgent matter at hand: getting the most marginalized people out alive, spirit and body intact. This, in turn, de-centers the adversary, who typically has more power to enact harm and thereby limit the choices and resources of the oppressed…or to freely choose liberation.

Many times we have been goaded by journalists to cast judgment on what or who is classified as nonviolent or violent—like if we don't take a high moral hand on "those people" doing something that seems aggressive or unsettling, then our own claim to being practitioners of nonviolent activism is also suspect.

At Soulforce, we take a humble approach. Power means access to resources, choices, and privilege. Those who sit in judgment tend to be those who already have power and therefore the luxury of options when it comes to their activism. It is not our place to judge or fault people who, when backed into a corner against ever-increasing income inequality and consolidation of political and financial power, do what they can to survive, whether "violently" or "nonviolently."[32]

If we are being totally honest, violence sometimes works. Saying so feels like a dirty secret in a world beset by pious and absolutist versions of Nonviolence, but honoring the reality that nonviolent struggles have advanced liberation alongside violent acts or struggles, knowingly and not, is vital to taking a pragmatic, non-imperious, and anti-white supremacist approach to exploring nonviolent activism.[33]

All of this is why I write about Soulforce practicing nonviolent activism or nonviolent resistance, not Nonviolence.

It's more than a semantic sleight of hand, and it's more than a rejection of corrupt uses of Nonviolence. It's a framework that shifts the emphasis to *resistance* itself, rather than implying that the central purpose or measure of success is to be nonviolent. Nonviolence with a capital *N* sets a trap, an idol of piety that forsakes strategy for aesthetics and gold stars.[34]

Nonviolence Wins?

This notion of "progress" or "winning" nonviolently is a contentious point; many would say that well-known movements like the one for independence in India, of which Mahatma Gandhi was a part, were wildly successful in portraying the plight of the colonized Indians in a way that shifted global sentiment and therefore political pressure. But some would complicate that image by offering that it was Great Britain's ever-expanding imperial battlefront that made them throw in the towel, so ultimately it was imperial over-extension of colonial violence that led to the

[32] Herrin and Hudson, *Nice Will Not Save Us*, Vol. I, paragraph 86. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[33] I paraphrase the work of Peter Gelderloos here, from *How Nonviolence Protects the State* (Cambridge, MA: South End Press, 2007), 12.

[34] Herrin and Hudson, *Nice Will Not Save Us*, Vol. I, paragraph 88. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

nonviolent movement's success—in a way, violence aiding nonviolent struggle.[35]

And others still would ask, *Why do we have to be publicly pitied in order to be liberated?* To some that would feel like self-inflicted spiritual violence.

Soulforce holds that all of these things can be simultaneously or temporarily true in diverse contexts. Nonviolent activism works sometimes. So does violent activism, sometimes. Often, they work in tandem in ways that are not immediately apparent. And, yes, it can be very distasteful to have to publicly suffer in order to inculcate sympathy to induce political allyship.

We, as an organization, do not endorse salvific suffering—the idea that we are somehow redeemed or made more valuable or worthy through pain. Suffering, public or not, serves no moral purpose in and of itself. We are not made more holy, more pure, more right, or more deserving of liberation because we suffer. Soulforce puts its energy and resources toward lessening internal suffering and halting the mechanisms that perpetuate it, so why would we claim suffering has any inherent value?

To What End

In the practice of nonviolence resistance, the means and the results are typically closely intertwined. This is a question that is larger than tactics or strategy. *To what end* speaks to a spiritual and political orientation. What is the vision? Are your adversaries a part of it? What is success?

This question is a starkly soul-defining question. Are you looking to win power? Are you seeking healing and self-love? Do you want your oppressors to become the oppressed, or is there the possibility of atonement and healing? How is power itself transformed?

The vision for liberation looks different for every person. At Soulforce, always and forever, even if we don't make a dent in the ideological and institutional powers set against us, our goals are healing and building up our indomitable spirits as an act of self-liberation.

In the tactical and very valid short term, it is about getting the most of our oppressed people out alive. In the long term, it is collective liberation where life is abundant, and people have personal sovereignty, bodily autonomy, community, safety, and well-being.

It is nothing so simple as being welcomed in the church or stopping the inflammatory rhetoric of the Pope, though those things are valuable and needed. It is a question of transforming how society is structured, from the individual and interpersonal to the institutional and ideological.[36]

Choosing Direct Action

I have woven quotes of Soulforce members throughout this chapter to demonstrate that nonviolent resistance can be as much an internal process as an external one, and it is not limited to physical, splashy direct action.

These stories recounted by our beloved members speak to the exciting actions *and* to the deep reflection that is all contained within our understanding of nonviolent struggle.

I tuck this section in near the end of the chapter because starting with the question of *what* you are going to do tends to conjure visions of bold and captivating actions that are not built on top of the self-work and research that Soulforce would suggest should come before the mapping of a direct action. It's important to start with knowing your ethical orientation and how you want to express your

[35] I draw again here from Peter Gelderloos' work in *How Nonviolence Protects the State*, 8–9. Though I would posit here that Gelderloos's definition of Nonviolence aligns more with "pacifism" and "not-violent" in the context of Soulforce, his point is well made that nonviolent struggles are never operating independently of violent systems and elements.

[36] I am drawing here from the work of Dismantling Racism Works (www.dismantlingracism.org) for their insightful taxonomy of the layers of power divided into internalized, interpersonal, institutional, and ideological.

principles, rather than trying to stitch those things onto a direct action after the fact.[37]

To be concrete about how we define the nature of direct action, here are the principles and hallmarks of nonviolent direct action that we uphold:

1. Accessible. It doesn't require a degree or pedigree. It strives toward inclusive empowerment.
2. Resourceful. It draws on values and tone of the cultural context in focus as its greatest tools rather than the most money or the biggest microphone.
3. Expressive. It captures attention and tells a story with every element of the action: bodies, location, timing, language, visuals, and the political backdrop.
4. Constructive. The means and the ends are intimately connected. There is a vision for replacing the old order with something new and more just. We live into that liberated future, if even just for a moment.
5. Power-conscious. It flips the script on power. It brings powerful institutions and leaders into intimate, human-scale contact. It uses vulnerability and the art of the jester to win public opinion and draw the adversary into accountability.[38]

So let's say, according to our ethical orientation to nonviolent activism above, you have connected or empathized (with your own struggle or that of others), studied, and strategized. We are now at the precipice of choosing direct action.

Here is what we ask ourselves in order to create an ethical logic that connects motivation to process and outcomes:

What change is needed?

How do you want to get there?

Why do you choose that path?

What we decide to do might readily appear like classic representations of nonviolent activism: marches, sit-ins, boycotts, teach-ins, banner drops, intentional trespass, and the like. There are infinitely more tactics, though, that one can classify as part of nonviolent activism that fall somewhere between the imperceptible rebellion of the spirit and highly charged, physical direct action.

All of these activities could be undertaken outside the framework of nonviolent activism as well. It means we can consider nearly any tactic as activists committed to nonviolent practice, but our measure of nonviolence rests on the *why*, the *how*, and the *to what end*:

> "I found me on the Equality Ride. Though my original purpose was to take an external journey to save the world, the Equality Ride became an intense internal journey that challenged EVERYTHING I thought I knew about myself. For the first time I was accepted and loved without conditions. And often in the face of hate and ignorance I stood in love and clarity–a ONENESS with God and my fellow Rider. I became a true leader, organizer and minister which has not only shaped my career but has led to my success and the success of those I now lead."[39]
> – Beau Reynolds

Action with Caution

I suggest being wary of becoming caught up in the shiny, public, kinetic actions and then trying to extrapolate from there what nonviolent activism means or accomplishes.

Thoughtful discernment about values, ethics, spirit longings, callings, and conscience—before any possible direct action—is the foundation of nonviolent activism. You have already accomplished a lot of the calling of nonviolent resistance if you have defined your spiritual and political orientation toward social change.

If I could point to one thing that is at the heart of every leading practitioner's way of thinking about nonviolent activism, it is that nonviolent activism demands a consistent through-line from the base of the soul to the action out in the world.

Nonviolent activism, like many frames of revolutionary thought, can be a welcome yet daunting taskmaster in this regard; a worthwhile ethical

[37] Herrin and Hudson, *Nice Will Not Save Us*, Vol. II, paragraph 67. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[38] Ibid, paragraph 77. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[39] Beau Reynolds. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

system is one that requires self-reflection, thoughtfulness, being grounded, and diligence.

The breadth nonviolent activism is not the stuff of nightly news. Only a small portion of the body of nonviolent activism is publicly captivating: highly visible activities that catch everyone's attention because they are daring, creative, physical, and shocking or capture a big truth. All parts of nonviolent struggle are worthwhile, though, especially the below-the-surface like self-reflection, growth, and ethical muscle building:

> "People often ask about the impact of the Equality Ride, and I always struggle to encapsulate its effect. We know that some schools changed their policies and became more accepting and affirming of LGBTQ students, and I'm confident that the Ride played a role in the larger cultural shift that's taken place in America over the last two decades by helping to expose and interrupt the true violence of fundamentalist Christianity. (When 'loving the sinner' involves police in riot gear, even the most devoted follower is often challenged to reconsider whether or not that's really what god intends.)
>
> But the changing of 'hearts and minds' is a difficult thing to measure, and the Ride's greatest impact is impossible to fully define, because I think its true legacy lives on in the individuals who heard, often for the first time in their lives, that god loves them just the way they are.
>
> In 2008, the Ride visited Louisiana College, a Southern Baptist institution in a small town called Pineville. The school's president was unwilling to allow us on campus or engage in any sort of dialogue, but we met with numerous community members, including several former students, who shared story after story of the spiritual violence they'd endured there. Together, we decided to hold a silent, candlelight vigil on our last night in town as a form of both solidarity and resistance.
>
> When we arrived at the predetermined location near the school's entrance, we were surprised to find a large group of students had gathered on a hill overlooking the small strip of sidewalk upon which we quietly assembled. A line of police officers stood between our two groups, and based on the one-directional porousness of their ranks, it was clear whom they intended to "serve and protect."
>
> A handful of young men from the school were allowed to pass through the police line, and as we stood there holding our small, flickering candles, these men began pacing back and forth behind us, muttering prayers under their breaths and occasionally pausing to lay hands on us, admonishing the "demon of homosexuality" to relinquish its control on our spirits. One of the men carried a giant, heavy flashlight in his hands, and rather than pray, he would simply tap the torch against the palm of his hand, the weight of it offering a steady, thudding beat of intimidation.
>
> Eventually, we broke our silence and sang through several of our usual songs, as much to bring comfort to ourselves as to communicate any particular message. In between songs, alumni of Louisiana College and other members of the community who had courageously joined our humble protest that night shared their stories, invited dialogue, and offered up messages of love to the menacing crowd gathered just a couple hundred feet away. Their response was to turn their backs.
>
> Eventually, we climbed back on the bus and headed to our hotel on the other side of town, feeling somber and defeated, as well as somewhat shaken. As we turned into the parking lot, I noticed an old pick up truck pull in after us, and watched it come to a stop and shut off its lights on the far side of the parking lot. Not wanting to alarm others, I approached the front of the bus and alerted our co-directors, Katie and Jarrett, of the situation. They consulted with one another and ultimately decided that Dondi and Bill should check it out while everyone else stayed on the bus.
>
> Within a few minutes they returned, accompanied by two young men, both students from Louisiana College, and both closeted gays. They sheepishly explained that they had never met out, gay Christians before, and just wanted to thank us for our presence.
>
> I don't know how many other young queer and trans students were similarly affected by the Equality Ride, but I'm sure that those two guys weren't the only ones, and I'm grateful to have had the opportunity to share god's boundless love with all of them."[40] – Cole Parke

Benefits of Nonviolent Activism

From the personal stories included in this chapter, you may have already picked up on some themes.

The process of nonviolent activism is long. Change is slow because it is often responding to stark power imbalances. Nonviolent activism can be spiritually demanding *and* spiritually liberating. For Soulforce, the choice of nonviolent activism has been beneficial to our aims.

[40]Cole Parke. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

Several denominations that used to detain us or lock us out now welcome LGBTQI people as members, ordained leaders, and families. Soulforce has used nonviolent struggle to change the institutions and ideologies espoused by elements of the Religious Right, as we set out to do.

Direct action specifically has a phenomenal track record at getting something, *anything*, started: people coming out of the closet to their families and spouses, people forming affinity groups for social change, the spark of optimism, and sense of agency to bring about liberation.

Sometimes we contribute to or achieve meaningful institutional change, as in the case of the 21 Christian campus policies and practices that changed for the better because of the Soulforce Equality Ride[41]:

> "I was a student at Abilene Christian University the first time you all came through our little neck of the Bible Belt. At the time, I was majoring in Christian Ministry and was proud of the way we opened our campus to you all when you came through. We all were. Although our contemporaries were not pleased with us, we made sure it was what I felt at the time was a safe place for Soulforce to come dialogue with students.
> And although members of Soulforce were grateful for the warm reception from what I can remember, I recall that this sense of pride was what kept me from really grasping the most important part of the Soulforce journey, to challenge university leaders to create a safe environment where GLBT folks could thrive as much as those students who were not.
> It has taken me 5 additional years to fully understand that it was not we at ACU who had something to be proud of, but you all and the work you do. It has taken me this long to fully and totally, without reservation, humanize GLBT people in my own mind and heart. I am sorry it took me so long."[42] – Mathis Vila Kennington, Abilene Christian University alum

Some days we do what we do so that we change the world, and some days we do what we do so that we are not changed.[43] More often than not, the win is internal. The way our soul thrives when we do not back down or stay quiet in the face of suffering. The replenishment we feel when we stick up for ourselves or our allies, especially when it's hard or way beyond our comfort zone. The relationships that are cemented for a lifetime when we labor on a vigil line together:

> "I don't know if I touched or changed one single Southern Baptist person. But I do know that I was changed by the experience. Personal transformation is what Soulforce is all about anyway.... Changing ourselves and therefore, changing society in the process.
> So…transforming oneself is the principle which comes to mind as I evaluate and try to understand what difference sitting in jail for two days in Orlando might have made.
> The obvious answer again comes to me … Of course, the experience in Orlando made a difference! Why? Because it made a difference in me; as a result, I will make some small difference in our world!" – Dotti Berry[44]

Most of our people at Soulforce are looking for a method of activism that aligns with their spirits and calls them into a refining fire of living by one's ethics, courageously and assiduously. They find it in our particular style of nonviolent activism that combines the sharp claws of aggression for justice with the tender maintenance of soul and body in the process:

> "I can genuinely say that, were it not for Soulforce, my life and my work would be radically different. Soulforce brought me hope as a Southern, Christian-identified college student struggling with identifying how to reconcile the love I had for my queer friends with the teachings of my faith tradition. A year later, Soulforce equipped me to do truly intersectional social justice work as an Equality Rider, where I not only gained skills in having conversations about faith, sexuality, and gender but also about race, class, ability, citizenship, and so much more.
> Soulforce was an integral part of my own growth and development as a queer, bisexual woman, but more importantly, an integral part of the work that

[41] The Soulforce Equality Ride is a young adult-led, recurring tour of conservative Christian campuses that took place from 2005 to 2016 and visited over 100 schools.

[42] Mathis Kennington. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[43] I am paraphrasing minister and activist A.J. Muste here. A reporter once asked him, "Do you really think you are going to change the policies of this country by standing out here alone at night in front of the White House with a candle?" A.J. Muste replied: "Oh I don't do this to change the country. I do this so the country won't change me."

[44] Dotti Berry. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

> I do every day. There is not a day that goes by that I don't draw from a tool that I learned from Soulforce and my community of activists and friends from the Equality Ride. I am empowered to work toward LGBTQ, racial, and social justice in every area of my life, and Soulforce and the people within it lit this fire within me."[45] – Chelsea Gilbert

Final Thoughts for the Healthcare Worker

There are two things I want to stress about nonviolent resistance work, to the outside observer in a position to provide services or healthcare. The first is that it is very possible there is a deep seam of conscious reflection going on beneath the surface of an activist's work, well before any direct action takes place.

The second is that there are many possible motivations to someone's activism, particularly in direct action, including but not limited to a desire to practice solidarity, harm reduction, avoiding the moral injury of inaction, and demonstrating love and affirmation.

To avoid the traps and assumptions of an unexamined perception of nonviolent activism, the following questions may be useful in understanding the subtleties of motivation, ethics, and desires:

What does your soul, your heart, your body get out of being an activist?

Does activism change how you relate to the world and your spiritual or political struggles within it?

Who benefits from your activism?

How do you feel after you have taken action?

Are there relationships that are strengthened in the course of your activism?

What are your hopes for the world, community, your family, yourself as a result of your activism?

Alternatively, there might not be an external aim. A client's activism may purely be about reclaiming one's agency and fostering the kinship of comrades in organizing. Sometimes it just feels spiritually and politically good to tell the truth with body and soul.

The creation and maintenance of an Indomitable Spirit should never be undervalued or underestimated.[46]

[45] Chelsea Gilbert. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

[46] Herrin and Hudson, *Nice Will Not Save Us*, Vol. II, paragraphs 31–61. Reprinted with permission from Soulforce. www.soulforce.org. All rights reserved

7

Macro-level Advocacy for Mental Health Professionals: Promoting Social Justice for LGBTQ+ Survivors of Interpersonal Violence

Nancy M. Fitzsimons and Michelle Anklan

Abstract

Violence, threats of violence, and fear of violence, in its many forms—self-directed, interpersonal, and collective, is an everyday reality of life for LGBTQ+ people. For LGBTQ+ victim/survivors of interpersonal violence, a focus on individual-level mental health intervention ignores the sociopolitical context that contributes to perpetuating such violence. This chapter aims to help mental health practitioners incorporate a critical response, focused on macro-level intervention, into their practice to challenge and change the oppressive, discriminatory, and disempowering systems, structures, and attitudes that contribute to violence in the lives of LGBQT+ people. The chapter explains how to engage in social justice cause advocacy as an activist/ally activist using a six-part critical response strategy: get educated, get empowered, get connected, be a connector and initiator for change, get political, and take action.

Introduction

Mental health practitioners (MHPs) come from a wide array of professional disciplines, including school counseling, mental health counseling, marriage and family therapy, social work, and psychology. All of these disciplines have a similar aim to alleviate psychological distress and enhance the well-being of people who receive their services. The mainstream approach to mental health problems, past and present, largely focuses on individual psychopathology (Maddux, Gosselin, & Winstead, 2012). From a **psychopathology of mental health perspective**, the role of MHPs is to assess the causes (i.e., psychological, social, and genetic), symptoms, and effects of psychosocial dysfunction, and develop a treatment or intervention plan to correct or alleviate the disorder, dysfunction, or problem—aimed almost exclusively at the micro- or individual level (often within a family context). This *psychopathology of mental health perspective* is dictated by the mental health care system where mental health practitioners are employed. MHPs may assess and acknowledge the social and environmental factors that contribute to individual problems of living—referred to as **contextual factors**. However, because the mental health care system almost exclusively pays only for the diagnosis and treatment of individuals, the *contextual factors* may be minimized or overlooked.

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E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_7

Regardless of the person, or identity of social group membership, the contextual factors matter and must not be ignored or discounted. However, for LGBTQ+ people who, past and present, are **oppressed** (devalued, exploited, and deprived of privileges), **marginalized** (relatively powerless people of little importance to the dominant cultural group), and **discriminated** against by the dominant cultural group, problems of living are intricately and detrimentally connected to the context of their lives. Thus, the psychological distress and disempowerment experienced by LGBTQ+ people must be understood within the historical, social, political, economic, cultural, and environmental context—referred to as the **sociopolitical context** for the remainder of this chapter. Furthermore, despite some gaps in our understanding of victimization experienced by LGBTQ+ people, cruel, dehumanizing, and unfair treatment is very much a part of their contextual story.

Violence, threats of violence, and fear of violence, in its many forms—*self-directed*, *interpersonal*, and *collective*, is an everyday reality of life for LGBTQ+ people.

- **Self-directed violence** refers to self-abuse and suicide (World Health Organization [WHO], 2019). Self-directed violence is connected to internalized oppression and internalized homophobia. Negative beliefs about oneself, resulting from systematic racism, sexism, heterosexism, cissexism, and other isms (Hagen, Hoover, & Morrow, 2018, p. 833), damage the self-concept, self-worth, and self-efficacy of LGBTQ+ people, contributing to self-hatred and self-directed violence.
- **Interpersonal violence** refers to violence between individuals (WHO, 2019). The two broad types of interpersonal violence are: **family** and **intimate partner violence** (e.g., child maltreatment; intimate partner violence (IPV); and elder abuse) and **community violence,** both acquaintance and stranger (e.g., assault by strangers, youth violence, violence related to property crimes, and violence in workplaces and other institutions) (WHO, 2019).
- **Collective violence** refers to social, political, and economic violence committed by larger groups of individuals (WHO, 2019).

Consult Lund, Burgess, and Johnson's (2020) introductory chapter in this volume for a review of the research about the problem of violence in the lives of LGBTQ+ people.

A Clinical Response Versus a Critical Response

For LGBTQ+ victim/survivors of interpersonal violence, a focus on individual-level intervention to treat the consequences of victimization ignores the sociopolitical context that contributes to perpetuating such violence. MHPs must consider the contextual factor of social injustice, in all of its forms—oppression, discrimination, inequality, invisibility, invalidation—associated with the perpetration of violence, the victim/survivors' experience of violence, and societal response (often a failed response) to the violence. In doing so, MHPs can move their practice from a *clinical response* to a *critical response*.

Advocacy entails speaking up, pleading the case for another, or championing a cause, often for individuals or groups unable to speak out on their own behalf (Reisch, 2018, p. 555–556). MHPs are familiar with and typically skilled in engaging in *case advocacy* given the *micro-level* emphasis of mental health practice. **Case advocacy** refers to "intervention—inside or outside an existing system—on behalf of an individual, family or group in conflict with an organization to secure a needed service or resource" (Reisch, 2018, p. 413). *Case advocacy* is part of a *clinical response* approach to mental health practice. A **clinical response** "focuses predominantly on personal and interpersonal change, direct practice, and micro-level interventions" (Miley & DuBois, 2007, p. 30–31). For example, a clinical response to post-traumatic stress disorder entails using evidence-based interventions to reduce symptoms and improve functioning, including cognitive behavior therapy (CBT), narrative exposure therapy, and psychopharmacology (APA, 2019).

Feminist therapy provides a framework for transcending the micro-level focus typical of mental health work by considering the effects that systemic disempowerment has on a minority individual. A primary goal of the therapeutic process is "reinstating power to those who are experiencing powerlessness" (Pusateri & Headley, 2015, p. 417), at both a systemic level and within the client/practitioner relationship. From a *feminist therapy framework*, MHPs must also engage in **macro practice** at the organization, community, and policy levels **"**aimed at bringing about improvements and changes in the general society" (Barker, 2014, p. 255), for the benefit of LGBTQ+ people. *Macro practice* "is a *collective and collaborative* endeavor that seeks to create *purposive* change" (Reisch, 2018, p. 6), through community practice, management, and policy practice (Reisch, 2018). *Macro practice* pushes the boundaries of mental health practice "by fostering a 'big picture' perspective that analyzes people's issues 'outside the box' and focuses on the prevention of problems—not merely their amelioration" (Reisch, 2017, p. 6). *Macro practice* aims to "transform people's 'private troubles' into 'public issues'" (Mills, 1963 as cited in Reisch, 2018, p. 13), in order to remedy the structural (i.e., laws, policies, procedures, social roles) and systemic (i.e., organization and institutions) forces that contribute to, create, and perpetuate private troubles.

The difference between case and cause advocacy is U (You)—Donna McIntosh (2010).

Mental health practice must move from solely engaging in case advocacy to including *class* or *cause advocacy***. Class** or **cause advocacy** refers to advocacy with "multiple groups of clients, potential clients, or constituents that seeks to address issues that affect the entire population through generating some form of social change or creating social policies that are more responsive and just" (Reisch, 2018, p. 413). McIntosh (2010) writes:

> Often when we think of case to cause advocacy, we think of large systems change through class action lawsuits and successful policy reform. This can scare most of us away from cause advocacy. However, case to cause advocacy is and should be in our daily […] practice with clients, compelling change in the agencies in which we work, the staff with whom we work, the recordkeeping we often lament, the training and professional development offered, and the forms we develop. It should be reflected in organizational practice of outreach, referral, intake assessment, intervention, discharge and aftercare. And the list goes on. (para. 2)

Cause advocacy is essential to taking a *critical response* to the violence experienced by LGBTQ+ people. A **critical response** focuses on macro-level interventions to challenge social injustices, join with others to create alliances for social change, and engage in activism to change social and economic policies that disadvantage LGBTQ+ people (Miley & DuBois, 2007, p. 31) and perpetuate violence. The last section of the chapter is devoted to explaining how to engage in a *critical response*.

In order to challenge and change oppressive, discriminatory, and disempowering systems, structures, institutions, and policies that contribute to violence in the lives of LGBTQ+ people, MHPs must assume a **social justice orientation** in their practice. **Social justice** refers to "an ideal condition in which all members of a society have the same rights, protections, opportunities, and social benefits" (Barker, 2014, p. 398). A clinical response can take a *social justice orientation* when the thinking and doing of mental health practice takes into account the sociopolitical context (Miley & DuBois, 2007) and promotes the empowerment of clients (Chung & Bemak, 2011b). However, only a **social justice-oriented critical response** can challenge and change the structures, systems, and societal attitudes (Chung & Bemak, 2011b, p. 142) that contribute to the daily adversities, including acts of violence, threats of violence, and fear of violence, experienced by LGBTQ+ people.

Defining Activism/Ally Activism

The focus of this chapter is on providing MHPs with essential information, skills, and resources to engage as an *activist/ally activist* in social justice cause advocacy with LGBTQ+ individu-

als and organizations. One of the goals of *activism/ally activism* is to change the norms, attitudes, practices, and policies that contribute to and perpetuate violence in the lives of LGBTQ+ people.

- An **ally** is "a person who is united to the cause of social justice for a group of people" (Eichler, 2010, p. 90).
- An **activist** is an individual who works to bring about social change through activism (Barker, 2014, p. 5).
- An **ally activist** is someone who is an ally to all or a *subgroup* of LGBTQ+ people, often a member of a dominant social group, also known as an **outgroup member** or **outgroup ally**,[1] and is taking action to promote social change with LGBTQ+ people to end violence and systems of oppression and to promote social justice (definition adapted from Eichler, 2010, p. 91; Perrin, Bhattacharyya, Snipes, Calton, & Heesacker, 2014, p. 241).

The reference to a "subgroup" in the definition of ally activist is in recognition that anyone can be an ally regardless of affectional orientation, assigned sex, or gender identity to others from differing identities. For example, a self-identified gay man can be an ally for a transgender woman and vice versa (Finnerty, Goodrich, Brace, & Pope, 2014, p. 327). This chapter is written with an understanding that most MHPs will be incorporating social justice cause advocacy into their primary role as a clinician, within a health, mental health, educational, or social services setting. In addition, MHPs may engage in activism/ally activism in a professional capacity as a form of service and/or as a private citizen.

[1]Language is constantly evolving and changing. Terminology acceptable in the past may no longer be acceptable language in the present. Terminology acceptable to an individual or group may not be acceptable to another individual or group. Unless a different term is used by a source cited, the term *outgroup member* or *outgroup ally* will be used to refer to people who identify as straight, heterosexual, and/or cisgender.

Becoming an Activist/Ally Activist: Clinical to Critical Response, Case to Cause Advocacy

> *While some incredible progress has been made towards equality and fairness for people who are LGBT, we're not there yet. Full equality can't happen without support from smart, energetic, compassionate, and dedicated straight allies* in partnership with LGBTQ+ people. Jean-Marie Navetta (2019, p.3).

Allies and activists are not born, they become. As an outgroup member, it is especially important to do personal work in preparation for doing public work with LBGTQ+ people. This personal work entails:

- Reflection and self-awareness on the role of MHPs beyond a micro-focused orientation to practice as a counselor, therapist, or clinician, refer to in this chapter as a *clinical response*.
- Exploration of the historical and contemporary sociopolitical context of oppression LGBTQ+ people.

Part of the preparation work also entails an examination of bias, privilege, and empowerment addressed later in the chapter. This personal work lays the foundation for becoming a *critically conscious* mental health professional.

Critical consciousness refers to "an awareness of the sociopolitical context of daily life" in order to make explicit "the often taken-for-granted realities about the way the world operates" (Almeida, Dolan-Del Vecchio, & Parker, 2012, p. 186). *Critical consciousness* is a hallmark of affirming, empowering, and social justice-oriented practice with LGBTQ+ people (Almeida et al., 2012; Singh & Burnes, 2010; Singh, Hays, & Watson, 2011) and lays the foundation for engaging in social justice cause advocacy.

People who identify as an **outgroup** member, should think of the process of becoming an LGBTQ+ ally activist as a journey. **PFLAG** (Parents, Families, and Friends of Lesbians and Gays) developed the *guide to being a straight ally*

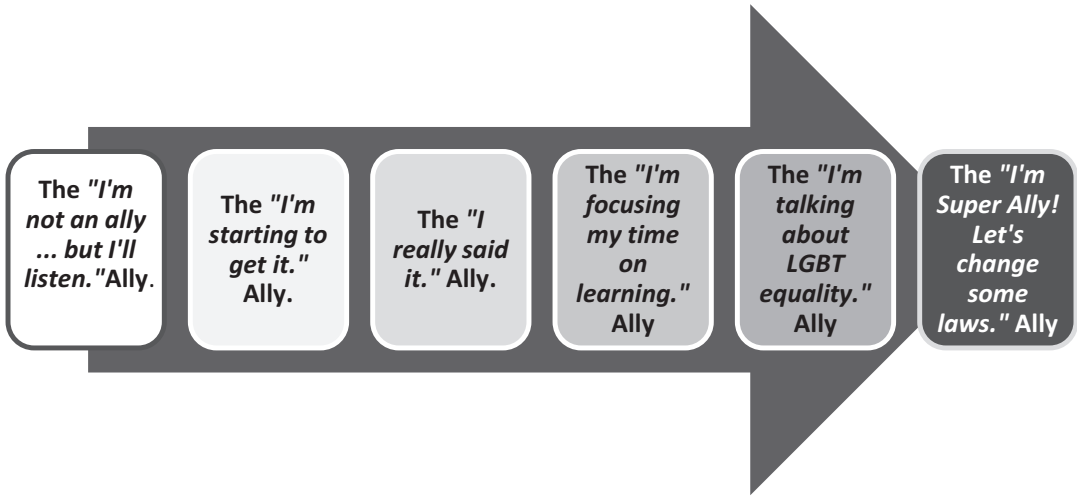

Fig. 7.1 PFLAG National Straight for Equality Ally Spectrum. (Source: Adapted from guide to being a straight ally, 4th Edition, by Jean-Marie Navetta 2019, p. 9. Straight for Equality®. Copyright ©2007, 2011, 2015, 2019 PFLAG National. All rights reserved. https://pflag.org/sites/default/files/4th%20Edition%20Guide%20to%20Being%20an%20Ally.pdf)

and the *guide to being a trans ally* as part of their **Straight for Equality® Project**. PFLAG identified a six-step process for becoming an LGBTQ+ ally referred to as the **Straight for Equality®** ***Ally Spectrum*** (refer to Fig. 7.1, Navetta, 2019, p. 9). Navetta (2019) explains that "the process of going from 'not my issue' to 'someone take me to my legislator to fix some laws!" rarely happens overnight" (p. 9). Rather, "it usually entails a process of learning more, becoming comfortable enough to talk about the issues openly, knowing how to take on pushback, and eventually being able to help others in their ally journeys" (Navetta, 2019 p. 9). Allies can be found across the *Spectrum*, with activism representing the most evolved and engaged form of allyship. Another resource to support ally development is the **United Nations Free and Equal Campaign:** ***Be There. Be An Ally.*** (https://www.unfe.org/bethere/).

Expanding the Role of Mental Health Professional

The choice to become a mental health practitioner likely began with the desire to "help" people, with a view of "helping" more compatible with a clinical response. Formal education likely reinforced the role of "helper" from a psychopathology of mental health perspective, with the role of advocate focused on case advocacy-oriented toward helping people access supports, services, and resources.

Formative Education: Curriculum Standards A review of the curriculum standards of three helping profession's accrediting bodies (American Psychological Association (APA) Commission on Accreditation, Counsel for Accreditation of Counseling and Related Education Programs, Council on Social Work Education) shows mixed results in terms of preparing graduates for becoming activists/ally activists who engage in cause advocacy to change the sociopolitical conditions that perpetuate problems of living for their clients. For graduates from accredited psychology, counseling, and social work programs, their formative education ideally provides a foundation for critically conscious mental health practice—an insufficient, but needed first step in becoming an activist/ally activist. Unfortunately, except for social work (in theory) (Reisch, 2017), the other disciplines appear to fall short in preparing MHPs to engage in social justice cause advocacy.

Codes of Ethics Formal education and professional practice is grounded in, and guided by, each disciplines' professional **code of ethics**. The *codes of ethics* governing the practice of MHPs all emphasize promoting the welfare of clients at the micro level. C*lients* refers to individuals, students, or individuals and families—as the *primary* responsibility (American Association for Marriage and Family Therapy [AAMFT, 2015]; American Counseling Association [ACA, 2014]; American Mental Health Counselors Association [AMHCA, 2015]; APA [2017]; American School Counselors Association [ASCA, 2016]; National Association of Social Workers [NASW, 2017]). This primary responsibility orients the advocacy work of most MHPs to the micro or case level, emphasizing a clinical response. Only social work provides a clear and compelling ethical obligation to engage in macro advocacy to change the structures and systems that contribute to injustice, inequality, and problems of living. Despite this limitation, evident in all *code of ethics* reviewed, are ethical obligations pertaining to competence in cultural diversity (varying in emphasis and detail), nondiscriminatory practice, and a mandate to avoid harm. Collectively, these can be interpreted as a mandate to become critically conscious about issues of oppression, discrimination, and violence in the lives of LGBTQ+ people. This critical consciousness is a necessary and important step to becoming an activist/ally activist.

Professional Standards, Guidelines, and Competencies Perhaps most instrumental in promoting the role of MHPs as critically conscious activists/ally activists are the standards, guidelines, and competencies that shape practice with LGBTQ+ people. Marriage and family therapy provides the weakest guidance with one competency of direct relevance: *Competence 1.2.1 Recognize contextual and systemic dynamics* (AAMFT, 2004, p. 2). The expectation to engage in **activism/ally activism**—meaning taking action to promote social change with LGBTQ+ people—is clearly evident, albeit varied in emphasis, in psychology, social work, and counseling.

Psychology has *Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients* (APA, 2012) and *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (APA, 2015) that provide "aspirational" guidance for critically conscious practice with LGBTQ+ people. One such guideline for psychologists is to "promote social change that reduces the negative effects of stigma on the health and wellbeing of TGNC people" (APA, 2015, p. 841). Another "encourages" psychologists to engage in activism/ally activism "to inform public policy to reduce negative systemic impact on TGNC people and to promote positive change" (p. 841).

Social Work has *Standards and Indicators for Cultural Competence in Social Work Practice,* which include LGBTQ+ people under the broad umbrella of diversity, with clear expectations for how a social worker will take a critical response to empower and advocate for marginalized and oppressed populations (NASW, 2015, pp. 35–37). Included in *Standard 6: Empowerment and Advocacy* is the expectation that culturally competent social workers "advocate for policies that address social injustice and institutionalized isms" (NASW, 2015, p.37).

Counseling provides the most comprehensive guidance on how to engage in critically conscious activism/ally activism with LGBTQ+ people. The ACA has endorsed competencies in four areas that support the empowerment and activism of LGBTQ+ people and counseling professionals.

- *ACA Advocacy Competencies updated* (Toporek & Daniels, 2018).
- *Competencies for Counseling Transgender Individuals* (ALGBTIC Transgender Committee, 2010).
- *Competencies for Working with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals* (ALGBTIC LGBQQIA Competencies Taskforce, 2013).

- *Multicultural and Social Justice Counseling Competencies* (The Multicultural Counseling Competencies Revisions Committee,2015).

The following passage provides a compelling rationale for why ***all*** MHPs must assume the role of activist/ally activist.

> Historically, the mental health community has pathologized LGBTQQIA individuals, groups, and communities. However, […] the struggles arise not as a result of individual dysfunction, but as a result of a natural response to increased stress of living in an environment that is hostile to those who hold a particular identity. It is for this reason […] that it is important to extend the role of counseling and related professionals beyond the confines of individual practices or settings to address the systemic issues that are responsible for these added stressors. (ALGBTIC LGBQQIA, 2013, p. 4)

Only by combining a *critical response* with a clinical response will MHPs uphold their professional obligations to engage in identity affirming and empowering, culturally responsive mental health practice with LGBTQ+ people who are victim/survivors of violence. Readers are referred to the supervision chapter in this volume for a more in-depth examination of ethical issues and mental health practice with LGBTQ+ victim/survivors of violence.

Nice Counselor Syndrome (NCS) Adopting a critical response is easier said than done for MHPs whose personal and professional identities are intricately tied to the need to be "nice" or be perceived of as being "nice". This can lead to MHPs continuously striving to promote harmony, while avoiding controversial, conflictual, or challenging issues at work or in their community (Bemak & Chung, 2008). This emphasis on "being nice" is referred to as **nice counselor syndrome** (NCS), and it is offered as an explanation for why some MHPs may resist incorporating a critical response into their professional practice (Bemak & Chung, 2008). Clearly, there is a place for MHPs to serve as mediators, problem-solvers, and harmonizers within their places of employment and within the larger community. However, when MHPs' overarching concern is "to be perceived as being nice people who promote acceptance, peace, and interpersonal harmony at any cost" (Bemak & Chung, 2008, p. 374), they inadvertently are contributing to the very struggles experienced by LGBTQ+ people that they purport to be helping to alleviate. Only by incorporating a *critical response* into one's mental health practice will MHPs be able to challenge and change the sociopolitical context that contributes to the daily adversities, including acts of violence, threats of violence, fear of violence, and ineffectual responses by criminal justice and other helping systems experienced by LGBTQ+ people.

The Historical and Contemporary Sociopolitical Context of Oppression

Becoming and being an activist/ally activist must come from understanding of the historical and contemporary oppression experienced by people from sexual and gender minority groups.

Oppression Oppression refers to the systematic marginalization and discrimination of individuals or groups, based on actual or perceived social identity group membership, by more powerful groups for the social, economic, and political benefit of the more powerful group (adapted from Hagen et al., 2018, p. 833; Israel, 2006). The oppression, discrimination, and violence experienced by people based on sexual and gender identity is compounded by membership in other non-dominant groups in society. Kimberlé Crenshaw (1989) coined the term **intersectionality** in order to describe the ways in which a Black woman's multiple identities of the non-dominant population in both gender and race affect their lived experiences. In discussing lessons learned in coalition building, Matsuda (1991) added to this idea of *intersectionality* as she emphasizes the importance of viewing situations and interactions through multiple lenses in order to comprehend the interplay of various forms of oppression:

> The oppression of LGBTQ+ people must be understood through the prism of *intersectionality*. Oppression must also be understood to occur within the LGBTQ+ communities. Bisexual (B) and transgender (T) people report experiences of discrimination, invisibility, and invalidation both within the LG communities and outside of the LGBTQ+ communities (Cashore & Tuason, 2009, p. 392).

External Oppression is rooted in prejudicial attitudes and beliefs and is experienced in the many forms of "isms" that are becoming increasingly pointed out in today's culture. MHPs are likely familiar with oppression that manifests externally through a variety of "isms" including sexism, ableism, racism, ageism, and classism. It is also important to consider the effects of *heterosexism*, *cissexism*, and *cisgenderism* (refer to Table 7.1). "Isms" are interconnected and contribute to layers of intersecting oppression in the lives of LGBTQ+ people.

Institutionalized Oppression Institutional oppression, as a form of **externalized oppression,** is supported and enforced by society through its structures and systems (Israel, 2006). Consult the film *Stonewall Uprising* or the book that it is based on, *Stonewall: The Riots that Sparked the Gay Revolution*, for a history of the first major protest by LGBTQ+ people that lead to the formation of the Gay Liberation Front and other LGBTQ+ civil rights organizations (Carter, 2013). LGBTQ+ people historically experienced oppression in the form of harassment, violence, and hate crimes, and discrimination in areas of marriage and family formation and recognition, housing, education, employment, health care, and access to human services (Harper & Schneider, 2003; Killian, 2010). Oppression was institutionalized in laws that either actively discriminated against LGBTQ+ people or failed to protect their civil and human rights (Harper & Schneider, 2003; Killian, 2010). According to Harper and Schneider (2003), "this oppression served its purpose for many years by keeping LGBTQ+ people closeted, invisible" (p. 246), and created, supported, and perpetuated a sociopolitical context of homophobia, heterosexism, cissexism, and cisgenderism fueled by negative images, based upon stereotypes, of LGBTQ+ people.

Table 7.1 Definition and examples of heterosexism, cissexism, and cisgenderism

Heterosexism	Cissexism	Cisgenderism
Definition: "The idea that heterosexuality is a normal, natural, or superior state of human sexual orientation, and the system of oppression based on that belief." Connected to the concept of *heternormativity:* "The belief or assumption that all people are heterosexual, or that heterosexuality is the default or "normal" state of human being."	*Definition*: "The belief that transgender people are inherently inferior to cisgender people" and the system of oppression based on that belief. *Cisgender* refers to "someone whose gender identity matches their body and the gender assigned to them at birth."	*Definition*: "The assumption that people who defy gender norms are less legitimate than people who conform to them" and the system of oppression based on that assumption. Connected to the concept of cisnormativity: "The assumption that all, or almost all, individuals are cisgender."
Example: Lack of legal protection from discrimination in employment, housing, and services; lack of representation of non-heterosexual relationships in textbooks, media, etc.	*Example*: A cis woman remains a "real" woman after having a mastectomy, whereas a trans woman does not qualify as a "real" woman before (and to some people, even after) undergoing gender affirming surgery.	*Example*: Designated men's and women's sections in clothing stores. Requirement to select from "woman" or "man" in order to book an airline flight.

Sources: The definition of cisgenderism is from Serano (2016, p.260). *Outspoken: A decade of transgender activism and trans feminism*. The definitions of heterosexism, heteronormativity, cissexism, cisgender, and cisnormativity are from *The Queer Dictionary* (2014): http://queer-dictionary.blogspot.com/

Perhaps one of the most egregious ways LBGTQ+ people have been oppressed is in how the medical community and MHPs have pathologized their very existence. Prior to December of 1973, when the American Psychiatric Association removed homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), homosexuality was viewed as deviant, a sign of defect, a sickness, and a social evil (Dreschler, 2015). However, despite the "removal," the pathology of some presentations of homosexuality continued for 14 more years (Dreschler, 2015). In the DSM-II, homosexuality was pathologized under a new diagnosis, Sexual Orientation Disturbance (SOD), for individuals for people who were in conflict over their sexual orientation (Dreschler, 2015). This "new diagnosis legitimized the practice of sexual conversion therapies (and presumably justified insurance reimbursement for those interventions as well), even if homosexuality per se was no longer considered an illness" (Dreschler, 2015, p. 571). SOD was later replaced in the DSM-III by a new classification called Ego Dystonic Homosexuality (EDH), which when removed in 1987 completely removed homosexuality from the DSM (Dreschler, 2015). It was not until 1990 that the World Health Organization (WHO) removed homosexuality from the International Classification of Diseases (ICD)-10 (Dreschler, 2015). In 2018 WHO, in its updated version of the ICD-11 coming out in 2022, has removed gender incongruence/transgender from classification as a mental health disorder (Reed et al., 2019). Transgender identity remains classified as a mental health disorder in the DSM-5, referred to as gender dysphoria (American Psychiatric Association, 2016).

Laws Protecting and Failing to Protect LGBTQ+ People For LGBTQ+ people, acts of violence, threats of violence, and fear of violence must be understood within a sociopolitical context of failure to protect their civil and human rights. Three platforms that track, analyze, and display data about laws and other information pertaining to the civil and human rights of LGBTQ+ people are:

- **ILGA (International Lesbian, Gay, Bisexual, Trans, and Intersex Association)**: Maps sexual orientation laws (previously lesbian and gay rights maps) as part of its state-sponsored homophobia report.
- **Equaldex®**: An LGBT knowledge base built by an international community of editors and LGBTQ+ activists.
- **Movement Advancement Project (MAP)**: An independent non-profit think tank that tracks laws, ordinances, and administrative policies in eleven areas: (1) Marriage and relationship recognition; (2) State and local non-discrimination laws/ordinances; (3) Foster care, adoption, and other parental recognition laws; (4) Safe school laws; (5) Health care laws and policies, (6) Identity document laws and policies; (7) Medical decision making policies; (8) Family leave laws; (9) Conversion therapy laws; (10) HIV criminalization laws; and (11) Religious exemption laws.

For the sake of brevity, six policy areas are profiled as examples to demonstrate the *oppressive sociopolitical context* for LGBTQ+ people in the United States: Hate crime laws, Anti-bullying laws, Conversion therapy laws, Identity document laws, Marriage and relationships recognition laws, and Intersex Policy. The information presented was taken from MAP June 9, 2019 using data last updated on June 6, 2019.

- **Hate crime laws**. Hate crime or anti-bias laws are designed to deter bias-motivated crimes. The Matthew Shepard and James Byrd, Jr. Hate Crimes Prevention Act of 2009 is a federal law that amended federal hate crime law to include gender, gender identity, sexual orientation, and disability (Govtrack.us, 2019b). At the time of this writing, eighteen states and the District of Columbia have laws that cover sexual orientation and gender identity, 13 states only cover sexual orientation, 15 states have existing hate crime laws that cover neither sexual orientation nor gender identity, one state explicitly interprets existing hate crime laws to include sexual orientation and/or gender identity, and four states have no hate crime legislation (MAP, 2019c). For more

information about hate crime laws go to the MAP website: http://www.lgbtmap.org/equality-maps/hate_crime_laws.

- **Anti-bullying laws.** Anti-bullying laws protect LGBT students from bullying by teachers, school staff, and other students on the basis of gender identity and/or sexual orientation (MAP, 2019a). Twenty states and the District of Columbia prohibit bullying on the basis of gender identity and sexual orientation, with 24 states having no laws protecting LGBT students (MAP, 2019a). Four states have regulations or teach code prohibiting bullying on the basis of sexual orientation, with one state prohibiting bullying on the basis of both sexual orientation and gender identity under regulations/teach code (MAP, 2019a). For more information about this and other safe school laws go to the MAP website: http://www.lgbtmap.org/equality-maps/safe_school_laws
- **Conversion therapy laws**. Conversion therapy laws ban licensed MHPs from subjecting LGBT minors to conversion therapy (a.k.a. reparative therapy, ex-gay therapy, sexual orientation change efforts (SOCE)) in an attempt to "correct" their gender identity or sexual orientation (MAP, 2019b). Religious-affiliated providers (e.g., religious counselors, lay ministers) are exempt from such bans. Eighteen states and the District of Columbia prohibit conversion therapy for minors, with 32 states having no laws (MAP, 2019b). To access the *LGBT Policy Spotlight Report: Conversion Therapy Bans* and other information about conversion therapy laws go to the MAP website: http://www.lgbtmap.org/equality-maps/conversion_therapy
- **Identity document laws and policies**. Birth certificate, driver's license, and name change laws dictate the ability for transgender individuals to change their legal name and gender marker to match their affirming gender identity (MAP, 2019d). Accurate and consistent identity documents and gender markers are essential to helping transgender people gain access to public resources and spaces, and to reduce their risk of discrimination, harassment, and violence. The process for changing identity documents is governed by a wide array of state laws and administrative policies that often include outdated and intrusive requirements, such as court orders and proof of sex reassignment surgery (MAP, 2019d). For example, 15 states require proof of sex reassignment surgery in order to change gender marker on a birth certificate (MAP, 2019d). For more information about Identity Document State Laws and Policies go to the MAP website: http://www.lgbtmap.org/equality-maps/identity_document_laws
- **Marriage and relationship recognition laws.** Marriage equality (i.e., the right to marry and to have their marriage recognized in all 50 states) between two people of the same biological sex and/or gender identity was legalized in all 50 states on June 26, 2015 in the U.S. Supreme Court ruling *Obergefell v. Hodges* (Ballotpedia, n.d.b). The ruling struck down all state bans on same-sex marriage and requires states to honor out-of-state same-sex marriage licenses. Six states also have comprehensive domestic partnerships or civil union laws that apply to same- and opposite-sex couples (MAP, 2019e). Efforts are ongoing across the United States to weaken marriage and relationship recognition laws through targeted religious exemption laws (MAP, 2019e). For more information about marriage and relationship recognition laws go to the MAP website: http://www.lgbtmap.org/equality-maps/marriage_relationship_laws
- **Intersex Policy.** "X" sex marker (along with "M/male" and "F/female") is an option on legal documents for "non-binary/intersex" identity in four states and Washington, D.C. (Thorn, 2014). There is no policy in the United States that addresses the rights of intersex children (Amnesty International, 2017). Australia and Malta are leading the way in protecting the autonomy and bodily integrity of intersex people. Australia implemented the Sex Discrimination Amendment Act in 2013—the first piece of legislation to specifically protect people from discrimination due to intersex status (United Nations Human Rights Office of the High Commissioner, n.d.). Malta implemented the Gender Identity,

Gender Expression and Sex Characteristics Act in 2015, becoming "the first country in the world to legally ban non-consensual medically unnecessary surgeries on intersex children" (Human Rights Watch, 2017, p. 30). The United Nations (Mendez, 2015), Human Rights Watch (2017), the World Health Organization (2015), Amnesty International (2017), and the Council of Europe (Amnesty International 2017) have condemned the practice of surgical intervention on intersex infants and children without their consent on the basis that it violates their human rights and lacks research supporting its effectiveness.

It is important to understand that this context, absent federal civil and human rights protections, means that LGBTQ+ people continue to be treated as second class citizens. The Equality Act (H.R. 5), which would finally provide explicit and comprehensive protection from discrimination for LGBT people, passed in the U. S. House of Representatives on May 17, 2019, but has stalled in the U.S. Senate (Govtrack.us, 2019a). Not only is social justice cause advocacy needed to achieve parity in all 50 states, such advocacy is needed to ensure that the hard-fought rights won will not be stripped away. It is crucial for MHPs who are *privileged* members of dominant social groups in our society to understand this sociopolitical context as part of their own journey of discovery of the many ways that their civil and human rights are protected and advantaged in our society.

A Critical Response: How to Engage in Social Justice Cause Advocacy

> *Adhering to our traditional roles as therapists and counselors contributes to maintaining and reinforcing the status quo, so that we end up politically supporting the social injustices, inequalities, and unfair treatment of certain groups of clients.*—Chung and Bemak (2011a, p. 177)

Awareness of social injustices and oppression opens the door to engaging in activism (Hagen et al., 2018). The next step is to walk through the door and take action "to be the change you wish to see in the world."[2] "Being the change" entails getting educated on the issues impacting LGBTQ+ people in your community from a place of *cultural humility*; getting empowered at the personal, interpersonal, and sociopolitical levels; connecting with LGBTQ+ people in your own community; being a connector and initiator for change; getting involved in electoral politics; and taking action to promote the rights and well-being of LGBTQ+ people. Begin by contacting the local or state chapter of your professional association to learn about *take action* opportunities. For example, social workers can *get political* by connecting with **PACE** (Political Action for Candidate Election) and can *take action* by connecting with **SPAN** (Social Policy Action Network) (Fig. 7.2).

Get Educated

Get educated on the laws and policies that govern your mental health practice. McIntosh (2016) writes about the importance of actually reading public policy, knowing it inside and out, in order to be a more informed and effective case and cause advocate. "There is a funny urban legend that happens with policies. It's like the old telephone game. People tell others what the law or policy says, and by the time it gets to you, there are many interpretations to it" (McIntosh, 2016, para. 6.). Thus, one of the best ways MHPs can promote the rights and well-being of LGBTQ+ clients is to read the actual laws and policies under which you operate and which impact, for better or for worse, the lives of LGBTQ+ people. For MHPs in the United States, a good source to start your search is **Findlaw.com**

Get educated on how to approach getting educated on the issues impacting LGBTQ+ people from a stance of *cultural humility*. How MHPs approach engagement as activists/ally activists is

[2]The "be the change" quote has been attributed to Mohandas Gandhi. However, there does not appear to be definitive evidence supporting this assertion. Refer to the Quote Investigator website for more information about the origins: https://quoteinvestigator.com/2017/10/23/be-change/

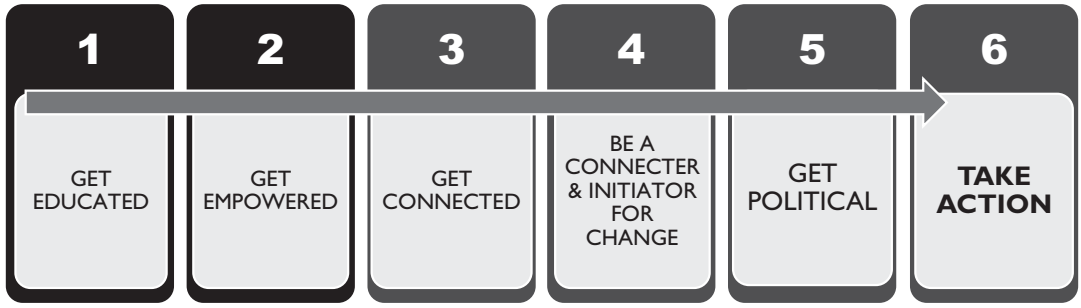

Fig. 7.2 Critical response process

as important as the actions actually taken to promote social justice. As stated in the *guide to being a straight ally* "one of the best ways to demonstrate your interest in moving equality forward and in being an ally is to get—and keep getting—educated" (Navetta, 2019, p. 23). Participation in ongoing professional development enhances knowledge and skills for practice as a culturally responsive MHP and activist/ally activist.

Cultural Humility Melanie Tervalon and Jan Murray-Garcia (1998) coined the term and conceptualized the three tenants of **cultural humility**: (1) engage in critical self-reflection and lifelong learning, (2) recognize and mitigate power imbalances, and (3) model these principles within institutional settings. MHPs are encouraged to watch the 30-min documentary *Cultural Humility: People, Principles, and Practice* available on YouTube to learn more about cultural humility: https://www.youtube.com/watch?v=_Mbu8bvKb_U&list=PL879555ABCCED8B50&feature=view_all

Practicing with *cultural humility* requires engaging in a transformative learning process to discover and change attitudes and biases that are harmful to LGBTQ+ people (Eichler, 2010). Hopefully, explicit bias is rare in MHP/client relationships and is immediately addressed when it occurs. However, **implicit bias**, which includes unconscious stereotypes and prejudices, certainly influences the provider/client relationship (Burgess, Beach, & Saha, 2017). BruinX (2016), the Research and Development arm of the UCLA Equity, Diversity, and Inclusion office, developed and has available on their website a seven-part implicit bias video series (https://equity.ucla.edu/news-and-events/bruinx-releases-seven-part-implicit-bias-video-series/) to learn more. Since implicit bias occurs unconsciously, it takes a conscious effort to recognize and correct it. **Project Implicit®**, based out of Harvard University, has developed a series of **implicit bias tests (IATs)** designed to measure implicit attitudes and stereotypes on an array of characteristics of human diversity, including sexuality, age, disability, religion, and race. One way to uncover hidden biases is to take the IATs (https://implicit.harvard.edu/implicit/). Once hidden biases are uncovered, debiasing, decoupling (BruinX, 2016), mindfulness techniques, and practicing loving kindness meditation can help interrupt the activation of implicit bias (Burgess et al., 2017).

The practice of *cultural humility* is also reflected in the language used. Word choice can be experienced as a **microaggressions—**subtle, often invisible acts of disenfranchisement or oppression, either intentional or unintentional, which perpetuate the "power-over" dynamic of dominant cultural identity (American Counseling Association, 2009). Examples of *microaggressions* include: People staring when holding your same-sex partner's hand, being told you do not "act gay" or "look trans", people presuming your spouse is the opposite sex. Despite their subtle and often invisible nature, microaggressions have a daily, cumulative impact that reinforces privilege and belonging (ACA, 2014). Social belonging is an important component of the human experience, and using inclusive language sends subtle, but explicit messages of belonging, both

on an individual level as well as on a group (Stout & Dasgupta, 2011), community, and broader societal level. Using inclusive language, such as partner(s), and having open-ended responses to questions, such as gender identity and sexual orientation, contributes to inclusive and affirming clinical and critical practice with LGBTQ+ people. A resource to enhance culturally responsive practice with people who identify as transgender is the **PFLAG Straight for Equality®** ***Becoming a Trans Ally 101*** webinar: https://pflag.org/transally101recording

Practicing with *cultural humility* requires exploring your *privilege*. **Privilege** refers to a set of unearned benefits or advantages that people receive based upon their identity (McIntosh, 1988). These privileges frequently go unnoticed by those who benefit from them. One step in becoming an LGBTQ+ ally is to recognize one's heterosexual, cissexual, and cisgender privilege. MHPs can use their awareness of their own privilege to engage in **privilege investment—**leveraging of privilege to work against heterosexism, cissexism, and cisgenderism in a manner that benefits LGBT individuals (Perrin et al., 2014, p. 242) in order to dismantle the unearned advantages that contribute to the continued disempowerment of people with non-dominant identities. On the flip side of recognizing one's own privilege, outgroup members must also work to validate the oppression, discrimination, and violence experienced by LGBTQ+ people (Perrin et al., 2014).

Ways to Get Educated on Issues Are you listening with a **critical ear**, not just a *clinical ear*? Education about the issues is occurring as MHPs listen "to the incredibly diverse stories and needs of your LGBTQ+ friends and colleagues" (Navetta, 2019, p. 25). Education about the issues is occurring every time MHPs meet with LGBTQ+ clients and listen as they share their daily struggles to be accepted for who they are, and share the multitude of ways they are subjected to cruel, dehumanizing, and unfair treatment. A client's "presenting problem" may be some form of interpersonal violence. When listening with a *critical ear*, and from an understanding of the sociopolitical context of LGBTQ+ people, intervention with a client whose "presenting problem" is some form of interpersonal violence is broadened to reflect this critical understanding. However, be mindful that while clients are experts in their own experience, it is not their responsibility to educate the professionals paid to provide services to them about structural and systemic problems that contribute to their individual issues.

MHPs have ethical and licensing obligations to engage in ongoing professional development. Get educated on the issues by connecting with global, national, state, and local organizations to take advantage of educational materials and learning opportunities, some of which have already been profiled in this chapter. A seminal resource for MHPs living in the United States to learn about violence against and within the LGBTQ+ community, and to obtain resources to turn knowledge into action, is the **National Coalition of Antiviolence Programs (NCAVP).** NCAVP produces annual reports on IPV and hates violence against LGBTQ and HIV-affected people; coordinates the National Training and Technical Assistance (TTA) Center on Lesbian, Gay, Bisexual, Transgender, & Queer (LGBTQ) Cultural Competency; and produces community action toolkits for addressing both IPV and hate violence against and within the LGBTQ communities. To learn about issues at an international level, MHPs can consult the ***International LGBT Advocacy and Programs: An Overview*** report documenting the work of 21 groups to secure the rights and welfare of LGBTQ+ people around the world (MAP, 2008). Another seminal resource, part of the **United Nations Free and Equal Campaign,** is the ***Justice for All Project*** that focuses on the protection of LGBTQ+ people from violence.

Get Empowered

> *If we work to promote self-determination and empowerment, how can we honestly achieve this with people we call clients if we ourselves give up some of our empowerment?*—Donna McIntosh (2016, para. 4)

Table 7.2 Connecting levels of empowerment with levels of activism

Level	Empowerment	Activism
Personal/ intrapersonal	A positive perception of self, a sense of self-efficacy, a sense of control over one's life and environment, and the internal motivation to act in accordance with one's values and best interest.	Consciousness raising/examine and challenge experiences of prejudice, discrimination, violence, and invisibility.
Interpersonal	The mindset and skills to constructively engage and influence people within one's immediate environments (e.g., live, learn, work, recreate, worship).	Connecting to others in the LBGTQ+ communities and allies who work to create social change.
Sociopolitical	Mindset, skills, resources, connections to influence, challenge and change personal and collective sociopolitical context (e.g., inequity, injustice, discrimination) by participating in community organizations and activities.	Challenge cultural beliefs, political systems, historical understandings, and "mainstream" societal systems, structures, and institutions.

Credit Line: Sources: Information about empowerment paraphrased and adapted from "Empowerment Theory" by M. A. Zimmerman 2000, in J. Rappaport and E. Seidman, *Handbook of Community Psychology*, pp. 46–47. Information about activism paraphrased and adapted from "A Grounded Theory of Sexual Minority Women and Transgender Individuals' Social Justice Activism" by W. B. Hagen, S. M. Hoover, and S. L. Morrow, 2018, *Journal of Homosexuality*, *65*, p. 834

Empowerment, at its core, is about having control (or power) over one's life and destiny (McIntosh, 2016). There are three **levels of empowerment**: **personal**, **interpersonal**, and **sociopolitical** (refer to Table 2). Empowerment is a *value*, a *process*, and an *outcome*. As a **value**, empowerment is a belief system that governs how MHPs and clients work together (Savage, Harley, & Nowak, 2005). Empowerment of clients is central to a clinical response to mental health practice. MHPs must recognize that although they often have more power than (as well as power over) clients, MHPs are not "doing" the empowering. As a **process**, empowerment is the way "people gain mastery and control over issues that concern them, develop critical awareness of their environment, and participate in decisions that affect their lives" (Savage et al., 2005, p. 133 based on the work of Zimmerman, 2000, p. 46). MHPs do not have the power to give or bestow empowerment upon clients, rather it is a MHP's role to help clients discover "the power within". Likewise, MHPs must undertake their own empowerment process journey to discover their own "power within". As an **outcome**, empowerment is the control over one's life that is achieved as a result of their attempts to gain greater control (Savage et al., 2005, p. 133 based on the work of Zimmerman, 2000, p. 46).

Engaging in *activism/ally activism* puts the work done by MHPs (and clients) to *get empowered* into action. **Activism** is action "designed to achieve social or political objectives through such activities as consciousness raising, developing a coalition, leading voter registration drives and political campaigns, producing propaganda and publicity and taking other actions to influence social change" (Barker, 2014, p. 5). Similar to empowerment, there are three **levels of activism**: **intrapersonal**, **interpersonal**, and **sociopolitical** (refer to Table 7.2). Engaging in activism puts personal problems stemming from oppression and systemic disempowerment into their rightful public and political place. Engaging in activism connects LGBTQ+ people to their "beloved community" (Hooks, 2003), or in some cases, activism serves to create the community that LGBTQ+ people need (Hagen et al., 2018). Activism can help "mitigate the everyday experiences of discrimination, social marginalization, isolation, shame, and internalized oppression" (Hagen et al., 2018, p. 834)—especially for people with multiple marginalized statuses. MHPs who are personally and professionally aversive to engaging in social justice cause advocacy or activism may inadvertently be using their privileged status in society to hinder the activism of their LGBTQ+ clients. MHPs need to recognize that for *privileged* people, *activism* is a choice. While for marginalized people, *activism* is a neces-

sity. ***Get empowered*** so you can model and support the empowerment of LGBTQ+ clients, family members, friends, colleagues, and community members.

Get Connected

Getting connected is associated with *interpersonal empowerment* and *interpersonal activism*. Connecting with LGBTQ+ people in the community, beyond clients, colleagues, family, and friends, is another way to learn about the issues and to begin to discover ways to partner in social justice cause advocacy. MHPs should be familiar with the array of health and human services, self-help, and advocacy organizations in their community. The aim in *getting connected* is to identify and reach out to groups and organizations in the community that have as a focus LGBTQ+ people. The following are three possible resources for getting connected.

- **College/University LGBT Center**. Check to see if a college or university near you has a LGBT Center within the institution. LGBT resource professionals will not only be knowledgeable about the issues (including violence in its many forms) impacting LGBTQ+ people at their institution, they will also know about the issues impacting people within the larger community. The Consortium of Higher Education LGBT Resource Professional has a tool on their website to *Find a LGBT Center*: https://www.lgbtcampus.org/find-an-lgbtq-campus-center
- **PFLAG** has over 400 chapters in nearly all 50 states, the District of Columbia, and Puerto Rico. Finding, meeting with, and joining a PFLAG chapter in your community will help you to learn about local issues and about the ways that you can partner as an ally. Use the *Find a Chapter* resource on the PFLAG website to see if there is a PFLAG chapter in your community: https://pflag.org/find-a-chapter
- **GLSEN (Gay, Lesbian, and Straight Education Network)** is a school-based student-educator collaboration focused on creating safe, affirming, and LGBTQ+ inclusive schools. For MHPs working with children and youth, understanding issues impacting LGBTQ+ youth in your community is essential for both clinical and critical practice. Use the *Chapter* resource on the GLSEN website to find, connect with, and support a GLSEN chapter in your area: https://www.glsen.org/chapters

Once you ***get connected***, use these connections to be a catalyst for change.

Be a Connector and an Initiator for Change

Everyone has a **sphere of influence**, meaning a network of personal and professional relationships, in organizations and in communities, which a person has the potential to engage, influence, and affect change. As an ally, one of the most basic ways that a person engages in allyship is by talking about LGBTQ+ issues and **speaking up** when hearing jokes or comments that are homo/bi/transphobic, or otherwise hostile or prejudicial toward LGBTQ+ people when spoken by people in their sphere of personal or professional relationships (Navetta, 2019, p. 29). An awareness of *nice counselor syndrome* and one's own *privilege* can help MHPs get past personal and professional barriers to speaking up.

Speaking up is an *on behalf of* or *in support of* ally activity—meaning you are engaging in these activities independently, not under the direction of or in collaboration with an LGBTQ+ coalition, organization, or people. For outgroup allies, the *guide to being a straight ally* and the *guide to being a trans ally* provide "honest forthright" guidance on "how" and "what" to say, including identifying yourself as an outgroup ally (Navetta, 2019, pp. 29–39). Movement Advancement Project (MAP, 2019f) has created a series of "research-based resources designed to help shape discussions with conflicted or undecided Americans—and help them better understand key issues of importance to lesbian, gay, bisexual and transgender (LGBT) people" (para. 1). Resources include: *Talking About Inclusive Hate Crime Laws*, *Talking About Suicide and LGBT Populations*, and *Talking About Family*

Acceptance and Transgender Youth. Go to the MAP website to access all of the *Talking About* LGBT issues resources: http://www.lgbtmap.org/talking-about-lgbt-issues-series

MHPs can use their professional *sphere of influence* as connectors and catalysts for community building and social change within affiliated organizations and communities. Building community is important for LGBTQ+ people, especially those members from multiple oppressed groups, to combat the fatigue and hardship of everyday life (Hagen et al. 2018, p. 852). The following are five ways to create more inclusive organizations, build community, and lay the foundation for social change.

- MHPs can initiate critical conversations with affiliated organizations about LGBTQ+ and ally issues using the PFLAG Straight Talk for Equality® monthly discussion resources: ***Something to Talk About*** and ***Talking Inclusivity***.
- MHPs can create opportunities to use toolkits and other resources developed by the National Coalition of Anti-Violence Programs, the National Center for Transgender Equality, and Forge to address intimate partner violence (IPV) and hate violence against and within the LGBTQ+ communities. For example, the New York State Lesbian, Gay, Bisexual, Transgender & Queer Intimate Partner Violence Network, a member of the National Coalition of Anti-Violence Programs, has initiated a statewide campaign to ensure that survivors of IPV across the spectrum of gender identity and sexual orientation can access safety, support, and services. Three resources were developed to support domestic violence shelters in moving beyond a heteronormative approach to IPV: ***Shelter Access Toolkit***, ***Best Practice Toolkit***, and ***Power and Control Assessment***.
- MHPs can use professional networking and multidisciplinary team skills to bring together stakeholders from the LGBTQ+ communities, domestic and sexual violence advocates, criminal justice professionals, and other community stakeholders to address violence and other forms of harm perpetrated against LBGTQ+ people.
- MHPs can initiate the formation of a PFLAG chapter at their place of employment or in the community. PFLAG defines a chapter as: "three or more individuals working together to further PFLAG's goals." Go to the PFLAG National's website for information about how to start a chapter in your community: https://pflag.org/start-chapter
- MHPs who work in or are affiliated with schools in their community can initiate the formation of GSLEN chapter(s). A chapter can be started by emailing chapterinfo@glsen.org.

An outgroup *ally* wants to make sure that their ***connecting*** and ***initiating*** is done *with* the LGBTQ+ communities, not *on behalf of* LGBTQ+ people.

Get Political

> *"I am only one person, my vote really doesn't matter." "It doesn't matter who gets elected, all politicians are the same." "Voting is a waste of time, none of the issues affect me."*

Do any of the aforementioned sentiments apply to you? While apathy, cynicism, and disgust are understandable given the contemporary political climate in the United States and in many other parts of the world, disengaging from the electoral process means that others who do not share the values and interests of MHPs get to make that rules that you and your clients must live by. Do not give away what power and influence you have by sitting on the sidelines.

Exercising Your Right to Vote Voting is the most basic, yet most important act of civic engagement. Your vote is your voice on the issues of most importance to you. When you cast your vote, you are electing people to enact and implement public policies and budgets that reflect your values, interests, and priorities. Eligible voters also have the opportunity to shape public policy by voting for or against *ballot initiatives*—also

referred to as a **referendum**. A **ballot initiative** is a "proposition placed on the ballot […] that enables voters to shape the policies of a city, county, or state" (Reisch, 2018, p. 556). *Ballot initiatives* are used "to determine tax policy," "commit the government to spend a certain proportion of revenue on a particular population," and "to expand or restrict the rights of a specific community (e.g., immigrants or LGBTQ population)" (Reisch, 2018, p. 556). While voting may not be explicitly identified as an ethical obligation of MHPs, it is certainly implied in every disciplines' code of ethics. It is impossible to promote the welfare of LGBTQ+ people if you are not voting on ballot initiatives and electing public officials at *all levels of government* who make public policy and budget decisions that, for better or worse, impact LGBTQ+ people.

In the United States, a lot of attention is paid to voting every 4 years during a presidential election, ignoring that elections are held every year to elect public officials at the local, state, and federal levels. At the local level, school board, city council, and county board members make public policy and budget decisions that most directly impact MHPs practice and clients. State legislators enact laws and budgets that are signed by governors, and executed by appointed officials who oversee major functions of state government, including health and human services, public safety, and human rights. The United States has a highly decentralized system of elections administration, including voter registration, with 24 states having an elected secretary of state as the chief election officer (National Conference of State Legislatures [NCSL], 2016). Most of the other states have a chief election officer and/or a commission/board who are appointed by the governor or the legislature (NCSL, 2016). The courts make public policy in three ways: deciding a case when there is no existing law or regulation governing the issues, interpreting laws enacted by legislatures, and interpreting and applying the constitution (Lens, 2015, p. 296). At the state level, judges are selected in a variety of ways, including elected by the people, selected by a legislative body, or appointed by a governor (Ballotpedia, n.d.a). At the federal level, district court judges, courts of appeals judges, and Supreme Court justices are nominated by the President and confirmed by the United States Senate (United States Courts, n.d.).

It is imperative that MHPs get educated on the candidates and their public policy positions, and vote in *every* election (i.e., primary and general election at the local, state, and national levels) and on *every* ballot initiative. A good source to get educated about politics in the United States at all levels of government is **Ballotpedia,** a digital encyclopedia of American elections and politics: https://ballotpedia.org Voting to elect public officials at the local, state, and federal (or national) levels who are members of the LGBTQ communities and/or who explicitly support LGBTQ+ rights is one of the easiest ways for an MHP to *be the change*. Contribute your time, knowledge of the issues, and monetary resources to support candidates from the LGBTQ communities or who support LGBTQ rights. A resource to support LGBTQ candidates is **Victory Fund**—the only national organization dedicated to electing openly LGBTQ people who can champion equality at all levels of government. Another resource is the **National LGBTQ Task Force's Queer the Vote Campaign**.

Supporting the Voter Engagement of Others Encourage family members, friends, coworkers, and clients to exercise their right to vote. As an MHP, use your *sphere of influence* at your place of employment to encourage their engagement in nonpartisan voter education and get out the vote efforts. 501(c)3 non-profit organizations (e.g., public charity, private foundation) (Reisch, 2018, p. 415) may engage in **nonpartisan voter education** activities and efforts designed to encourage people to participate in the electoral process (Internal Revenue Service [IRS], 2018c). 501(c)3 non-profit organizations may not engage in **political activities** defined as "participating in, or intervening in, any political campaign on behalf of (or in opposition to) any candidate for elective public office," including making contributions to any candidate for public office (IRS, 2018c, para. 1). Refer to Table 7.3 for a list of 501(c) 3 dos and don'ts.

Table 7.3 501(c)3 non-profit electoral politics dos and don'ts

Dos	Don'ts
Educate the public about issues relating to elections.	Endorse candidates in writing, in person, or online.
Attend candidate forums and town hall meetings personally or as a representative of your agency.	Participate in any political campaigns or conduct campaign outreach at agency meetings.
Organize public forums where ALL candidates are invited and if chose to attend have equal opportunity to speak.	Invite a candidate or staff to an agency meeting to recruit volunteers or to give out (or sell) agency membership lists.
Ask ALL candidates about LGBTQ+ issues.	Donate to any candidate on behalf of your agency.
Wear clothing that supports specific issues, as long as it cannot be linked to a political party or candidate.	Engage in partisan discussion at agency meetings.
Issue public statements in favor or opposition of elected officials' or candidates' positions on LGBTQ+ issues.	Wear clothing or other paraphernalia pertaining to or endorsing specific political parties or candidates.

Source: *Voting Matters: The PFLAG National "Get Out the Vote" and Voting Guide,* by PFLAG, 2020, p. 2. Copyright 2020 PFLAG National. Adapted with permission

Shaping political party platforms It is impossible to disconnect public policy from politics. The people who make public policy are elected officials typically affiliated with a political party. Political parties work to enact public policies compatible with their values, interests, and ideology. An **ideology** is "a unified, generally coherent collection of beliefs or worldview, of religious or secular origin, that explains a multitude of phenomena and provide the framework for an individual or group's interpretation of its environment" (Reisch, 2018, p. 562) and influences public policy making decisions. Political parties may organize around a political or economic ideology, or to promote a specific interest, like the environment or a religious group (Constitutional Rights Foundation [CRF], 2019, para. 4). Political parties operationalize their ideology into a party platform. A **party platform** "is a set of principles, goals, and strategies designed to address pressing political issues. Each party's platform is broken down into 'planks', or declarations that speak to each specific issue" (CRF, 2019, para. 6). In the United States, political parties are organized at the local, state, and national levels, and meet every 2 years (state level) and every 4 years (national level) "to approve a party platform of issues and positions upon which the candidates will run" (CRF, 2019, para. 6).

One way to *get political* is to research the political parties in your system of government, read party platforms paying particular attention to policy positions pertaining to the rights of LGBTQ+ people, and then reach out to local party affiliates to learn about opportunities for getting involved. Getting involved can include participating in the ongoing revision of a political party's platform. Party platforms are created by party members through a series of steps that begin at the local level with the proposal of *resolutions*. A **resolution** is a written motion to request a specific action on an issue or topic of importance.[3] The policies and procedures governing political parties at each level (local, state, and national) are spelled out in a party's **constitution** and **by-laws**. Anyone who is a member of the political party can propose a *resolution*, as long as the proper process, outlined in the by-laws, is followed. A resolution has three core parts: (1) The topic and the position on the topic ("in support of" or "in opposition to"), (2) the *preamble* builds the argument written as a series of "WHEREAS" statements, and (3) The *action* being sought written as "THEREFORE BE IT RESOLVED" statements (NFTY, 2014). Watch the YouTube video *How to Write a Resolution* for additional guidance: https://www.youtube.com/watch?v=oyoH6gZvgpg

It is not difficult to draft and propose a resolution once you understand the issues and the process. Blank resolution forms can be found with an online search of your state, preferred political party, and the term "resolution form." Many nonprofit and political advocacy organizations offer

[3]Definition is a complication of ideas taken from many sources.

prefilled resolutions that can be presented at a local party primary or caucus. Refer to Box 7.1 for an example of a resolution that could be submitted for consideration on the topic of sexual orientation change efforts (SOCE). Once a resolution is adopted at the local level, it is presented to the next level of the party; going through a similar process at the county, state, and potentially national level to be adopted into the party platform.

Professional associations and other membership organizations have a similar such process for drafting resolutions that convey the policy position, priorities, and recommended action on issues of importance to the group. For example, on August 5, 2009 the American Psychological Association adopted the resolution on *Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts* (Anton, 2010). Consult your professional association for the resolution process and current resolutions on issues of importance to the LGBTQ+ communities.

Getting Political is an act of empowerment. So, exercise your right to vote, support the voter engagement of others, and shape the agendas and priorities of political parties in ways that promote the rights and well-being of LGBTQ+ people.

Take Action

> *Taking no action—remaining silent—is an action.*—Donna McIntosh (2004, p. 1)
> *One voice can change the world.*—PFLAG National (2017)

"One voice can change the world" is the title of *The PFLAG National Policy Guide and Advocacy Toolkit* (2017). All of the information provided in this chapter has led to this final section—engaging in social justice cause advocacy to change the sociopolitical context of oppression, discrimination, and violence in the lives of LGBTQ+ people. For outgroup allies, this is your opportunity to become a "super ally" (Navetta, 2019, p. 9).

Box 7.1 Sample Resolution

Resolution Title: Oppose Sexual Orientation Conversion Efforts.

Author/Submitting Organization: Nancy Fitzsimons & Michelle Anklan

WHEREAS:

Sexual orientation change efforts (SOCE), also referred to as "reparative "or "conversion" therapy, consist of psychological or behavioral treatment intending to change an individual's sexual orientation from a lesbian, gay, or bisexual orientation to a heterosexual orientation; or from a transgender/gender nonconforming identity to a cisgender identity (where one's gender identity matches their sex assigned at birth/not transgender);

WHEREAS:

There is a lack of proven efficacy for SOCE and potential harm of clients, particularly children and vulnerable adults;

WHEREAS:

Lesbian, gay, bisexual, and transgender (LGBT) people have increased instances of mental health issues stemming from minority stress and discrimination;

WHEREAS:

Every professional counseling organization has recommended against the practice of SOCE, including the American Psychological Association, the American Psychiatric Association, the National Association of Social Workers, the American Medical Association, the American Counseling Association, and the American Academy of Pediatrics;

BE IT RESOLVED THAT:

The _____ party of the state of _____ opposes the practice of sexual orientation conversion efforts.

This resolution was: ☐ Adopted ☐ Defeated on this date of _____

Taking action—engaging in *social justice cause advocacy*—is the pinnacle *critical response* that MHPs can take to join with LGBTQ+ people to "build a world where no one has to be afraid because of their sexual orientation or gender identity" (Guterres, 2015, para. 1). The good news for outgroup member MHPs about taking action as an ally activist is the expectation for you to join with the LGBTQ+ communities to support their efforts, their struggles—not lead or take ownership of the issues. The model proposed for taking action is a **three-prong advocacy campaign**, with education and information dissemination incorporated into each of the prongs (Avner, 2013).

Public Policy Advocacy **Public policy advocacy** (also referred to as legislative advocacy) is simply efforts to influence policy and budget (generating revenue and making expenditures) decisions made by publicly elected officials at the local, state, and national (federal) levels of government (Reisch, 2018, p. 413). Advocacy to influence specific legislation—including proposing, supporting, and opposing, is referred to as **lobbying** (IRS, 2018b). Depending upon the systems of government, targets for lobbying include city council members, county board members, state legislators, and federal legislators. *Public policy advocacy* also targets elected official in the executive branches of government who sign bills into law (e.g., the governor at the state level and the president at the federal [or national] level) and administer the laws at each level of government (e.g., boards, commissions, and government departments) (Reisch, 2018, p. 413). MHPs have the most direct influence on public officials whom they elect. Go to USA.gov for links to identify and contact federal, state, and local elected officials: https://www.usa.gov/elected-officials. Always identify yourself as a **constituent** when advocating or lobbying with elected officials who directly represent you. The most basic way for MHPs to engage in *individual advocacy* or *lobbying* is through in-person meetings, making telephone calls, writing letters and emails, and attending town hall meetings. Refer to ***The PFLAG National Policy Guide and Advocacy Toolkit*** (2017) for tips on how to effectively engage in individual advocacy (pp. 6–15).

To be an effective public policy advocate it is important to understand **how a bill becomes a law**. The general steps in the law-making process, linked to opportunities for advocacy at each step in the process, are presented in Table 7.4. Based upon jurisdiction, the process outlined may deviate. The first step in the process is proposing an **idea** for creating a new law, or for changing or repealing an existing law. Consult with LGBTQ+ advocacy organizations for ideas for public policy change and sample legislation that you can use to initiate the law-making process. For example, a resource MHP can consult to support their advocacy efforts to protect youth from "so-called" conversion therapy is the National Center for Lesbian Rights (NCLR) and the Trevor Project's ***Sample Legislation and Advocacy Toolkit to Protect Youth from "Conversion Therapy"*** (http://www.nclrights.org/wp-content/uploads/2014/06/Conversion-Therapy-Toolkit.pdf).

At any step along the way, the bill may die—meaning no action is taken to keep the process moving forward during the legislative session. Sometimes your advocacy may entail trying to stop a bad bill from getting signed into law, thus the bill "dying" is a good thing. An analysis done by CQ Roll Call found that "Congress passed about 4 percent of the bills that were introduced by lawmakers, while states passed an average of 25 percent" (Justice, 2015, para. 6). While *public policy advocacy* at all levels is important, your advocacy efforts will be most successful at the local and state levels. As a bill is working through the process in the legislature, simultaneously lobby the executive leader (president or governor). While the executive's formal role comes at the end of the process, they can use the power of their position to ensure the passage of legislation favorable to LGBTQ+ people. Go to **USA.gov** for information about how laws are made at the U.S. federal level and to your state's legislative website for state-specific information about the process.

Testifying MHPs can have the greatest impact on shaping public policy while bills are in committee because this is the step in the process where the issues are given the most time, attention, and scrutiny. The thought of *testifying* may be overwhelming. However, know that as an educated, licensed,

Table 7.4 Steps in the law-making process linked to opportunities for advocacy

The law-making process	Advocacy
Every law starts with an idea.	Ideas can come from anyone. Contact your elected representatives to propose ideas for new laws or changing existing laws.
A legislator takes the idea and gets it written into bill form.	Suggest specific provisions to be included in the bill.
The bill is introduced by its primary sponsor (a.k.a. lead author) in either chamber (i.e., house and senate).	Help to get other legislators to add their name as co-sponsors of the bill.
The bill is assigned to a committee with primary jurisdiction over the subject matter of the bill. The role of the committee is to research, discuss, and make changes to the bill.	Work with the chair of the committee and its members to help them understand the issue and to prevent them from making changes that would weaken the bill. Advocate for the chairperson to conduct hearings to discuss the bill.
Hearings are conducted to discuss the bill.	Testify at hearings.
The committee votes to accept or reject the bill and its changes before sending to another committee with jurisdiction over the subject matter or to the entire legislative body (i.e., house floor or senate floor) for debate.	Lobby (visit, write, telephone) committee members to share how you would like them to vote on the bill. If the bill is assigned to another committee, keep advocating.
If the bill passes through all the committees, it is sent to the entire legislative body for debate, to propose changes or amendments, and then voted upon.	Lobby legislators to support or amend the bill. Target swing legislators who are undecided or have no strong position on the issue. Engage in grassroots lobbying to generate telephone calls, letters, email, lobby visits, and media from allies.
If the majority vote for and pass the bill, it moves to the other chamber (house or senate) to go through a similar process of committees, debate, and voting. It is possible that the other chamber is already working on its own bill(s).	Repeat the process. Line up co-sponsors, work with committee leaders and members to strengthen support for the bill, testify at hearings, lobby swing legislators. Activate grassroots lobbying efforts.
If the bill passes both the house and the senate it will most likely need to go to conference committee to work out the differences between the two bills.	Lobby members of the conference committee to keep favorable provisions intact and to prevent them from making changes that would weaken the bill.
The full house and the full senate vote on the compromised bill.	Activate grassroots efforts to tell legislators how you would like them to vote on the final bill.
If the bill passes both the house and senate it is sent to the executive (the president or governor) for action: Sign, veto, choose not action, pocket veto.	Use traditional and social media to publicize the bill's passage and activate support for action.
If the executive signs the bill, it becomes a public law.	Action taken depends upon whether you support or oppose the final bill. If you support, celebrate, and use media to publicize passage. Regardless of support or opposition, the next step is to get involved in the making of the regulations (or rules) that will govern the implementation of the law.

Ideas paraphrased, organized into steps, and adapted from: The Legislative Process, Interest Groups, and Lobbying, by L. K. Cummins, K. V. Byers, & L. Pedrick, 2011, *Policy Practice for Social Workers: New Strategies for a New Era*, pp. 243–256

and otherwise credentialed and experienced MHP, you will almost certainly know more about the issue to which you speak then the elected officials listening to your **testimony**. Keep it simple. Speak with passion and conviction. Share information and tell stories based upon your professional, and if applicable, personal experiences as a member of the LGBTQ+ community or as a friend or family member (PLAG, 2017, p. 5). As an ally activist, elevate the voices of LGBTQ+ people by supporting individuals who are safely out and in a position to testify (PFLAG, 2017, p. 5).

Each committee has an administrator responsible for supporting the work of the committee, including coordinating speakers to testify at public hearings. Once the committee considering the bill is determined, contact the committee administrator to get on the agenda to testify. Ask for written guidelines for preparing and delivering testimony. Expect no more than 5 min (really, more likely 2 or 3 min) for your testimony, followed by a few minutes for committee members to ask questions. Provide the committee administrator with a written copy of your testimony or bring enough paper copies to distribute to all committee members. Your written copy will be entered into the official committee hearing record. Refer to the following general guidelines for **structuring your testimony**:

- Thank the committee for the opportunity to testify.
- Introduce yourself: Provide your name, organization affiliation (if applicable), and credentials.
- Introduce the issue: Identify the issue or topic that you are there to discuss. If applicable, identify specific bill(s), including number, name, and purpose.
- State your position on the issue.
- Make *the ask*: Tell your target audience what action or position you want them to take (e.g., support, oppose, or amend).
- Provide a compelling rationale. Make a case for the existence of the problem and policy change needed. Present your data—quantitative and qualitative. Tell why the issue is of importance to you on a professional level, if appropriate, at a personal level, and as a member of the geographic community (e.g., city, county, state, country).
- Restate the issue, your position on the issue, and *the ask*.
- Thank the committee for the opportunity to testify. Refer the committee to your written testimony with your contact information and references (if applicable). Offer to be a resource.

Refer to Box 7.2 for an example of *testimony*. Beware that the committee hearing may be live-streamed, video or audiotaped, and available to the general public for later viewing or listening.

Encourage Public Policy Advocacy at Affiliated Organizations MHPs can also engage in activism by encouraging the places where they work to engage in public policy advocacy. Contrary to common perception, **501c3 non-profit organizations** in the United States can engage in public policy advocacy and *lobbying—direct and grassroots*. **Direct lobbying**, "attempts to influence a legislative body through communication with a member or employee of a legislative body, or with a government official who participates in formulating legislation" (IRS, 2018a, para. 1), is permissible as long as it falls within the limits established under the *substantial part test*[4] and *expenditure test*[5] (IRS, 2018b). **Grassroots lobbying,** defined as **"**attempts to influence legislation by attempting to affect the opinion of the public with respect to the legislation and encouraging the audience to take action with respect to the legislation," is also permissible, but with restrictions (IRS, 2018a, para. 1). 501c3 organizations may engage in some *grassroots lobbying* as long as it falls within the limits established under the **substantial part test** and **expenditure test** (IRS, 2018b). Advocacy in the form of public education (e.g., educational meetings, dissem-

[4]The general guidance is no more than 5 percent of an organization's time and efforts can be spent in direct lobbying. Refer to *Seasongood v. Commissioner*, 227 F.2d 907, 912 (6th Cir. 1955)

[5]The expenditure test limits how much money can be spend in direct lobbying based on the size of the organization. Refer to the IRS for information about the expenditure test: https://www.irs.gov/charities-non-profits/measuring-lobbying-activity-expenditure-test

Box 7.2 Sample Testimony

Name of Governmental Body
Name of Committee
Name of Chair: Title, First Name, Middle Initial, Last Name
Date

Michelle Anklan, MSW, CSW
[Address]
[Phone Number]
[Email]

Chairman [Last name] and Committee members, I thank you for the opportunity to speak to you today about the need to establish legislative protection against medically unnecessary surgical intervention on intersex infants and children in the state of Utah.

My name is Michelle Anklan, and I am a certified social worker in the state of Utah. As part of my Master of Social Work degree, I completed a 6-month internship at the Transgender and Intersex Specialty Care Clinic at Mayo Clinic in Rochester, MN. The term "intersex" refers to individuals born with "anatomies that are considered 'atypical' for either male or female bodies" (Human Rights Watch, 2017). There are over 40 variations of sex development that can be referred to as "intersex" (Amnesty International, 2017), and up to 1.7% of children are born with intersex variations (Human Rights Watch, 2017).

Due to social and cultural influences, as well as a lack of policy regarding the treatment of intersex people, many intersex infants undergo medically unnecessary genital "normalization" surgery, which constitutes "all surgical procedures that seek to alter the gonads, genitals, or internal sex organs of children with atypical sex characteristics too young to participate in the decision, when those procedures both carry a meaningful risk of harm and can be safely deferred" (Human Rights Watch, 2017, p. 1–2).

These irreversible, nonconsensual surgical interventions are a form of physical and psychological violence against intersex people. In the 2012 documentary *Intersexion*, Cheryl Chase described her experience of medically unnecessary intersex surgery saying, "people treated me like a freak, people lied to me, cut me up, they harmed me in ways that prevent me from being romantically or sexually intimate with people, they caused me to feel like my body is disgusting" (LaHood, 2012). Early experiences of surgical intervention were so traumatizing that many intersex adults refer to this practice as "intersex genital mutilation" (LaHood, 2012).

The United Nations (Mendez 2015), Human Rights Watch (2017), the World Health Organization (2015), and Amnesty International (2017) have condemned the practice of surgical intervention on intersex infants and children without their consent, on the basis that it violates their human rights and lacks research supporting its effectiveness. There are currently no laws in the United States that protect the bodily integrity of intersex infants and children (Amnesty International, 2017), and the state of Utah has the opportunity to be a leading force on this issue.

I ask you all, as members of the Health and Human Services Committee, to take action to protect intersex infants and children from the harmful act of early surgical intervention. Please refer to the policy brief (Anklan, Matejcek, & Tinaglia, 2018) provided for additional information. I will gladly answer any questions. Thank you for your time and consideration of this very important human rights issue.

References

- Amnesty International. (2017). *First, do no harm: Ensuring the rights of children with variation of sex characteristics in Denmark and Germany*. Retrieved from https://www.amnesty.org/en/documents/EUR01/6086/2017/en/

(continued)

Box 7.2 (continued)

Anklan, M., Matejcek, J., & Tinaglia, L. (2018, July). *Applying social work values to the care and treatment of intersex people*. Retrieved from Minnesota State University Mankato, Department of Social Work website: http://sbs.mnsu.edu/socialwork/intersex_policy_brief_07082018.pdf

Human Rights Watch. (2017). *I want to be like nature made me: Medically unnecessary surgeries on intersex children in the U.S.* Retrieved from https://www.hrw.org/report/2017/07/25/i-want-be-nature-made-me/medically-unnecessary-surgeries-intersex-children-us

Lahood, G. [Producer], & Keir, J. [Director]. (2012). *Intersexion: Finding a place in a two-gender world* [Motion Picture]. Kilbernie, New Zealand: Ponsonby Productions Ltd.

Mendez, J. E. (2015, March 5). R*eport of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*. United Nations Human Rights Council. Retrieved from https://www.refworld.org/docid/56c436dc4.html

World Health Organization. (2015). *Sexual health, human rights and the law*. Retrieved from https://www.who.int/reproductivehealth/publications/sexual_health/sexual-health-human-rights-law/en/

ination of materials) on the issues is *always* permissible. Examples of public policy advocacy to promote sociopolitical empowerment at the organization level are as follows:

- Invite elected officials to meet with clients, staff, and board members at the agency to learn first-hand about the issues impacting LGBTQ+ people.
- Organize attendance at town halls. Call or check the website of your elected officials to find out when they will be holding their next town hall. You can also locate town halls at https://townhallproject.com/
- Support LGBTQ+ clients in testifying at legislative and other public hearings on issues of importance to them.

Remember that the work of *public policy advocacy* occurs 365 days a year, not just when legislative or other governmental bodies are officially in session. Some elected officials (e.g., city council, county board) work year round, so connect year round. Use the time when state and federal legislators are not in session to connect with them, to establish and build effective working relationships, to educate them on the issues, and to solicit their support for issues of importance to your organization and LGBTQ+ communities.

Coalition Building and Grassroots Organizing One of the easiest ways to engage in public policy advocacy is to become a member of a coalition or grassroots advocacy organization. Through such affiliations, MHPs will be exposed to the many ways to engage in *social justice cause advocacy* with LGBTQ+ people. A **coalition** is "a group of organizations and individuals formed to advocate for change in a public policy or to support a particular cause" (Reisch, 2018, p. 557). **Grassroots organizing** is "an aspect of community practice that focuses on work at the neighborhood level or among a particular population directly affected by a specific issue or problem. Also called direct action organizing" (Reisch, 2018, p. 561–562). MHPs are not expected to be coalition builders and community organizers, but are encouraged to support existing efforts. MHPs, in their professional role and as private citizens, can contribute their time, knowledge of the issues, voice, and monetary resources to LGBTQ+ rights coalitions and advocacy organizations at the local, state, and national levels.

Coalitions and grassroots advocacy organizations try to make *taking action* easy by posting an

array of opportunities for getting involved on their websites and other social media platforms. Sign up for **action alerts** to tell you "when," ideas for "what to say," and "how" to *take action*. Examples of opportunities to be a part of a grassroots movement:

- Attend marches, town hall meetings, days at the capital, and issue forums.
- Participate in letter writing/email/social media campaigns to educate the public and influence public policy makers.
- Participate in electoral activities, such as telephone banking, door knocking, and attend house parties and other fundraisers to elected LGBTQ+ candidates and elect officials who support LGBTQ+ rights.

As private citizens, MHPs may participate in any of the aforementioned opportunities. Because there are restrictions on what MHPs can do in a professional capacity at their places of employment, seek guidance from your employer before *taking action*. Use your sphere of influence to encourage your employing or other affiliated organizations to join coalitions or grassroots movements working to promote the rights and well-being of LGBTQ+ people.

Using the Media to Spread Your Message

> *Education is the most powerful weapon which you can use to change the world.*—Nelson Mandela

Michael Reisch, (2018) Professor of Social Justice at the University of Maryland writes: "In today's environment, the use of various forms of media is critical to the survival and success of community organizations, social services agencies, and policy advocacy campaigns" (p. 464). **Media advocacy** refers to "efforts to use media to influence public opinion and the actions of key policy makers" (Reisch, 2018, p. 413). There are three types of **media**: *paid media*, *earned media*, and *social media*. **Paid media,** the placement of ads in newspapers, television, radio, the internet, and paid public service announcements, is cost-prohibitive for MHPs and most small organizations (Reisch, 2018, p. 465). *Earn media* and *social media* are more readily accessible ways to influence public opinion and the actions of policy makers.

Earned media **Earned media** refers to stories, opinion essays, editorials in newspapers, television or radio coverage, and reporting on blogs or websites (Reisch, 2018, p. 465). Options for engaging in advocacy using *earn media* include:

- Use a **media advisory**, such as a **press release**, to invite the media to attend a press conference, presentation, public or other types of event (PFLAG, 2017; Reisch, 2018).
- Write an op-ed essay or guest editorial. An **op-ed** or **guest editorial** is typically 600 to 1000 words in length and written by someone considered to be an expert on the subject matter (Reisch, 2018, p. 472).
- Participate in a **media interview** on radio, television, or podcast (Reisch, 2018).

However, the most readily available way that MHPs can use the *earned media* to engage in social justice cause advocacy is writing *letters to the editor*. A **letter to the editor** can be submitted by anyone, typically the readers of a newspaper, magazine, or other sources, about an issue of importance to the publication's audience (PFLAG 2017, p. 20). Keep the following guidelines in mind when writing *letters to the editor*:

- Look up and follow submission guidelines, including maximum word court (typically around 200 to 300 words).
- Write concisely, short simple sentences, using plain language.[6]
- Write about what you know from your professional and/or personal experience and point of view.
- Explain why the issue is relevant to readers. Connect the issue to the local community.
- Tell readers what they can do to support your cause.

[6]For more information about plain language go to: https://www.plainlanguage.gov/

Refer to Box 7.3 for an example of a letter to the editor about banning the practice of sexual orientation conversion therapy (SOCE).

Social Media Using **social media,** such as Facebook, Twitter, Instagram, and YouTube, is the least expensive and quickest way to communicate a message and bolster other advocacy efforts (PFLAG, 2017; Reisch, 2018, p. 465–466). PFLAG (2017) identifies three concrete ways to use *social media* to promote the rights and welfare of LGBTQ+ people:

- Tweet elected officials about a specific piece of legislation when you cannot meet with them in person.
- Write a Facebook post as part of a grassroots organizing effort to encourage others to write, call, email, or tweet their elected officials about a harmful or helpful bill.
- Advertise an advocacy-oriented event on Instagram (p. 21).

In addition, refer to the PFLAG document ***2020 Presidential Candidates: 501c3 Guidelines and Social Media Best Practices*** for more information about how to use social media for electoral advocacy.

For ideas in how to use *social media* to combat violence against LGBTQ+ people consult the National Coalition of Anti-Violence Programs (NCAVP). NCAVP uses *social media* as a tool in their campaign to end hate violence. NCAVP launched their **#NOT1Story Campaign** via a Twitter Town hall; created images that can be shared on Facebook, Instagram, and Twitter; and created messages that can be tweeted using the hashtag **#Not1Story.**

Concluding Thoughts

MHPs have an ethical obligation to be among the "small group of thoughtful committed citizens" working with other LGBTQ+ activists/ally activists to *build a world where no one has to be afraid because of their sexual orientation or gender identity*. Unlike much of micro-level mental health practice, macro practice is by its very nature a collective, collaborative, community engagement endeavor. No one person can, nor is

Box 7.3 Sample Letter to the Editor

[Today's Date]
[Name of Newspaper]
[Attn: Letters to the Editor]
[Mailing Address]
[City, State, ZIP Code]
Dear Editor:

Utah is one of 46 states in the U.S. that allows mental health professionals to practice sexual orientation change efforts (SOCE) on clients. SOCE, commonly known as "conversion" or "reparative" therapy is the use of psychological or behavioral treatment intending to change someone's sexual orientation from a lesbian, gay, or bisexual orientation to a heterosexual/straight orientation, or change one's gender identity from transgender or gender nonconforming to cisgender (a person whose gender identity aligns with their sex assigned at birth, or a non-transgender person).

SOCE contributes to depression, anxiety, shame, and refusal or delay in accepting one's sexual orientation and/or gender identity. Every professional counseling organization, including the American Psychological Association, the American Psychiatric Association, the National Association of Social Workers, the American Medical Association, the American Counseling Association, and the American Academy of Pediatrics, opposes the use of SOCE.

In the 2019 legislative season, Utah was on track to become the most conservative state in the U.S. to ban SOCE before the bill was tabled for this legislative session. As we prepare for Salt Lake City's annual pride festival next week, I encourage you to contact your elected officials and tell them why this issue matters to you and your community.

Sincerely,
[Your name]
[Your professional credentials]
[Your address]
[Your phone number]
[Your e-mail address]

responsible for, dismantling the historical and contemporary structures and systems of oppression, discrimination, and violence that detrimentally impacts the lives of LGBTQ+ people and their families. The work of structural and systemic change requires a long-term investment of many individuals, groups, organizations, coalitions, communities, and countries all working to create a more *just, affirming, and inclusive* world for LGBTQ+ people. The work of *social justice cause advocacy* can take an emotional toll on all people engaged in this work, which is why the practice of self-care is imperative. However, the emotional cost is greatest for members of the LGBTQ+ communities, and especially burdensome for people with multiple marginalized identities. This is why the work of activists/ally activists is done collectively, through collaboration, and within community—

- To share the burden
- To support, encourage, and inspire one another
- To plan, take action, process, and reengage
- To celebrate every success, no matter how big or small, along the way.

All that is being asked of you, as an MHP and citizen of the world, is to use your sphere of influence to make the *private troubles* of LGBTQ+ people *public issues,* and to engage with other like-minded activists/ally activists to *build a world where no one has to be afraid because of who they are or who they love*. Now, go do your part to be one of the many activists/ally activists around the globe building a better world for LGBTQ+ people and their families.

List of Advocacy Organizations

- **Aging**: Services and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders (SAGE)/sageusa.org
- **Advocacy**: Human Rights Campaign/hrc.org
- **At-Risk LGBT Youth**: The Trevor Project/thetrevorporject.org
- **Electoral Politics:** Victory Fund/victoryfund.org/
- **Faith**: Institute for Welcoming Resources/welcomingresources.org
- **Global**: International Lesbian, Gay, Bisexual, Trans and Intersex Association/ilga.org
- **Health**: GLMA Health Professionals Advancing LGBTQ Equality/glma.org
- **Human Rights**: Human Rights Watch—LGBT Rights/https://www.hrw.org/
- **Intersex Youth:** InterACT Advocates for Intersex Youth/https://interactadvocates.org/
- **LGBTQ+ Anti-Violence:** National Coalition of Anti-Violence Programs/avp.org/ncavp/
- **LGBT Parents**: Family Equality Council/familyequality.org
- **Peer to Peer Support**: LGBTribe/support.therapytribe.com/lgbt-support-group/
- **Transgender**: National Center for Transgender Equality/transequality.org
- **Transgender Anti-Violence**: Forge/forge-forward.org
- **Schools**: Gay, Lesbian, and Straight Education Network/glsen.org
- **Workplace**: Out & Equal Workplace Advocates/outandequal.org

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8 Like a Candle Flickering in the Mist: Violence Against the Trans Community

Victoria M. Rodríguez-Roldán

Introduction

In March of 2019, Ashanti Carmon was shot to death in Fairmount Heights, Maryland, a couple blocks near the boundary with the District of Columbia.[1] She was a transgender woman who had been homeless because of family rejection stemming from her being trans, and had resorted to sex work to survive.[2] One thing that compounds this tragedy is that it wasn't unique even in its location or time frame: Only a few months later, in June of 2019, Zoe Spears was also shot to death a couple blocks away from where Ashanti's murder took place.[3] The day before her death, she had texted a friend asking for $10 so she could eat.[4] These two murders, as well as all the others that are memorialized in candle-lit vigils on Trans Day of Remembrance every November 20th, are simply the end result of society's pervasive transphobia and discrimination against the trans community. In this chapter, we intend to examine the topic of violence against the trans community, including the nuance often lacking in many conversations about hate crimes as well as including police perpetrated anti-trans violence.

Set Up to Fail: The Conditions Leading to Violence Against Trans People

We often see anti-trans violence framed primarily through the limited lens of hate crimes legislation and prosecution. Under federal law, namely the *Matthew Shepard and James Byrd, Jr. Hate Crimes Prevention Act of 2009*[5] a hate crime against a trans person occurs when there is willful causing of bodily injury or attempting to do so with a dangerous weapon, and the crime was committed **because** of the person's actual or perceived gender identity.[6] Other forms of violence that are not necessarily entirely motivated by gender identity, or where prosecutors cannot or do not wish to meet the burden of proof that this was a bias-motivated crime, end up not counted. We also rarely examine the topic of the systemic discrimination that leads to violence against trans people, and for that matter, why are trans people often placed in positions where they are more vulnerable to violence. One could argue that there is a pipeline toward marginalization and failure in which the trans community is placed in due to transphobia and discrimination.

[1] https://www.washingtonpost.com/local/social-issues/as-a-homeless-transgender-woman-she-turned-to-sex-work-to-survive-then-she-was-killed/2019/04/06/be157636-57e7-11e9-8ef3-fbd41a2ce4d5_story.html?utm_term=.6eb90b401f49

[2] Id.

[3] https://www.nbcwashington.com/news/local/Prince-Georges-County-Police-Investigate-Death-of-Trans-Woman-511313332.html

[4] https://dcist.com/story/19/06/17/community-mourns-zoe-spears-second-trans-woman-killed-on-eastern-avenue-this-year/

[5] 18 U.S.C. § 249

[6] Id.

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E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_8

This pipeline starts in the home. According to the U.S. Transgender Survey performed in 2015, 44% of respondents reported experiencing at least one form or other of family rejection.[7] This includes things like violence, ending relationships, not being allowed to wear clothes of the desired gender, or being sent to some form of conversion therapy. A quarter of respondents who were out to their families reported their relationships ending with family members because of their being trans.[8] In turn, nearly a tenth had experienced being kicked out of their homes due to being transgender, an experience correlating with higher likelihoods of homelessness, unemployment, incidence of HIV, or having done sex work, among other risk factors.[9]

The pipeline that starts in the home continues into school. Approximately 77% of transgender people who were out as K-12 students faced negative experiences due to their status as a trans person.[10] These include verbal harassment, physical or sexual assault, or not being allowed to dress according to their gender identity. This has consequences: 17% of those who were either out or perceived as trans in a K-12 school left school because of bullying and harassment – in the process denying them or delaying their diplomas and access to a meaningful education.[11] This education phase of the pipeline is worsened by roadblocks placed against legal and policy measures that intend to protect transgender students. For example, in February of 2017, the Department of Education and the Department of Justice withdrew their guidance on the protection of transgender students under the sex discrimination provisions of Title IX of the Education Amendments Act of 1972.[12] Currently, the interpretation that Title IX protects the LGBTQ community, including trans students, from bullying, harassment, and discrimination in schools is under litigation by opposing school districts.[13] Thus, attempts to protect trans youth from violence in our schools continue to face an uphill climb and opposition.

Once more, the pipeline of violence and vulnerability snowballs itself. If accessing an education is significantly harder for a trans person because of the bullying and discrimination they might face, it is much more difficult to access legal forms of making an income, to retain housing, and to stay out of the streets.

This is coupled with the topic of employment discrimination. 67% of transgender people who have held a job in the year prior to being surveyed reported experiencing negative actions against them (fired, forced to resign, not hired for a job they applied for or denied a promotion) because of their being transgender.[14] While multiple federal courts have held that the sex discrimination provisions of Title VII of the Civil Rights Act of 1964 ban discrimination against trans applicants and employees, this topic is now (as of the time of this writing in 2019) before the Supreme Court, and that may change.[15] There is currently no explicit protection from discrimination against trans people in the workplace in 29 states in the union.[16]

All these forms of discrimination interact with each other to create a situation where only 35% of respondents had full-time employment, and where they are three times more likely to be unemployed than the rest of the U.S. popula-

[7] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.

[8] Id.

[9] Id.

[10] Id.

[11] Id.

[12] *Dear Colleague Letter Withdrawing Previous Guidance on Transgender Students,* February 22, 2017 https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201702-title-ix.pdf

[13] *G.G. v. Gloucester County School Board,* https://www.aclu.org/cases/gg-v-gloucester-county-school-board

[14] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.

[15] *R.G. and G.R. Harris Funeral Homes v. EEOC,* https://www.scotusblog.com/case-files/cases/r-g-g-r-harris-funeral-homes-inc-v-equal-opportunity-employment-commission/

[16] *Non discrimination laws,* Movement Advancement Project http://www.lgbtmap.org/equality-maps/non_discrimination_laws

tion.[17] Twenty-two percent of transgender people reported having an income of less than $10,000 a year.[18]

Set Up to Fail: The End Result of Being Channeled into Failure by Systemic Discrimination

When faced with systemic barriers, discrimination, and marginalization throughout every facet of life, many trans people are channeled into discrimination. The end result is a higher likelihood of homelessness, where 30% of transgender people have reported experiencing homelessness,[19] and of resorting to criminalized forms of making a living, such as sex work, the sale of drugs, among others. Resorting to the underground economy means a higher likelihood of police interactions and of acquiring a criminal record, which comes with its own barriers to employment, housing, and education.

The end result is a higher likelihood to be a victim of violence, be it because trans people have to place their lives in danger to survive, because they face violence in everyday settings, or because they are exposed to a greater threat of police violence due to their financial circumstances. People like Ashanti Carmon and Zoe Spears are among the many trans people who have struggled as a result of systemic oppression and who find themselves at a much higher risk of violence than the rest of the population.

They're not alone. In 2018 alone, there were at least 23 other similar murders of transgender people in the United States, *that we know of.*[20] Of course, the motivations and circumstances of each one of these killings vary. Some have died at the hands of intimate partners. Others were engaging in high-risk activities such as street-based sex work. Some have died at the hands of law enforcement or in incarcerated settings. But in the vast majority, an increased vulnerability to violence and danger because of systemic oppression has played a part. Thus, the focus of this paper, rather than the usual, narrower topic of hate crimes.

Police Perpetrated Violence Against Trans People

No writing about violence against the trans community is complete without going into the prevalence of violence perpetrated by the state, namely, that of police. There is a certain question of "Who watches the Watchmen?" here, for in this case it represents the very agencies tasked with protecting us from violence and other violations of the Lockean social contract. Additionally, as noted before in this paper, interactions with police increase the likelihood of developing a criminal record, in this case in a population that is less likely to afford legal counsel and have the necessary privilege to fight back criminal charges or false arrests. Criminal records place further barriers and risks of being the victim of further violence.

In a 2015 Lambda Legal survey, 32% of transgender and gender non-conforming respondents who had interacted with police in the prior 5 years said that police had been hostile toward them.[21] Twenty-two percent reported verbal harassment, 7% reported sexual harassment, and 4% reported physical assault from police officers.[22] Thirty-four percent of transgender respondents also reported having been falsely accused by the police, and 6% reported having been subject to false arrest.[23]

[17] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.

[18] Id.

[19] Id.

[20] https://tdor.info/

[21] Lambda Legal, *Protected and Served?* https://www.lambdalegal.org/protected-and-served/police

[22] Id.

[23] Id.

This report is not alone in its findings. In the U.S. Trans Survey, 22% of respondents who had been arrested reported feeling that their arrest was because of their transgender status.[24] Fifty-eight percent of those who had had police interactions reported negative treatment, such as refusal to address them by their pronouns (49%), verbal harassment (20%), and officer questions about gender transition or genitals (19%), among others. Four percent reported being physically attacked by police, and 3% being sexually assaulted by police.[25] Unsurprisingly, a majority (57%) of respondents felt uncomfortable asking the police for help.[26]

Conclusions

When violence against trans people is discussed, many conversations take the focus on the relatively limited topic of hate crimes, and by extension, recommend as a matter of policy solutions the implementation of tougher hate crime laws. These laws usually include measures such as longer sentences for hate-motivated crimes, and greater tools for law enforcement to prosecute these crimes. We do not recommend that. First, we do not recommend increasing the power of law enforcement given its history of police perpetrated violence against the trans community. Second, we do not recommend the use of measures that only are effective after violence has taken place or a life has been taken.

We do recommend the passage of explicit non-discrimination measures that address the topic of discrimination and pushing trans people to the margins that leave them vulnerable to violence. These include bills that protect trans people in educational spaces, in the workplace, and in public accommodations. We also recommend the decriminalization of non-violent forms of making a living, such as in drugs and sex work, and quality of life laws such as loitering or homeless encampments, to prevent more trans people from falling into the trap that is having a criminal record.

The trans community, when it comes to violent, can be at times like a candle flickering in the mist. We must take measures to change that, for everyone to be able to live their fullest lives.

[24] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.

[25] Id.

[26] Id.

9 Intimate Partner Violence in Women's Same-Sex Relationships

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We need to consider a multitude of factors when considering an act of violence perpetrated by one individual against another. What are the motives, feelings, beliefs, and attitudes of the perpetrator and victim? What is the sociocultural context of the violence? What are the positions of perpetrator and victim within that context? What are their histories with family, society, and one another that influence this act? In this chapter, we take up these questions with our focus narrowed to one type of violent act: intimate partner violence (IPV) within female same-sex relationships. We present a model to help us understand IPV in female same-sex couples (SSIPV) and to help us organize our review of the research literature on female SSIPV, including studies on the individual, relationship, and sociocultural factors that are related to its occurrence, its consequences, and its treatment and prevention. We find that while a great deal has been written about IPV between opposite-sex partners, there is less research literature on IPV between same-sex partners and even less on prevention or treatment for this population (Winstead et al., 2017). Furthermore, a quick overview of peer-reviewed articles in the past 3 years found two and a half times more articles about IPV in male same-sex relationships compared to female same-sex relationships. Nevertheless, increasing attention to understanding sexual minority experiences and in particular the phenomenon of female same-sex IPV provides theory and research that can advance our knowledge and contribute to efforts at prevention and intervention.

One of the barriers to exploring this topic is the ways in which researchers identify the population they want to study. In some cases, surveys ask about sexual identity, often in the form of "lesbian" or "bisexual," and then ask questions about relationship violence. However, individuals, whatever sexual orientation they identify with, may have relationships with same- or opposite-sex others. For example, using the 2010 National Intimate Partner and Sexual Violence Survey (NISVS), Walters, Chen, and Breiding (2013) reported that lifetime prevalence of sexual abuse, physical violence, and/or stalking by an intimate partner was 44% for lesbian women, 61% for bisexual women, and 35% for heterosexual women. Within these groups, however, 89.5% of bisexual women and 33% of lesbian women reported male perpetrators (Brown & Herman, 2015). We will focus on studies that look at sexual identity and same-sex relationships. Furthermore, while we will use terms discussed in the articles reviewed, it is important to note that labels attached to sexual identity are increasingly being questioned as are labels for gender itself; a woman in an intimate relationship with another woman may not think of herself or her partner in terms we

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E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_9

frequently use in our research. It is imperative to allow our participants to describe themselves and their relationships in ways that are meaningful to them. Nevertheless, as we adopt a stance of greater openness to terms to refer to gender and sexual identity, we must remain aware that individuals living outside of rigidly defined female and male heterosexual norms still experience rejection, hostility, and vilification by individuals, institutions, and governments.

Prevalence of IPV in Sexual Minority Women's Same-Sex Relationships

Prevalence rates of IPV for sexual minority women are difficult to establish. Issues affecting prevalence rates include variability in definitions of IPV (e.g., whether it includes emotional, physical, and/or sexual), variability in measures of IPV (e.g., specific acts vs. global questions), variability in time frame of IPV (e.g., lifetime vs. past year), variability in samples (e.g., college, community, representative), and variability in how sexual identity is defined, particularly whether the focus is on sexual identity and/or the sex/gender of the partner. Brown and Herman (2015), reviewing 42 studies, estimated the range of lifetime IPV among sexual minority women (lesbian and bisexual) in relationships with women to be 13–40% and intimate partner sexual abuse (based on one study) to be 11%. In a meta-analysis focusing specifically on rates of IPV for lesbian women in same-sex relationships, Badenes-Ribera, Frias-Navarro, Bonilla-Campos, Pons-Salvador, and Monterde-i-Bort (2015) found the rate of any psychological aggression over a lifetime to be 43%; physical violence, 18%; and sexual violence, 14%. They argue for studying IPV in bisexual women separately from lesbian women because, as noted above, bisexual women report higher rates of IPV overall. Balsam and Szymanski (2005) found that, while bisexual women reported more aggression based specifically on sexual minority status in a same-sex relationship in the past year, lesbian women reported more psychological aggression in same-sex relationships over a lifetime. Messinger (2011) found that rates of controlling behaviors and verbal, physical, and sexual aggression were higher for lesbian women in same-sex relationships than for bisexual women in same-sex relationships. Eaton et al. (2008), however, found no differences between lesbian and bisexual women in terms of IPV in same-sex relationships. Variability in outcomes among studies is common. Even focusing on self-identified lesbians in same-sex relationships, Badenes-Ribera et al. found a high level of heterogeneity among studies, as have others reviewing the literature on IPV in sexual minority populations (Edwards, Sylaska, & Neal, 2015). Of the studies reviewed by Edwards et al. (2015), only 22% inquired about the sex and/or gender identification of the partner. Despite the complex issues that arise in studying IPV among sexual minority women, studies reveal that IPV is an important and relatively frequent concern for these women.

Seeking to Understand IPV in Sexual Minority Women's Same-Sex Relationships

Understanding IPV requires us to look both within and beyond the relationship itself. Meyer (2003) proposed a model of sexual minority stress that established the paths of distal, objective stressors, such as prejudice and discrimination toward LGB persons and antigay violence, and proximal, subjective stressors, such as expectations of rejection, sexual identity concealment, and internalized homophobia, to negative mental health outcomes. The impact of sexual minority stressors may be ameliorated by social support and coping behaviors, but Meyer's model and supporting research demonstrate the power of minority status within society to contribute to negative outcomes for individuals.

Herek (2007) also proposed a framework understanding and studying sexual stigma. He describes a structural level of stigma, including institutional policies and practices and ideological systems; enacted stigma which includes behavioral expressions of stigma, such as dis-

crimination and violence; felt stigma which includes stigma consciousness and stereotype threat and might lead to concealment; and internalized or self-stigma which is often defined as internalized homophobia or homonegativity.

Although most research has focused on aspects of stigma reported by individuals, such as enacted stigma (e.g., experiences of discrimination), felt stigma (e.g., stigma consciousness), or internalized stigma, Hatzenbuehler and colleagues (Hatzenbuehler, Keyes, & Hasin, 2009, b; Hatzenbuehler & Bränström, 2018; Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010) have focused on structural stigma, defined as "societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and well-being of the stigmatized" (Hatzenbuehler & Link, 2014, p. 2.). They have shown how living in communities with structural stigma leads to mental and physical health disorders as well as risky behavioral outcomes, such as increased alcohol misuse and rates of unprotected sex.

Enacted stigma in the lives of lesbian, gay, and bisexual (LGB) individuals is also undeniable. Katz-Wise and Hyde (2012) reviewed 138 studies examining the victimization experiences of LGB persons. Based on these studies published between 1992 and 2009, 55% of participants reported experiencing "verbal harassment"; 45% experienced "sexual harassment"; 37% were "threatened"; and 28% were "physically assaulted." In addition, 41% reported that they knew an LGB person who had been victimized. Roberts, Austin, Corliss, Vandermorris, and Koenen (2010) found that lesbian and bisexual women and gay men were twice as likely as the heterosexual participants in their sample to experience violence. Furthermore, research demonstrates that experienced discrimination is positively associated with negative mental health outcomes (Hatzenbuehler et al., 2010; McCabe, Bostwick, Hughes, West, & Boyd, 2010; McLaughlin, Hatzenbuehler, & Keyes, 2010).

The occurrence of stigma can also lead to internalized attitudes and beliefs that affect individuals and relationships. Knowledge of the rejection, discrimination, and vilification of sexual minority persons leads to felt stigma (Herek, Gillis, & Cogan, 2015) which can cause individuals to act in ways to avoid being stigmatized, to concealment and social isolation, and to enacting stigma toward others. Experiences of sexual minority stigmatization also affect self-evaluation, potentially leading to internalized stigma, often referred to as internalized homophobia or internalized homonegativity. Internalized homophobia refers to the internalization of other people's or society's negative views about gay, lesbian, or bisexual individuals (Newcomb & Mustanski, 2011). This construct has been studied extensively in a variety of subgroups within the LGB community and has been shown to be related to, among other things, mental health problems (Feinstein, Goldfried, & Davila, 2012), physical health symptoms (Williamson, 2000), lower self-esteem, less social support, and psychological distress (Szymanski & Kashubeck-West, 2008).

Our understanding of how stigma-related experiences lead to deleterious outcomes has been enhanced by psychological mediation models that have proposed psychological mechanisms that connect stigma-related events to negative outcomes. For example, experienced discrimination may lead a sexual minority individual to internalize negativity about their sexual identity, and this internalized negativity may lead the individual to experience mental health problems (Feinstein et al., 2012). In an experience sampling study over 10 days, Hatzenbuehler, Nolen, Hoeksema, and Dovidio (2009, b) found that ruminating about a stigma-related event mediated the relationship between the event and psychological distress. Negative social experiences can also lead to efforts to conceal one's status if that is possible. Although African American participants reported more social support on days that included stigma-related stressors, LGB participants reported less social support on those days and also isolated themselves more on days when stigma-related stressors were reported. Hatzenbuehler et al. (2009, b) speculate that since sexual identity is potentially concealable, this may reduce opportunities for sexual minority individuals to seek out social support from similar

others. It may also contribute to a strategy of concealment in an effort to avoid stigma and discrimination.

Proposed Model of Women's SSIPV

We propose a model of women's SSIPV that takes into account three levels of stigma-related constructs: structural stigma, enacted stigma, and felt stigma and/or internalized stigma (see Fig. 9.1). We live in communities, cities, counties, states, and nations, which may or may not have laws and policies that discriminate against sexual minorities. These public policies reflect and reinforce heterosexist social norms, attitudes, and beliefs. In this way, structural stigma also influences enacted sexual stigma, which includes objective sexual minority stressors such as prejudice and discrimination and even violence. Both structural stigma and enacted stigma have a negative impact on sexual minority individuals through rejection, exclusion, and discrimination as well as by creating barriers to acquisition of resources or personal goals (e.g., marriage, adoption). These external sources of stigma and negativity can also be internalized, leading to felt stigma (i.e., stigma consciousness, fear of rejection, concealment) and/or internalized stigma (i.e., internalized homophobia/homonegativity). Felt or internalized stigma may result in self-doubt, increased substance use, diminished social support, and even self-harm. We argue that other-perpetrated and/or self-perpetrated experiences of aggression or violence play a critical role in the development of IPV within female same-sex relationships and in the reactions of women seeking (or not seeking) legal and/or personal help to these incidents of violence. Living in a world where one is the target of aggression may lead to an aggressive response, in some cases, toward close, intimate partners. We also know that SSIPV tends to be mutual or bidirectional, creating more frequent and more severe violence. We will review the empirical research that demonstrates these connections between experienced aggression based on stigmatization and partner violence between women in intimate relationships.

Research Connecting Stigmatization to Same-Sex Intimate Partner Violence

Although our model, based on the work of Meyer, Herek, and Hatzenbuehler, suggests that different levels and types of stigma experience are distinguishable, empirical research studies do not always make these distinctions in their operationalizations of stigma. Enacted, or external, stigma is oftentimes measured and analyzed separately from felt or internalized stigma. However, felt and internalized stigma are often considered interchangeable. Furthermore, structural stigma is frequently analyzed separately from other types of stigma, and few studies incorporate all three levels simultaneously. The research literature is not yet rich enough for us to trace each path with care. In time, we hope research will reveal the particular effects of each level and type of stigma to help us better understand and combat these effects for sexual minority women as well as other stigmatized groups.

Structural Stigma

We expect structural stigma to be the primary source of a cascade of negative experiences and behaviors that sexual minority persons experience. The first link in our model is between structural stigma and enacted stigma. Pachankis and Bränström (2018) collected data from sexual minority participants living in 28 countries to examine the impact that varying degrees of country-level structural stigma had on sexual orientation concealment and life satisfaction. Their index of structural stigma included laws and policies on things such as asylum provision, protections against discrimination, and recognition of same-sex partnerships and parenting. They found that sexual minority participants in high-stigma countries experienced significantly more victimization and day-to-day discrimination than sexual minority participants in low-stigma countries. They also found that more structural stigma was associated with lower levels of life satisfaction, and concealment mediated this association. That

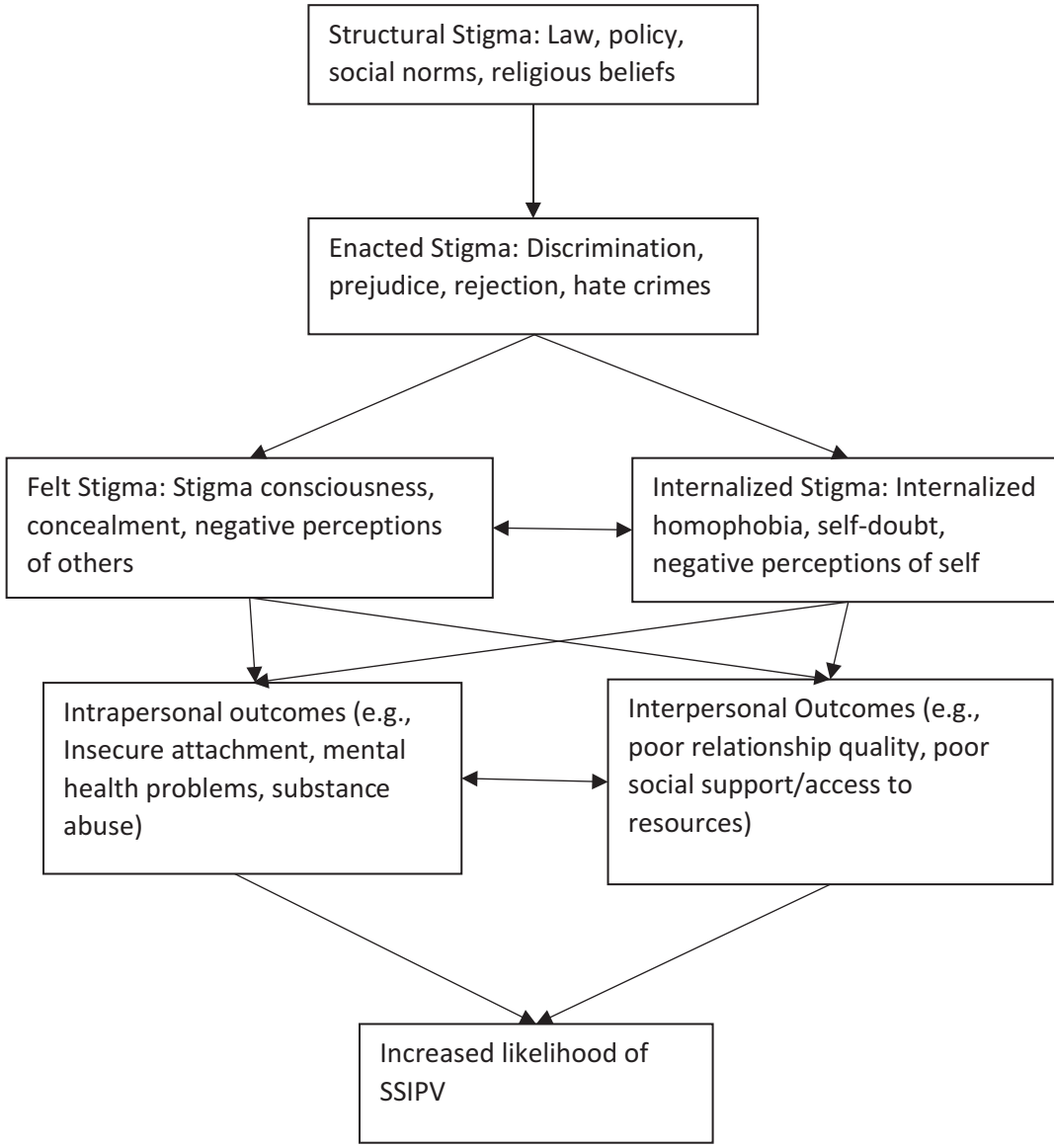

Fig. 9.1 Model of effects of stigmatization on same-sex intimate partner violence

is, sexual minorities living in countries high in structural stigma were nearly twice as likely to conceal their sexual orientation as their peers in countries with low structural stigma, and this concealment was associated with lower life satisfaction. Thus, one insidious impact of structural stigma is its ability to suppress and silence the self-expression of sexual minorities because self-expression is likely to lead to greater exposure to interpersonal threats, such as discrimination and violence. Knowing that being identified as a sexual minority could lead to rejection, even jail or death in some nations, individuals will surely hide their identity, making it harder to find relationships or community. Furthermore, these societal-level attitudes are often internalized, leading to sexual minority individuals feeling shame and self-hatred.

Examining the impact of LGBTQ policies and resources on college campuses, Woodford,

Kulick, Garvey, Sinco, and Hong (2018) found that campus antidiscrimination policies that include both sexual orientation and gender identity predicted fewer reports from sexual minority participants of victimization and microaggressions. In multivariate analyses, these researchers found that sexual orientation and gender identity antidiscrimination policies, having at least one for-credit LGBTQ course, and having a higher ratio of LGBTQ student organizations were related to fewer reports of experiencing heterosexism on campus and were indirectly related to less psychological distress and greater self-acceptance.

The impact of structural stigma is also seen in studies of health disparities. Hatzenbuehler, Jun, Corliss, and Bryn Austin (2015) found that differences between sexual minority adolescents and heterosexual adolescents in use of marijuana and illicit drugs were greater in states with higher structural stigma. In the study, structural stigma was defined as the combination of the density of same-sex couples per 1000 households, the proportion of public high schools with Gay-Straight Alliances, state policies and laws related to sexual orientation discrimination, and public opinion toward homosexuality.

In addition to research exploring negative outcomes, some studies have investigated positive outcomes associated with recent policy and law changes that are supportive of civil rights for sexual minorities. For example, Hatzenbuehler, Bränström, and Pachankis (2018) examined health disparities and victimization rates among gay men and lesbian women living in Sweden between 2005 and 2015. This 10-year period is significant because extensive legislative changes associated with discrimination protections and social acceptance of sexual minorities occurred during this time. At the start of this 10-year period, gay men and lesbian women were over two and a half times more likely to report psychological distress than their heterosexual peers; however, that disparity was no longer significant in 2015. Demonstrating that enacted stigma is likely to be one source of these changes in outcomes, these researchers found that the decrease in structural stigma across this 10-year period was associated with lower levels of victimization and threats of violence reported by gay men and lesbian women, and this reduction in victimization partially mediated the reduction in psychological distress noted above. Looking at structural changes, Everett, Hatzenbuehler, and Hughes (2016) found that passing civil union legislation was associated with decreased stigma consciousness, perceived discrimination, and depressive symptoms among sexual minority women.

Research on structural stigma demonstrates that laws, policies, and societal attitudes do influence enacted stigma as well as, directly or indirectly, concealment, psychological distress, health disparities, and lower levels of life satisfaction and self-acceptance. On the other hand, research also shows that policy change can have a positive impact on the health and well-being of sexual minorities and that the negative impacts of structural stigma may be lessened or potentially prevented by implementing more laws and policies that protect and include sexual minorities. Decreasing structural stigma appears to "trickle down" to interpersonal events and intrapersonal appraisals. Including structural stigma in our understanding of sexual orientation stigma and its outcomes is critical for proposing and advocating for changes that work.

Enacted Stigma

Enacted stigma, victimization and experiences of discrimination, has been found to be directly related to IPV in sexual minority women's same-sex relationships (Balsam & Szymanski, 2005; Carvalho, Lewis, Derlega, Winstead, & Viggiano, 2011; Edwards & Sylaska, 2013), although not in all studies (e.g., Barrett & St. Pierre, 2013; McKenry, Serovich, Mason, & Mosack, 2006). In a sample of lesbian and bisexual women reporting on IPV in same-sex relationships, Balsam and Szymanski (2005) found that lifetime discrimination was directly related to IPV victimization and perpetration. Internalized homophobia was directly related to having experienced physical/sexual violence in same-sex relationships, but the relationship between

internalized homophobia and IPV perpetration was a trend. Looking at recent IPV in relationships, Balsam and Szymanski (2005) tested a path analysis that showed that internalized homophobia was negatively related to relationship quality, which then predicted both IPV perpetration and IPV victimization in the past year.

In a study of female and male college students in same-sex relationships, Edwards and Sylaska (2013) found that sexual identity concealment and internalized homonegativity were related to perpetration of physical IPV, internalized homonegativity was related to perpetration of sexual IPV, and sexual-orientation-related victimization was related to perpetration of psychological partner abuse. Internalized homonegativity was also related to experiencing psychological victimization. As reports of IPV victimization and perpetration are highly correlated, Edwards and Sylaska examined IPV perpetration controlling for self-reported IPV victimization. The relationship between sexual-orientation-related victimization and psychological abuse was no longer significant, but internalized homonegativity remained a significant predictor of perpetration of physical and sexual IPV.

Looking at victims and perpetrators in a community sample of lesbian women and gay men, Carvalho et al. (2011) compared individuals who reported having experienced or perpetrated "domestic violence" with a same-sex partner to those not having experienced or perpetrated IPV. While internalized homophobia did not predict IPV, stigma consciousness and outness were related to experiencing IPV, and stigma consciousness was related to perpetration of IPV. Although the sample included both women and men, gender did not affect any of these outcomes. Stigma consciousness, an aspect of felt stigma, represents the expectation of prejudice and discrimination and may help us understand how the experience of stigmatization translates into the ever-present anxiety and concern about future incidents of discrimination. Although the negative effects of outness may seem surprising, outness itself may be a two-edged sword. On the one hand, outness may prevent concealment, which has been shown to have a negative impact (Pachankis, 2007). On the other hand, outness exposes a person to the reactions of others, including their negative and aggressive reactions.

Other Predictors of SSIPV

While stigmatization has been shown to play a role in IPV among sexual minority women in relationships with women, various other individual and relationship factors are also related to IPV. In a critical review of IPV among a sexual minority sample, Edwards et al. (2015) identified numerous factors that are related to IPV victimization and perpetration. Some of these factors are individual characteristics that are common to female or male same-sex or opposite-sex relationships in which IPV occurs. These include insecure attachment, higher levels of stress, poor relationship quality, and substance use/abuse. Craft, Serovich, McKenry, and Lim (2008) found that both perceived stress (financial, family, work, relationships) and insecure attachment were related to perpetration of relationship violence (psychological, sexual, and physical) in a sample of gay men and lesbian women.

As in heterosexual couples, substance use and abuse also play a role in women's SSIPV. In a sample of lesbian and bisexual women in same-sex relationships, poor relationship quality was related to IPV perpetration and victimization (Balsam & Szymanski, 2005). In a large, nationally representative sample of lesbian women, Deschamps, Rothblum, Bradford, and Ryan (2000) found that lesbian women who reported IPV victimization also reported higher daily stress, depression, and alcohol abuse. Bimbi, Palmadess, and Parsons (2007) examined the relationship between substance abuse and domestic violence in same-sex relationships. For women, recent use of cocaine was related to experiencing physical violence in a same-sex relationship, and recent use of alcohol and marijuana was related to experiencing nonphysical abuse. Studying perpetration of domestic violence, Fortunata and Kohn (2003) found that lesbian women who were batterers reported higher rates of alcohol problems and more alcohol-

dependent and drug-dependent symptoms compared to lesbian women who were not batterers. Kelly, Izienicki, Bimbi, and Parsons (2011) reported a significant relationship between mutual partner violence and alcohol use and substance abuse treatment in a female sexual minority sample.

Research Connecting Stigmatization to These Predictors

While these characteristics have been found to be related to self-reports of experiencing and/or perpetrating IPV, they are also characteristics that are related to enacted, felt, and internalized stigma (e.g., discrimination, concealment, internalized homophobia). By their very nature, stigmatizing experiences contribute to general stress and are indeed often conceptualized as sexual minority stressors. They have been found to contribute to physical health problems (Frost, Lehavot, & Meyer, 2013) and depression (Lewis, Derlega, Berndt, Morris, & Rose, 2001) among sexual minority individuals. Enacted, felt, and internalized stigma are also related to substance use and abuse which have been consistently linked with IPV. For example, lesbian and gay youth who are heavy or binge drinkers have higher levels of internalized sexual stigma compared to social drinkers (Baiocco, D'Alessio, & Laghi, 2010). In a sample of sexual minority women, Lehavot and Simoni (2011) found that sexual minority victimization, internalized homophobia, and concealment were indirectly linked, through social-psychological resources, to substance use and mental health problems and that LGB victimization and internalized homophobia were also directly related to substance use. Lewis, Mason, Winstead, and Lau-Barraco (2017, b) demonstrated the specific links between discrimination and stigma consciousness and alcohol problems. Discrimination and stigma consciousness predicted both social constraints and social isolation which in turn predicted coping motives (for drinking) and depressive symptoms which predicted alcohol problems.

Stigmatization is also related to relationship characteristics. As noted above, Balsam and Szymanski (2005) found that internalized homophobia internalized homophobia was negatively related to relationship quality. Otis, Rostosky, Riggle, and Hamrin (2006) also examined the impact of internalized homophobia and perceived discrimination on same-sex couples' perception of the quality of their relationships and found that internalized homophobia, but not perceived discrimination, consistently predicted lower levels of relationship quality. They also looked at dyadic effects, finding that internalized homophobia affects oneself and one's partner, creating interrelated partner effects of higher levels of internalized homophobia relating to poorer relationship quality.

Another variable that has been found to be a correlate of SSIPV among women is a history of child abuse. Fortunata and Kohn (2003) reported that perpetrators of IPV in a sample of lesbian women were significantly more likely than non-perpetrators to have been a victim of childhood violence or physical abuse and were more likely to have been sexually abused as a child. While a cycle of violence is not unique to women perpetrators of SSIPV, it is the case that child victimization is more common in lesbian and bisexual populations (Austin et al., 2008).

Research Examining Mediators Between Stigmatization and SSIPV

Some researchers, recognizing that discrimination and internalized stigma may affect a sexual minority woman's experience or perpetration of IPV through their effects on psychological mechanisms, have tested models in which these forms of sexual minority violence are expected to predict psychological variables which then predict SSIPV. As noted above, Balsam and Szymanski (2005) found that internalized homophobia was negatively related to relationship quality. They also examined relationship quality as a mediator for recent SSIPV and found that internalized homophobia was nega-

tively related to relationship quality that then predicted both IPV perpetration and victimization in the past year.

Lewis, Milletich, Derlega, and Padilla (2014) examined the indirect relationship of internalized homophobia (an aspect of internalized stigma) and social constraints, i.e., difficulty talking to friends about one's sexual identity (an aspect of felt stigma), to psychological aggression toward one's partner in lesbian women's same-sex relationships. Internalized homophobia and social constraints were positively related to rumination or brooding. More rumination predicted lower relationship satisfaction, and relationship satisfaction was negatively related to psychological aggression toward one's partner. In the same model, the indirect link of internalized homophobia and social constraints with friends through rumination to psychological aggression was also significant. Experiences of internalized and felt stigma led to brooding which led to more perpetration of psychological aggression.

The ways in which stigmatization and psychological factors work together to contribute to IPV were also illustrated in research that tested a model of IPV among lesbian women in same-sex relationship. Lewis, Mason, Winstead, and Kelley (2017) examined sexual minority specific and general risk factors and found that experiences of discrimination as a consequence of sexual identity in the past year were related to internalized homophobia and anger, which were both related to alcohol problems. Anger was also related to relationship dissatisfaction and perpetration of psychological aggression. Alcohol problems were related to perpetration of psychological aggression. Psychological aggression was related to perpetration of physical violence. Perpetration of psychological aggression and physical violence were related to experiencing psychological aggression and physical violence, respectively, from one's partner. This sequence of events, from being discriminated against based on one's sexual identity to negative personal outcomes, such as anger, alcohol misuse, and relationship dissatisfaction, to experiencing and perpetrating psychological and physical IPV, is an illustration of the ways in which direct and indirect violence perpetuated by social injustice can have an impact on individuals that leads to violence within their most intimate relationship.

Bidirectionality in SSIPV

There is an understandable wish to approach IPV by asking about perpetrators and victims, and, as can be seen in our review, this is often how data are collected and analyzed. Nevertheless, it is the case that self-reports of experiencing IPV are highly correlated with self-reports of perpetrating IPV, and this is true in both opposite-sex (Straus, 2015) and same-sex relationships (Longobardi & Badenes-Ribera, 2017). In their sample of lesbian and bisexual women reporting on relationships with women, Balsam and Szymanski (2005) found that of the women reporting perpetration or victimization over their lifetime, 10% reported victimization only, 7% reported perpetration only, and 31% reported both victimization and perpetration. Similarly, in a sample of college women and men, 13% reported same-sex victimization only, 7% reported same-sex perpetration only, and 22% reported both (Edwards & Sylaska, 2013). We know relatively little about what factors distinguish unidirectional violence from bidirectional violence, but importantly we do know that among heterosexual couples bidirectional IPV is related to higher levels of violence and more severe violence (Marcus, 2012; Whitaker, Haileyesus, Swahn, & Saltzman, 2007). In a recent study of lesbian women in relationships with women, Winstead, Hitson, Bronson, Bolanos, and Lewis (2018) reported a similar finding. Women in relationships with bidirectional IPV reported more psychological aggression and minor physical assault (both victimization and perpetration) and more victimization in the form of severe physical assault and minor injury compared to women who reported unidirectional IPV (i.e., being a perpetrator only or being a victim only). The most common measure of IPV, the Revised Conflict Tactics Scale (Straus, Hamby, Boney-McCoy, & Sugarman, 1996), provides data on both perpetration and victimization, but it does not inquire about initia-

tion or self-defense. Peterman and Dixon (2003) warn that mutuality may be a misconception. Without more information we cannot know what is abuse and what is self-defense. Nevertheless, the greater severity and danger of psychological and/or physical harm in mutually violent relationships indicate that researchers need to focus greater attention on bidirectionality in SSIPV.

While there is no research that we are aware of that helps us to understand how individual or relationship characteristics lead to bidirectional SSIPV, Lewis et al. (2015) tested a model of how emotional distress, drinking to cope, and drinking behaviors predict bidirectional partner violence. In a sample of lesbian women in relationships with women, they found that emotional distress is directly related to bidirectional IPV and indirectly linked through its relationships with drinking to cope which is then related to drinking quantity or maximum drinks that predicted bidirectional IPV. A model including alcohol-related problems found only the indirect link, from emotional distress to drinking to cope to alcohol problems to bidirectional SSIPV. Although both models had adequate fit, the model using alcohol-related problems and finding indirect paths from emotional distress to drinking to cope to alcohol-related problems to bidirectional SSIPV yielded the better fit.

Stigmatization and Help-Seeking for SSIPV

Survivors of IPV are faced with the decision of whether to seek help and what sources of support (e.g., friends, family, police, mental health professionals) from which to seek help. Seeking help may be a challenge for any person who has experienced IPV. However, additional barriers to help-seeking exist for individuals who identify as a sexual minority. In a review of the relevant literature, Calton, Cattaneo, and Gebhard (2016) identified three important barriers to help-seeking: lack of understanding of the problem of LGBTQ IPV, sexual stigma, and institutional inequities. Calton et al. (2016) emphasized that the issue of limited understanding of sexual and gender minority IPV is driven by a lack of research in this area, specifically how aspects of IPV unique to same-sex couples may affect their health. Regarding sexual stigma, the barrier for help-seeking is bidirectional, such that it may prevent survivors from seeking help and prevent potential helpers from offering support (Calton et al., 2016).

In addition, as mentioned above, structural stigma (e.g., policies that favor opposite-sex couples) perpetuates inequality and creates barriers to resources for sexual minorities. One important area of institutional inequity is the laws regarding domestic violence. Historically, many states have not been inclusive of same-sex couples in their laws regarding domestic violence protective orders. However, North Carolina is currently the only state where domestic violence protective orders are not equally available to those in opposite-sex and same-sex relationships. Nevertheless, although opposite-sex partners who are unmarried and do not live together can receive protective orders, same-sex partners in a similar relationship cannot receive protection (Brook, 2019). Many states have only recently extended their protective orders to be inclusive of same-sex couples regardless of marital status, such as South Carolina and Louisiana that did so in 2017 (Doe v. State, 2017; New Orleans Bar Association, 2017). If women in violent relationships with women choose to seek help from family, friends, crisis centers, mental health professionals, and/or law enforcement, what attitudes and beliefs might they encounter? Seelau, Seelau, and Poorman (2003) asked university students to read domestic abuse scenarios in which the sex of perpetrators and victims was systematically varied (i.e., M perpetrating IPV with F partner, F perpetrating IPV with M partner, M perpetrating IPV with M partner, and F perpetrating IPV with F partner). They found that victim gender but not sexual orientation was the main factor predicting seriousness and recommendations for intervention. When women were victims, the scenario was rated as more serious and the victim more in need of help. Although male perpetrator-female victim scenarios were considered the most serious, they did not vary significantly from female perpetrator-female vic-

tim scenarios. In a similar study, however, Poorman, Seelau, and Seelau (2003) found that participants perceived male perpetrator-female victim scenarios to be significantly more serious than same-sex scenarios, and participants were more likely to recommend that the victim press charges in the former scenarios. They also rated same-sex victims as less believable, and believability was correlated with more severe sentencing recommendations.

Other researchers have focused on the perceptions and attitudes of mental health counselors. Wise and Bowman (1997) gave domestic violence scenarios of heterosexual or lesbian couples to counseling graduate students. These participants viewed heterosexual IPV as more violent than IPV in the lesbian couple and reported that they would be more likely to charge the male heterosexual perpetrator than the lesbian perpetrator with assault. They were also more likely to recommend couples counseling for the lesbian couple compared to the heterosexual couple. Couples therapy has been considered a controversial approach for IPV because victims have been found to feel uncomfortable speaking freely and to fear partner retaliation from their partners (Jory, Anderson, & Greer, 1997).

Brown and Groscup (2009) presented domestic violence crisis staff members with domestic violence scenarios. When the scenario involved a same-sex couple, compared to an opposite-sex couple, crisis center staff members thought that the abusive situation was less serious, less likely to get worse over time, and less likely to happen again and that it was easier for the victim to leave the relationship. The recommendations of crisis staff members also varied across couples, such that they were less likely to suggest that victims in a same-sex couple leave their partner (Brown & Groscup, 2009). Similarly, Basow and Thompson (2012) examined the effect of sexual orientation and type of abuse in vignettes on the perceptions of IPV of domestic violence shelter service providers. These service providers were less likely to perceive the woman as a victim if she was in a same-sex relationship, compared to an opposite-sex relationship, in situations of non-physical/emotional abuse (Basow & Thompson, 2012). However, when the situation involved physical abuse, there was no difference in perception of the lesbian women and heterosexual women as victims.

For women who seek immediate help in response to an incident of IPV, police officers are likely to be the first responders. Russell and Sturgeon (2018) investigated how police officers perceive hypothetical incidents of IPV among heterosexual and same-sex couples. When asked to what extent they thought it was fair to refer a perpetrator to a domestic violence hotline, police officers reported that it was fairer to refer same-sex perpetrators, compared to heterosexual perpetrators (Russell & Sturgeon, 2018). Russell and Sturgeon (2018) suggested that police officers may have difficulty identifying the perpetrator in same-sex relationships and therefore provide these referrals to a hotline rather than suggesting other interventions.

Research has also investigated how these perceptions generalize to real-life situations. Using the 2000 National Incident-Based Reporting System database, Pattavina, Hirschel, Buzawa, Faggiani, and Bentley (2007) examined factors associated with arrest for IPV among same-sex and heterosexual couples. When comparing the probability of arrest based on various predictors (e.g., mandatory arrest, aggravated assault, and intimidation), Pattavina et al. (2007) found that the results were similar for same-sex and heterosexual couples. However, important differences emerged when comparing female and male same-sex couples. Among female same-sex couples, the factor that most increased the likelihood of an arrest was the existence of a mandatory-arrest law for incidents involving IPV (Pattavina et al., 2007). Within mandatory-arrest states, seriousness of the offense was the strongest predictor of arrest for female same-sex couples (Pattavina et al., 2007). Interestingly, whether in a mandatory-arrest state or not, Pattavina et al. (2007) found that inclusive language was the strongest predictor of arrest among male same-sex couples.

Given the evidence that women experiencing IPV in same-sex relationships are likely to be

taken less seriously than women in heterosexual relationships, how do these women make decisions about how, when, and with whom to seek help? Several qualitative studies have explored factors influencing the decision to seek help among sexual minority women who have experienced IPV. Turell and Herrmann (2008) found two primary concerns about seeking support, including avoiding homophobia and heterosexism outside of the LGBT community and avoiding disclosure of the IPV within the LGBT community. Outside of the LGBT community, participants worried about how service providers would react to abuse between two women and that it might not be taken seriously. Within the LGBT community, participants expressed concern about maintaining a perfect image of their relationship. In a focus group and interview study with bisexual, lesbian, and transgender women who had been in abusive relationships, Bornstein, Fawcett, Sullivan, Senturia, and Shiu-Thornton (2006) found that these women felt profoundly isolated, both due to tactics employed by their partners and by lack of awareness of SSIPV in the sexual minority community and by the general isolation of the sexual minority community from the larger society. In a relatively small, closely interconnected and stigmatized group, women experiencing SSIPV expressed concerns that they might not be believed by others who knew their abuser, that they did not want to bring negative attention to the community, and that they did not want their abuser harmed if they reported her. Similarly, Walters (2011) found that lesbian survivors of IPV felt silenced and isolated by gendered beliefs about violence (i.e., women do not perpetrate violence) and homophobia and heterosexism (e.g., dismissal by law enforcement).

Another qualitative study investigated how women in same-sex couples who had experienced IPV perceived responses from criminal justice systems, healthcare systems, and domestic violence services. Three themes emerged from the women's stories: reinforced marginalization ("We are beyond second class"), system incompetence ("Laughing it off"), and compounding abuse ("If you can't protect us, at least don't abuse us"; Alhusen, Lucea, & Glass, 2010). Alhusen et al. (2010) highlighted the need for increased acknowledgment and awareness of IPV among women in same-sex couples, suggesting that professionals in system response fields (e.g., healthcare) partner with sexual minority community leaders. In addition to barriers to help-seeking, Hardesty, Oswald, Khaw, and Fonseca (2011) investigated factors that influenced lesbian and bisexual mothers in their decision to seek help. Hardesty et al. (2011) identified three factors that influenced lesbian and bisexual women, specifically mothers, to define their situations of IPV as intolerable and led to them seeking help. These factors included negative health and safety impacts due to an increase in IPV severity, profound physical and emotional tiredness, and a negative impact on their family or loved ones.

These studies reveal that there is lack of understanding of women's experiences of SSIPV leaving them vulnerable to receiving inadequate help. Women in same-sex relationships are less likely to be seen as victims and less likely to be treated seriously by law enforcement. This research also shows that women recognize that they are likely to be perceived and treated differently and this leaves them vulnerable to experiencing relationship violence without seeking any professional help.

Interventions for IPV in Women's Same-Sex Relationships

Unfortunately, should a woman experiencing IPV in her same-sex relationship seek help from mental health professional, there is little to guide that professional. Reviews of the literature have found no studies that test the effectiveness of interventions for women (or men) in violent same-sex relationships (Murray, Mobley, Buford, & Seaman-DeJohn, 2007; Winstead et al., 2017). Batterer intervention programs are based on the perspective that IPV is a gendered crime shaped by a social system of male dominance. The programs are based on the premise that male batterers of women need

to confront and change beliefs and attitudes that support this system. This pervasive perspective has led to the development of programs that largely ignore the reality of same-sex IPV or even the possibility of female batterers. Kernsmith (2005) notes that lesbian perpetrators of IPV would typically receive treatment designed for male perpetrators in heterosexual relationships. In a qualitative study of bisexual, lesbian, and transgender women who experienced SSIPV, Bornstein et al. (2006) found that while most participants did not seek legal intervention or use shelters, many did seek mental health counseling, but most of these reported negative experiences. They found that therapists minimized the violence and did not recognize the controlling and abusive tactics that they experienced.

Considering how the mental health profession can help women perpetrators and victims, Winstead et al. (2017) recommend culturally tailored SSPIV interventions that would include "culturally competent LGB interventionists and inclusive and sensitive language regarding relationship and partner status" as well as consideration of "(a) unique factors impacting lesbians' and gay men's decisions to remain in abusive relationships, such as a limited pool of available alternative relationship partners, concern about HIV status, lack of social support (e.g., family support), or fears of being outed to family or coworkers; (b) minority stress; (c) differential relationship dynamics; (d) unique experiences of same-sex individuals in the legal system; (e) history of trauma, discrimination, or rejection; (f) lack of domestic shelters; and (g) fear of bringing attention to the gay and lesbian communities" (p. 8). Similarly, Murray et al. (2007) suggest counseling practices for women in violent relationships, such as focusing on the impact of sexual orientation on IPV experiences, psychoeducation of clients about what is known about SSIPV, more research to improve our understanding of SSIPV and especially to develop effective interventions for perpetrators and victims, and advocacy for attention to the problem and services for those in the female sexual minority community affected by it.

Recommendations for Moving Forward

IPV is a significant problem in the community of women in same-sex relationships. Why would a woman hurt the person who is closest and most intimate with her? Drawing on the theoretical and empirical work of Meyers, Herek, and Hatzenbuehler, we propose that part of this conundrum is explained by the aggression and rejection experienced by a societally stigmatized group. Starting with structural stigma, we follow the path to enacted stigma to felt and internalized stigma to intrapersonal and interpersonal problems that lead to same-sex IPV. Through these paths, the experiences of physical and/or emotional violence experienced by women in relationships with women are internalized and sometimes re-enacted on their intimate partners. The problems of same-sex couples who experience IPV are further exacerbated by a history of rhetoric and research that presents IPV as a male perpetrator-female victim event. The victimization of and discrimination against lesbian and bisexual women and the ignoring and rejecting of the reality of SSIPV exacerbate this form of violence in the lives of sexual minority women.

Research on SSIPV among lesbian and bisexual women is impressive, although more is needed. Reviews of research on IPV sexual minority populations regularly note problems in this body of research, including unrepresentative samples, samples that include women and men or persons with different sexual orientations without the power for separate analyses, wide variety in operational definitions of sexual identity and all levels of stigma (e.g., structural stigma, enacted stigma, felt stigma, internalized stigma), and differences in definitions and measure of IPV. As Herek (2009) has noted, it is particularly important that sexual orientation and gender identity questions be included in national surveys, so that researchers, policy makers, and clinicians can develop a clearer idea of the populations and communities that they aim to serve. Katz-Wise and Hyde (2012) argue for the importance of researchers developing consistent definitions and measurement of sexual orientation and victimization,

which would increase the generalizability between different studies of stigma. While it would not be helpful to dictate the sample and measures for every study, we urge researchers to pursue studies that are fully informed by models of SSIPV and previous research.

This review has demonstrated that an important source of stigmatization with multiple negative effects for sexual minority women is structural stigma, that is, the laws, policies, and beliefs that exist in the populace. Changing these to be protective and inclusive of sexual minority women and men is critical. In some nations, including the United States, progress has been made on the level of laws and policies. Survey results find that US adults have become markedly more accepting of same-sex sexual behaviors over the last four decades, but especially since the early 1990s (Twenge, Sherman, & Wells, 2016). Nevertheless, changes in laws are consistently challenged, and a substantial number of people still believe that same-sex relationships are wrong. In other parts of the world, same-sex relationships are illegal, and disclosure of one's sexual minority status can be life-threatening. The violence directed toward sexual minority individuals, direct or indirect, forceful or subtle, informs their lives and, as we have shown, leads potentially to perpetration and experiencing of that violence in sexual minority women's most intimate relationships.

Our review demonstrates that there are multiple levels where efforts at intervention and prevention might be useful for SSIPV. Treatments for individuals experiencing SSIPV might be tailored for sexual minority women, and these women might receive appropriate treatment for substance abuse, psychological distress, relationship distress, and other problems that contribute to SSIPV. Healthcare providers, shelters, and law enforcement might be trained to be aware of and sensitive to the particular needs and concerns of the sexual minority population, and sexual minority women might be helped to find resources and community that can counter the debilitating effects of stigmatization and SSIPV. As Alhusen et al. (2010) suggest, one way of improving care and resources for sexual minority women is for agencies to partner with members of the sexual minority community. Finally, and, we would argue, most importantly, governments might adopt and enforce laws and policies that protect sexual minority persons and permit them to be full citizens and members of society, and social, religious, and cultural organizations might promote humane, inclusive, and respectful attitudes toward all persons.

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Violence Against Gay Men

10

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Abstract

Gay men experience violence at disproportionate rates. This disparity is driven by state-sanctioned structural violence, homophobia, and problematic masculine norms. The present chapter reviews the historical legacies of violence against gay men and provides an overview of research on current prevalence rates. The authors introduce multiple theoretical frameworks (e.g., minority stress theory) to elucidate the experiences of gay men with multiple marginalized identities. Common risk factors (e.g., gender nonconformity) and forms of violence (e.g., intimate partner violence) in this population are discussed. Subsequently, barriers to reporting violence and the consequences associated with violence are reviewed. The chapter concludes with a discussion of practice and policy recommendations and implications.

Violence Against Gay Men

Violence affects gay men at disproportionate rates (National Coalition of Anti-Violence Programs [NCAVP], 2016) and is supported by a larger cultural landscape of homophobia and hegemonic masculine norms of physical aggression and toughness. Gay men with multiple marginalized identities, such as gay men living with HIV, contend with stress related to their disadvantaged statuses and thus face heightened risk of stigma-based violence (Kertzner, Meyer, Frost, & Stirratt, 2009). This chapter focuses on violence against gay men in general as well as highlights unique vulnerabilities of gay men with multiple marginalized identities.

In this chapter, we explore historical legacies of violence against gay men and frame this violence in the context of stigma-related stress. We begin with a history of violence against gay men in the USA, contextualizing interpersonal

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E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_10

anti-gay violence as a logical consequence of institutional exclusion, violence, and erasure. Next, we describe unique experiences of gay men who not only experience sexual orientation-based prejudice but also face additional challenges related to their multiple stigmatized identities. We then highlight minority- and non-minority-specific forms of violence commonly experienced among gay men and note determinants of violence in this population. In addition, we discuss gay men's exposure to intimate partner violence (IPV), including a sexual and gender minority (SGM)-specific form of IPV. Given that many gay men also perpetrate violence in partnerships, we review recent literature on correlates of IPV perpetration. We then discuss barriers many gay men encounter in reporting violence.

Next, we use syndemic theory as a framework for better understanding how stigma and discrimination perpetuate co-occurring epidemics of violence exposure and health risks among gay men. In addition, we focus on clinical practices and treatment recommendations for working with violence-exposed gay men. Finally, we review the research on contemporary anti-violence advocacy by and for gay men, including intersectional approaches to responding to violence against gay men with multiple marginalized identities.

History of Systemic Violence Against Gay Men

The alarming prevalence of individual acts of violence against gay men is not random, nor does it occur in a vacuum. Rather, violence against gay men persists due to a historical legacy of systemic violence, or state-sanctioned exclusion, discrimination, and physical harm committed by governing bodies or defended and protected by social systems.

Criminalization of Gay Men

Systemic violence against gay men has occurred in the form of criminalization: the practice of transforming individuals of particular groups into criminal subjects, rendering their activities, identities, or desires illegal. Gay men have been criminalized since the founding of the USA, facing both threats of violent criminal prosecution (e.g., castration) and subsequent stigma, discrimination, and violence (Herek, 2007). Beginning with the Jamestown colony in the early 1600s, colonial governments adapted British *buggery laws*: regulations later known in the USA as *sodomy laws* that criminalized certain sexual behaviors such as anal and oral sex, bestiality, and sexual intercourse between two men. Although not regularly enforced, sodomy laws rendered same-sex sexual intercourse a capital offense punishable by death, perhaps the starkest example of systemic violence against gay men. Sodomy laws persisted through the end of the 1900s. Before Illinois repealed its sodomy laws in 1961, every US state continued to criminalize sexual behavior between men. Sodomy laws were federally critiqued in two major cases brought before the Supreme Court, Bowers v. Hardwick in 1986 and Lawrence v. Texas in 2003, finally decriminalizing gay sex on a national level (Herek, 2007). Although these laws were not regularly enforced, their very threat of violent punishment for sexual behavior between men created a social environment in which interpersonal violence against gay men was fostered, condoned, and systemically justified (Leslie, 2000). A second iteration of legal prosecution against gay men came in the late twentieth century when most states instituted *HIV criminal laws*: specific state-level statutes applying misdemeanor and felony convictions for actual or potential HIV transmission risk behavior (Mykhalovskiy, 2011).

Medical Intervention

Systemic violence against gay men has also occurred in the form of unnecessary, often harmful, medical and psychiatric intervention to "fix" same-sex desire in the late nineteenth and early twentieth centuries. Historically, the field of psychiatry conceptualized homosexuality as a medical and/or mental illness: a sexual or genital "inversion" to be "cured" through psychiatric and

medical procedures. Homosexuality was codified as a psychiatric diagnosis in the first editions of the *Diagnostic and Statistical Manual* (*DSM*): described in the *DSM-I* as an illness "primarily in terms of society and conformity with the prevailing cultural milieu" (American Psychiatric Association, 1952) and in the *DSM-II* as "deeply ingrained maladaptive patterns of behavior" (American Psychiatric Association, 1968). During this era, gay men faced violent intervention, including electroconvulsive therapy, psychosurgery, and chemical castration (Comstock, 1992). These interventions exacerbated other forms of violence against gay men, such as IPV, rendering gay men both a criminal underclass and a diseased community (Shapiro & Powell, 2017). It was not until 1973, due to protest from gay rights activists, that the American Psychiatric Association replaced the diagnosis of "homosexuality" with "sexual orientation disturbance," thus depathologizing same-sex desire.

Judicative Bias

A third form of systemic violence against gay men has occurred in the form of judicative bias, or legal protection of perpetrators of violence against gay men (Lee, 2008). Across multiple well-known cases in the late twentieth century, perpetrators of violence against gay men had their charges acquitted and/or sentences reduced due to the sexual orientation of their victims. In 1988, for example, a then 18-year-old man Richard Lee Bednarski murdered two gay men in a Texas park. Claiming the men had made sexual advances, Bednarski received a more lenient sentence because the judge deemed the men he murdered had acted inappropriately and obscenely. Another famous case was that of Stephen Bright, a then 33-year-old man who murdered a gay man in his home after meeting the man in a bar. Bright strangled the man after he allegedly made a sexual advance and was later charged with second-degree murder. In court, however, Bright claimed he was so disturbed by the man's sexual advance that he entered a state of "gay panic." He was acquitted of the murder charge, setting a legal precedent for the "gay panic defense" and framing gay victims of violence as guilty sexual predators (Lee, 2008).

The same "gay panic defense" was successfully re-employed in multiple cases until 1998, when two men were charged for the brutal murder of Matthew Shepard, a gay HIV-positive man living in Wyoming. During the trial, a defense lawyer put forward a "gay panic defense" similar to Bright's a decade prior. Unlike Bright's case, the 1998 defendant was charged with felony murder and sentenced to two life terms without parole. This outcome radically shifted advocacy around violence against gay men, leading eventually to the 2009 passing of the Matthew Shepard and James Byrd Jr. Hate Crimes Prevention Act, codifying sexual orientation-based violence as prosecutable under hate crime legislation.

Framing Violence Against Gay Men in the Context of Minority Stress

SGM individuals face general risk factors associated with violence (e.g., homelessness) as well as minority-specific risk factors (i.e., *minority stressors*; Meyer, 2003). According to minority stress theory (Meyer, 2003), gay men experience *distal minority stressors*, such as workplace discrimination, which often maintain and exacerbate gay men's *proximal stressors*, including maladaptive interpersonal and self-schemas (e.g., chronic feelings of exclusion; Pachankis, Goldfried, & Ramrattan, 2008).

Unique Considerations for Gay Men with Multiple Stigmatized Identities

Gay men with multiple stigmatized identities face challenges in addition to sexual orientation-based prejudice. For example, gay men of color experience multiple forms of discrimination (e.g., racism and homophobia), as well as racism within SGM communities and heterosexism within communities of color (Balsam, Molina, Beadnell, Simoni, & Walters, 2011). In SGM communities, gay men of color encounter

racism in relationships, dating apps, and community events (Choi, Han, Paul, & Ayala, 2011). Further, discrimination based on race, immigrant status, and sexual orientation increases overall acculturative stress and mental health issues among Latino gay men (Polanco-Roman & Miranda, 2013).

Heterosexist stigma remains widespread in communities of color (Balsam et al., 2011). For example, Latinx cultural views may construe same-sex sexual behavior as a gender-role violation (Domanico & Crawford, 2000). Similarly, sexual minority orientations threaten the continuation of family lineage in Asian cultures (Greene, 1994), and given the importance of religion, homosexuality is considered sinful in many African American communities (Nemoto et al., 2003). Indeed, heterosexism in communities of color contributes to internalized stigma and identity concealment among gay men of color (Moradi, DeBlaere, & Huang, 2010) and pressure to choose between one's racial/ethnic and sexual orientation identity (Nemoto et al., 2003). These intersecting issues exacerbate gay men's risk for violence victimization and/or perpetration.

Common Forms of Violence Exposure Among Gay Men

Minority-Specific Victimization

Gay men withstand homophobic victimization, such as hate crimes and verbal threats, as well as non-bias victimization, such as physical and sexual assault (Katz-Wise & Hyde, 2012). Homophobic victimization is rooted in *heterosexism*, or the ideological system that denies, denigrates, and stigmatizes non-heterosexuality (Katz-Wise & Hyde, 2012). Violence or illegal acts committed against individuals based on their sexual orientation represent *hate crimes*, including murder, rape, aggravated assault, and property vandalism (Willis, 2004). These crimes differ from *hate incidents* (i.e., biased actions not involving physical assault, such as nonphysical forms of bullying; Willis, 2004).

Gay men disproportionately experience homophobic victimization compared to other sexual minority populations, including queer, bisexual, and lesbian individuals (NCAVP, 2016). Specifically, of those who reported hate crimes in 2016, 47% were gay men, compared to those who identified as lesbian (17%), queer (8%), and bisexual (8%; NCAVP, 2016). Gay men most often report homophobic victimization that occurs in public places and is committed by a group (Gruenewald, 2012). Gay men also experience stalking, robbery, violent assault, and sexual and verbal harassment more often than other sexual minority groups (Katz-Wise & Hyde, 2012).

Racial disparities in homophobic victimization exist among gay men. For instance, compared to White gay men, gay men of color disproportionately experience violence based on sexual orientation (Berrill & Gregory, 1992). Moreover, in 2016, of the 1036 hate incidents reported, most survivors identified as gay men and people of color (NCAVP, 2016). Among youth populations, Black gay youth report higher levels of homophobic victimization compared to White or Latino youth (Garofalo, Mustanski, Johnson, & Emerson, 2010).

Nonminority-Specific Victimization

In addition to homophobic victimization, many gay men experience nonminority-specific forms of victimization (e.g., childhood sexual abuse; Lloyd & Operario, 2012). Although nonminority-specific victimization experiences do not *explicitly* relate to anti-gay bias, these experiences may still be *motivated* by it. Sexual minorities, including gay men, report higher rates of adverse childhood events (e.g., physical abuse) than heterosexual men and women (Andersen & Blosnich, 2013). Many gay men report more family-related psychological, physical, and sexual abuse during childhood than their heterosexual siblings of the same sex (Balsam, Rothblum, & Beauchaine, 2005). In fact, estimates of childhood sexual abuse among gay men reach as high as 47% (O'Cleirigh, Safren, & Mayer, 2012). This risk of sexual victimiza-

tion continues throughout development as gay men also report higher rates of sexual violence in adulthood compared to heterosexual men (Balsam et al., 2005).

Gender Nonconformity as a Risk Factor for Victimization

Gender nonconformity is a unique risk factor for elevated minority- and nonminority-specific victimization among gay men. *Gender nonconformity* refers to gender expressions or behaviors incongruent with expectations based on birth-assigned sex and reflects a particular social deviance for men (Alanko et al., 2010). The devaluing of traditionally female attributes contributes to male gender roles being more rigidly defined than female gender roles, which might allow for gender nonconformity to go unnoticed or even welcomed in cisgender females (Kane, 2006). Parents often hold negative views about gender-nonconforming boys, such as beliefs that they will be psychologically maladjusted (Kane, 2006), which may lead to physical, psychological, and sexual abuse by parents (Roberts, Rosario, Corliss, Koenen, & Austin, 2012).

Homophobia and sexism drive elevated risk of victimization among gay men across the lifespan. Specifically, gender-nonconforming gay men report more childhood sexual abuse exposure than gender-conforming gay men (Sandfort, Melendez, & Diaz, 2007). In addition, gender nonconformity in childhood may relate to elevated levels of victimization across the lifespan, especially among boys (Bos, de Haas, & Kuyper, 2016). For instance, among gay men, self-reported gender nonconformity in childhood predicts peer rejection and school victimization (Sandfort, Bos, Knox, & Reddy, 2016). Moreover, studies suggest that gay men who experience additional stress in their families, including homophobic cultural or religious beliefs, report increased risk of childhood physical and sexual abuse by family members (Guarnero, 2007).

Intimate Partner Violence

Gay men experience IPV at substantially higher rates than heterosexual men and women (Finneran & Stephenson, 2013). Across studies, 26% to 33% of gay men experience some form of IPV in their lifetime (Walters, Chen, & Breiding, 2013). Many IPV organizations structure support for cisgender heterosexual women; thus, many services (e.g., domestic violence homeless shelters) are inaccessible for gay male IPV survivors (Walters et al., 2013).

A recent systematic review among gay men demonstrated higher rates of IPV among gay men of color, gay men with lower levels of education, gay men living with HIV, and young gay men (15–24 years; Finneran & Stephenson, 2013). Many IPV-exposed gay men face higher risk of HIV transmission, attributable to trouble negotiating safer sex practices due to a decreased perception of control over sex, fear of violence, and unequal power (e.g., financial) within the relationship (Heintz & Melendez, 2006).

Identity Abuse

IPV patterns among gay men differ from heterosexual individuals given their experiences with stigma-related stress (Scheer, Woulfe, & Goodman, 2018; Woulfe & Goodman, 2018). More specifically, identity abuse refers to the ways that abusers use homophobic, biphobic, and transphobic societal and structural norms against their gay male partners by discrediting, undermining, or devaluating their stigmatized sexual identity (Guadalupe-Diaz & Anthony, 2017; Woulfe & Goodman, 2018). Four domains of identity abuse tactics include (1) disclosing a partner's sexual orientation status; (2) undermining, attacking, or denying a partner's sexual identity; (3) using homophobic slurs or derogatory language; and (4) isolating a partner from gay male communities (Woulfe & Goodman, 2018). The broader context of stigma may fuel abusive power dynamics in intimate relationships among gay men.

IPV Perpetration

Though research on IPV perpetration is sparse, gay and bisexual men (36%) have a twofold higher frequency of perpetrating IPV compared to heterosexual men (18%; Welles, Corbin, Rich, Reed, & Raj, 2011). Many of the documented correlates of IPV perpetration unique to gay men include proximal minority stressors, such as internalized homophobia and identity concealment (Edwards, Sylaska, & Neal, 2015). These minority stressors can lead to IPV perpetration through poor communication, low self-esteem, and maladaptive coping mechanisms such as substance use (Klostermann, Kelley, Milletich, & Mignone, 2011). Other risk factors for IPV perpetration among gay men include greater conformity to masculine norms, suppression of emotional vulnerability, and positive HIV status (Oringher & Samuelson, 2011).

Reporting Patterns of Violence Exposure

Gay men, especially those with multiple marginalized identities, face barriers to reporting violence such as history of police violence and difficulty identifying violence exposure. Many gay men report and seek help for IPV at lower rates than heterosexual men and women due to fear of heterosexism and rejection from providers (Bartholomew, Regan, White, & Oram, 2008). Gay men may also normalize physical and psychological injuries as part of being a man (i.e., physical strength, power, manliness) and, consequently, may actively work to conceal their IPV experiences (Bacchus et al., 2017).

Many gay men also underreport homophobic-related hate crimes to police because of real or perceived maltreatment or stigma from law enforcers (Berrill & Gregory, 1992). For instance, many survivors of homophobic violence report experiences of police misconduct after the incident of violence, including excessive force, unjustified arrests, entrapment, and raids (NCAVP, 2016). Law enforcement may also dismiss homophobic victimization reports (Herek, 2002). Gay men of color are even less likely than White gay men to report homophobic-related hate crimes (Zaykowski, 2010). Among those who do report homophobic victimization, Black gay men are 2.8 times more likely to experience excessive force from police than those who do not identify as Black (NCAVP, 2016). Likewise, immigrant gay male survivors face considerable structural barriers to safety, including immigration law, resulting in lower rates of reporting violence exposure to law enforcement or service providers. Barriers also exist prior to immigration (e.g., social pressure to marry women) and because of immigration (e.g., economic disadvantage; Erez, Adelman, & Gregory, 2009).

Consequences of Violence Exposure Among Gay Men

Violence against gay men plays a key role in the proliferation of sexual orientation disparities in health (e.g., suicidality, substance use, and HIV infection), as highlighted by a major report by the Institute of Medicine (Lloyd & Operario, 2012). A recent meta-analysis documented that gay men with histories of childhood sexual abuse were more likely to live with HIV, engage in unprotected anal intercourse, and abuse substances (Lloyd & Operario, 2012). Homophobic victimization exposure results in not only poor physical health if the individual is injured but also adverse mental health such as depression and posttraumatic stress disorder (PTSD; Boroughs, Bedoya, O'Cleirigh, & Safren, 2015). Additionally, studies document associations between witnessing violence, substance use, fear of community violence, and depression among young gay men of color living with HIV (Phillips et al., 2014). Notably, homophobic victimization may be more highly associated with negative mental health outcomes than nonminority-specific forms of violence (McDevitt, Balboni, Garcia, & Gu, 2001). Further, experiencing or fearing homophobic victimization can cause gay men to alter their behavior in significant ways, including sexual minority identity concealment, which can lead to significant mental health consequences, such as shame and depression (Pachankis, 2007).

Violence exposure, mental health issues, and HIV status co-occur and mutually reinforce psychosocial risks among gay men (Kurtz, Buttram, Surratt, & Stall, 2012). Syndemic theory provides a framework for better understanding how stigma and discrimination perpetuate these co-occurring epidemics (Singer et al., 2006). For instance, adverse social and structural conditions give rise to the interconnected psychosocial epidemics such as substance use and violence exposure among marginalized populations (Singer, 1994). Syndemic frameworks highlight how the concentrated clustering of and interactions between multiple psychosocial epidemics adversely affect the health of particularly disadvantaged and marginalized populations, such as gay men (Singer et al., 2006). Specifically, the interaction of violence exposure and health problems commonly arises because of adverse social conditions (e.g., poverty, stigmatization) that put socially devalued groups at heightened risk (Singer et al., 2006).

Clinical Practice and Treatment Recommendations

The current section addresses clinical practices and treatment recommendations for working with violence-exposed gay men. We begin with a de-identified case study of Mr. L., which is based on a collection of narratives of multiple gay men with histories of sexual violence exposure in the military to illustrate common themes. Next, we use Mr. L's narrative to further discuss clinical issues and elucidate better practices, evaluation/assessment techniques, current available treatment modalities, and barriers to treatment. Finally, we suggest treatment recommendations and clinical considerations.

Case Study: Mr. L

Mr. L, a self-identified White, gay man, entered the military at 18 years old, shortly after becoming sexually active. He was acutely aware that disclosing his sexual identity could lead to discrimination and violence and, therefore, chose to conceal his identity. During his time in the military, he was immediately targeted by heterosexual service members, attacked, drugged, and raped. Due to the military's widely known homophobic culture, Mr. L discretely hid his physical wounds from the assault and created a narrative that concealed his sexual orientation and the assault to keep himself safe from further abuse while he completed his military service. After being discharged, he attempted to report the assault and seek treatment for associated mental health symptoms; however, he faced further discrimination from various clinical providers. Subsequently, he discontinued psychiatric appointments and disengaged from sharing his traumatic experience and sexual identity with others. For many years, Mr. L suffered in silence from PTSD, anxiety, and depression. He continued to seek intermittent treatment focused on his symptom presentation while making a conscious choice to conceal his sexual identity and sexual violence history. Over time, he became further socially isolated and avoidant of relationships with other men, experienced internalized homophobia, and had employment difficulty. During his most recent pursuit of treatment, he continued with a familiar pattern of approach-avoidance with his new provider until his history was appropriately evaluated and treated. As a result, Mr. L became less isolative, depressed, and anxious and more connected with himself and others.

Posttraumatic Growth

Some literature explores the possibility that traumatic events can also positively impact mental health. Specifically, trauma can act as a catalyst that enhances well-being and relates to resilience, meaning-making, growth, and positive change – also known as *posttraumatic growth* (Tedeschi & Calhoun, 1996). Posttraumatic growth is defined as "positive personal change" which occurs through "re-examination of core beliefs about the assumptions about the world" (Tedeschi, Calhoun, & Cann, 2007; p. 403). Though a rela-

tively new concept, posttraumatic growth has been part of the human experience for centuries. Although most research on traumatic events focuses on the negative physical and psychological influences of trauma (Tedeschi & Calhoun, 1996), modern trauma research extends to include posttraumatic growth. Posttraumatic growth is observed after diverse experiences of trauma (e.g., rape, bereavement, combat, natural disasters) and occurs through changes in self, interpersonal relationships, and philosophy of life (Tedeschi & Calhoun, 1996). Posttraumatic growth is related to lower rates of depression and increased well-being following an event that "results in a struggle significant enough to force re-evaluation of worldview" (Boals & Schuettler, 2011; p. 817).

SGM-Affirmative Violence Assessment

Gay men experience stigma within mental health systems, which create reporting barriers similar to those experienced in the criminal justice system. For example, Mr. L's disclosure and initial pursuit of treatment were met with discrimination and stigmatization, resulting in detrimental effects on his well-being and ability to access appropriate treatment. Although many clinicians initially focus on building trust, this is paramount for survivors of violence and sexual minority clients, given that trust in others is compromised and many relationships are fraught with physical and emotional pain. By prioritizing safety, clinicians can facilitate a reparative relational experience for survivors, which can have positive implications for their mental health.

Within the therapeutic context, violence evaluation and assessment should be considered a fluid and ongoing process. Although many clinicians conduct an initial intake during the first session, it is important continually to revisit evaluation methods as therapeutic trust further develops and clients disclose more about themselves and their histories (Bess & Stabb, 2009). During Mr. L's most recent engagement in treatment, he did not disclose his sexual identity or assault history until a year into treatment with his therapist, when trust, safety, and rapport were firmly established.

Language is a tool that clinicians can use to help build trust and safety. SGM-affirming language (e.g., communicating that same-sex sexuality is healthy) may allow SGM clients to feel safe to share any/all aspects of themselves (Mizock & Lewis, 2008). Questions related to gathering a trauma history should be carefully phrased and timed to allow space for discussion, especially for those who have suffered systemic and institutional marginalization. Psychoeducation and transparency are essential intervention tools when assessing or discussing violence with gay men, as these techniques prioritize equalizing the therapeutic relationship and working collaboratively. Other important aspects of the therapeutic process are noticing misattunement with clients, processing ruptures, and building toward repair to further develop safety and trust within the therapeutic alliance as well as generalize to other relationships.

It is also vital for clinicians to understand the nuanced ways that posttrauma symptomatology can manifest for each client. While PTSD symptoms may occur, other mental health symptoms such as anxiety or depression may emerge. In most cases, mental health symptoms appear shortly after traumatic experiences; however, symptoms may also have a delayed onset across months or even years (Leahy, Holland, & McGinn, 2011). Some individuals, much like Mr. L, can experience remission of symptoms, whereas others may experience symptoms for an extended period of time (Leahy et al., 2011), calling attention to the importance of recurring psychological assessment during treatment.

Trauma-Focused Treatment

Multiple evidence-based practices exist that focus on improving trauma survivors' mental health. Several treatments with demonstrated empirical support for their efficacy in treating trauma-related mental health issues (e.g., PTSD) include Exposure Therapy, which incorporates

principles of fear learning and shares procedural similarities with extinction training (McLean & Foa, 2011); Cognitive Processing Therapy, which consists of two integrated components, cognitive therapy and exposure in the form of writing and reading about the potentially traumatic event (Resick & Schnicke, 1992); and Eye Movement Desensitization and Reprocessing, which alleviates the distress associated with traumatic memories (Shapiro, 1989). These evidence-based treatments are widely used across clinical settings to help reduce PTSD and increase posttraumatic growth responses by helping individuals process and habituate to their traumatic experiences (Foa, Keane, & Friedman, 2000). Group psychotherapy can also act as a supportive outlet that enhances one's sense of community, especially for minority individuals, as this treatment focuses on building trust with other group members who have similar experiences (Chouliara et al., 2017). However, these modalities have not been specifically used with gay male survivors of violence, despite the high prevalence of trauma exposure within this population. As such, there is strong need to adapt trauma-focused treatment to become more SGM-affirming to treat effectively both nonminority trauma and adverse outcomes related to minority stress in this population (Pachankis, 2014).

SGM-Affirmative Psychotherapy

In light of minority stressors and subsequent mental health consequences facing gay men and other sexual minority populations, the American Psychological Association developed professional guidelines that emphasize the importance of adapting standard psychotherapy to help promote stigma coping among sexual minority clients (American Psychological Association, 2012; Burton, Wang, & Pachankis, 2017). The ESTEEM (Effective Skills to Empower Effective Men) treatment model is the first adaptation of cognitive behavioral therapy with demonstrated efficacy for reducing sexual orientation health disparities among young gay and bisexual men, including depression, anxiety, and sexual risk behavior (Pachankis, 2014). ESTEEM is delivered across ten modules and guided by six principles: (1) mood and anxiety symptoms are normal responses to minority stress; (2) early and ongoing experiences with minority stress can teach sexual minority individuals powerful, negative lessons about themselves; (3) sexual minorities can be empowered to effectively cope with the unfair consequences of minority stress; (4) sexual minorities possess unique strengths; (5) same-sex sexuality is healthy; and (6) genuine relationships are essential for the health of sexual minorities (Burton et al., 2017; Pachankis, 2014). It is critical for mental health professionals to incorporate these principles into their practice when working with gay male clients in effort to reduce sexual orientation health disparities facing this population.

Policy and Advocacy

The current section explores contemporary community-led efforts to understand, measure, and curb violence against gay men. We begin with a brief history of community advocacy followed by a discussion of legal advocacy. Finally, we discuss potentials for future, intersectional approaches to anti-violence advocacy led by and for gay men.

Contemporary Anti-violence Advocacy

Community Advocacy In the later parts of the twentieth century, gay men and allies began a significant legacy of community-based advocacy to curb violence against gay men. During the 1970s, this occurred through the formation of *gay-safe streets patrols* (e.g., San Francisco Street Patrol): civilian coalitions who established a radical infrastructure of community, rather than police, violence prevention (Hanhardt, 2008). In the 1980s, gay and HIV-positive activists formed community-specific anti-violence organizations (e.g., Anti-Violence Project in New York City). In 1995, this effort broadened when the NCAVP

was formed, establishing the first national organization addressing violence against SGM communities. Violence against gay men in recent US history is informed and reinforced by systemic and interpersonal HIV stigma; thus, effective organizations and leaders are making concerted efforts to center people living with HIV in their analysis, intervention, and legal advocacy. Community advocacy in the contemporary US continues to be a leading force in both supporting gay survivors of violence and spearheading violence prevention efforts (Hanhardt, 2008).

Legal Advocacy Gay men and allies have also led legal battles to measure and curb rates of anti-gay violence. The rise of community advocacy and victim-rights groups led to the incorporation of sexual orientation into hate crime legislation (Herek, 1989). Alongside the fight for hate crime legislation, legal scholars in the late twentieth century began to address the historic lack of data collection on violence against gay men, missing largely due to issues of stigma, mistrust of police particularly among gay men of color, and fear of being outed as gay, engaging in sex work, and/or living with HIV. Until 1984, most US jurisdictions did not include anti-gay bias crimes in their surveillance of hate crimes, thus erasing decades of empirical evidence of anti-gay violence. At this time, the National Gay & Lesbian Task Force conducted the first national study on anti-gay hate violence, finding that over 94% of respondents had experienced some sort of violent victimization whether primary or secondary (i.e., additional victimization after a crime due to societal homophobia; Berrill & Herek, 1990). Legal advocacy, importantly, led to the demand that states begin to count violence against gay men in order to address it through system-level, evidence-based efforts.

The Future of Intersectional Gay Anti-violence Advocacy

The current political climate has inflamed rhetoric of hate and violence against gay men. This has been associated with a demonstrated rise in hate crimes and increased safety risk for gay men (NCAVP, 2016), as well as a groundswell of community advocacy including collaborations with anti-racist, women's, and sex work organizations and communities. In recent years, gay anti-violence advocacy has begun to incorporate an intersectional framework in an effort to respond to violence against multiply marginalized people (e.g., SGMs of color; those living in poverty or with disabilities). A relatively new field termed "Queer Criminology" has emerged with a focus on intersectionality and developing systems of safety and violence prevention that do not rely on police or carceral punishment (Woods, 2014).

The future of gay anti-violence advocacy may center community-based strategies to reduce violence rather than relying on potentially oppressive systems for protection (Russell, 2017). A leading example of this is the New York-based group *Safe Outside the System*, an anti-violence organization led by and for people of color striving for community safety and grassroots justice strategies (Anderson-Zavala, Krueger-Henney, Meiners, & Pour-Khorshid, 2017). Activists today continue to push for alternative paradigms to measure, interpret, and address violence against gay men in the contemporary USA (Russell, 2017).

Conclusion

This chapter provides an overview of both the historical and contemporary disparity in violence exposure faced by gay men. The disproportionately high rate of violent victimization in the gay male community was born out of a history of state-sponsored homophobic violence that has only recently begun to be addressed through legislative change. This violence most commonly manifests in the forms of IPV and homophobic victimization, which have detrimental consequences for physical and mental health. Barriers to reporting, including anticipated stigma and discrimination from law authorities and healthcare providers, compound these effects. Notably, gay men with multiple marginalized identities

often face additional stigma-related experiences, such as racism in the SGM community and heightened homophobia in some cultural, religious, and ethnic communities.

Though the current political climate has increased risk for violence among gay men, mental healthcare providers, educators, policy makers, and advocates are increasingly working to enhance their safety and well-being. Clinicians can foster health and growth in their violence-exposed gay male clients through SGM-affirming and trauma-informed practices. Optimal care necessarily involves the assessment of the myriad ways in which stigma impacts the well-being of gay men, ongoing trauma evaluation, and identity affirmation. Finally, community and legal advocates have made great strides such as adding sexual orientation into hate crime legislation. These efforts are increasingly intersectional in nature and suggest a promising road forward in violence reduction and prevention for gay men.

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11 Contextualizing Evidence-Based Approaches for Treating Traumatic Life Experiences and Posttraumatic Stress Responses Among Sexual Minority Men

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Abstract

Sexual minority men (SMM), including gay, bisexual, and other men who have sex with men, experience disproportionately high rates of trauma, including childhood sexual abuse (CSA), intimate partner violence, and chronic trauma in the form of stigma and discrimination. In this chapter we will (1) broadly explore trauma including types of trauma impacting SMM, (e.g., CSA, intimate partner violence, stigma, and discrimination); (2) briefly review existing evidence-based trauma treatments and their limitations for SMM; (3) present a treatment rationale, description, and preliminary results for cognitive behavioral therapy for trauma and self-care (CBT-TSC), an intervention that aims to address trauma and sexual health concerns among SMM; and (4) discuss implications of and future directions for CBT-TSC.

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Background

Sexual minority men (SMM), including gay, bisexual, and other men who have sex with men, experience disproportionately high rates of trauma, including childhood sexual abuse (CSA), intimate partner violence, and chronic trauma in the form of stigma and discrimination. In this chapter we will 1) broadly explore trauma including types of trauma impacting SMM, (e.g., CSA, intimate partner violence, stigma, and discrimination); 2) briefly review existing evidence-based trauma treatments and their limitations for SMM; 3) present a treatment rationale, description, and preliminary results for cognitive behavioral therapy for trauma and self-care (CBT-TSC), an intervention that aims to address trauma and sexual health concerns among SMM; and 4) discuss implications of and future directions for CBT-TSC.

Historically, psychosocial intervention research has focused on treatments targeting one problem (e.g., trauma or depression). However, given the

E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_11

interrelated nature of many problems impacting SMM with traumatic life experiences and the need to deliver effective interventions with constrained resources, this narrow approach is insufficient (Westen, Novotny, & Thompson-Brenner, 2004). This approach may not be optimal in the case of SMM's health given the numerous interrelated psychosocial health threats facing this group. This chapter describes how trauma defined broadly impacts SMM. Further, we emphasize the need to create and assess transdiagnostic interventions that simultaneously reduce interrelated, or syndemic (Stall et al., 2003), conditions facing SMM at the level of their shared psychosocial pathways. We then describe CBT-TSC, an intervention designed for SMM with histories of CSA to treat trauma and increase self-care behaviors, including HIV risk reduction. This chapter positions minority stress as a key driver of these shared pathways and suggests intervention principles and techniques that can address the pathways through which minority stress yields interrelated health threats for SMM.

Trauma

Determining what qualifies as a traumatic event can be difficult, with the definition of trauma varying with context. Broadly, a traumatic event is considered an extremely stressful experience that may result in PTSD. Notably, many individuals who experience a traumatic event do not develop PTSD. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), defines a traumatic event as an experience or event that includes experiencing, witnessing, or having to deal with actual or threatened death, serious injury, or physical or sexual violence to the individual or someone else (DSM-5, 2013). Diagnostically, PTSD is characterized by four unique symptom clusters: re-experiencing the event, avoidance, negative cognitions and mood, and arousal. An individual may re-experience the traumatic event through memories, flashbacks, and dreams, and emphasis is placed on symptoms occurring more than once in a defined period of time. Avoidance is characterized by an active dismissal of thoughts, memories, or feelings and can also include avoidance of places or people that bring on recollections of the event. Negative cognitions and mood encompass the individuals' feeling of themselves, others, and the world, as well as consistently depressed or apathetic affect. Finally, arousal includes hypervigilance, risky and/or self-destructive behavior, and distractibility. These symptom clusters need to be present at least 1 month after the traumatic event for a diagnosis of PTSD to be made (DSM-5, 2013).

Types of Trauma Impacting SMM

Childhood Sexual Abuse Childhood sexual abuse (CSA) is a type of early-life trauma that has alarming prevalence rates in SMM. Many studies conducted in the United States have attempted to quantify the rate of CSA experienced by SMM, with estimations ranging from 20% to 39.7% (Doll et al., 1992; Lenderking et al., 1997; Mimiaga et al., 2009; Paul, Catania, Pollack, & Stall, 2001), astoundingly higher than estimates between 5% and 10% among the general male population (Finkelhor, 1994). In addition to increased risk for developing PTSD, SMM who have experienced CSA are more likely to report lower self-efficacy and poorer communication skills around issues of safe sex (Mimiaga et al., 2009). History of CSA has also been associated with increased rates of fear, anxiety, depression, anger, and aggression. These negative psychological states can create impactful long-term effects, including decreased self-esteem, as well as increased experiences with stigma, isolation, and substance use (Browne & Finkelhor, 1986).

CSA among SMM has been associated with sexual risk-taking behavior in later life (O'Leary, Purcell, Remien, & Gomez, 2003; Stall et al., 2003). Specifically, SMM who experienced CSA were more likely to have higher rates of unprotected receptive anal intercourse and were more likely to participate in risky sex compared to those who did not experience CSA (Lenderking et al., 1997; Paul et al., 2001). While CSA is con-

sidered a risk factor for HIV infection, traditional HIV prevention interventions may not be as efficacious for individuals who have a history of CSA due to the high prevalence of co-occurring psychosocial conditions (Halkitis, Wolitski, & Millet, 2013; Mimiaga et al., 2009; Safren, Reisner, Herrick, Mimiaga, & Stall, 2010; Mimiaga et al., 2015).

Other Interpersonal Victimization In addition to being disproportionately affected by CSA, SMM are more likely to experience other interpersonal victimizations related to increased risk of developing PTSD compared to other men, including rape in adulthood and intimate partner violence (Pantalone, Rood, Morris, & Simoni, 2014; Pantalone, Schneider, Valentine, & Simoni, 2012; Schumm, Briggs-Phillips, & Hobfoil, 2006). A 2011 review conducted by Rothman, Exner, and Baughman reported that 12–54% of SMM had experienced sexual assault in their lifetime. A better understanding of how interpersonal trauma impacts SMM and how treatment strategies can most effectively meet the needs of the victims and reduce the perpetration of intimate partner violence is needed.

Stigma Though not always conceptualized as a form of trauma, experienced stigma and discrimination have been shown to elicit traumatic responses (Ferlatte, Hottes, Trussler, & Marchand, 2014; Geibel, Tun, Tapsoba, & Kellerman, 2010). Stigma is often related to sexual minority or HIV status and can be related to internalized homonegativity, criminalization of same sex behaviors, perceptions of HIV, and discrimination based on sexual orientation. Meyer's (1995, 2003) minority stress model provides a theoretical framework for how experiences of discrimination and stigma can put an individual at risk for physical and mental health issues later in life. The model postulates that internal and external stressors faced by many sexual minority individuals predispose those individuals to mental health concerns, such as PTSD. When a sexual minority individual experiences stigma and discrimination, maladaptive coping strategies can form, creating vulnerability for depression, anxiety, expectations of rejection, negative cognitions about oneself, difficulty regulating emotions, and other reactions that are associated with traumatic experiences (Batchelder, Ehlinger, et al., 2017; Hatzenbuehler, 2009; Meyer, 1995, 2003).

Intersecting Stigma and Discrimination In addition to sexual minority stigma, discrimination based on racial and ethnic minority identity, which can intersect with stigma and discrimination based on sexual identity, can greatly impact mental health and HIV-related outcomes among SMM. These outcomes, which include depression, anxiety, and a higher prevalence of sexual risk-taking, may be related to negative attitudes toward homosexuality—specifically same sex behaviors and perceived femininity of SMM—among minority populations (Choi, Hans, Paul, & Ayala, 2011; Han, Proctor, & Choi, 2014; Jeffriesm, Marks, Lauby, Murrill, & Millet, 2013). In support of this theory, Glick, Cleary, and Golden (2015) found that racial and ethnic minority respondents to the General Social Survey experienced more negative attitudes toward sexual minorities than their white counterparts.

Existing Evidence-Based Trauma Interventions

The American Psychological Association strongly recommends four psychotherapy interventions for treating PTSD: cognitive behavioral therapy, cognitive therapy, prolonged exposure therapy, and cognitive processing therapy, and conditionally recommends eye movement desensitization and reprocessing (EMDR) therapy, brief eclectic psychotherapy, narrative exposure therapy, and medications (American Psychological Association, 2017). While all the strongly recommended intervention strategies are based on or derived from cognitive behavioral therapy, the conditionally recommended interventions are more divergent. For example, eye movement desensitization and reprocessing (EMDR) therapy is a structured therapy that involves briefly focusing on the traumatic mem-

ory while concurrently experiencing stimulation bilaterally (i.e., eye movements), which has been associated with a reduction in the vividness of the traumatic memories and the associated emotions (Shapiro, 2017).

Of the strongly recommended treatments for PTSD, there are similarities and key differences. Cognitive behavioral therapy for PTSD focuses on changing patterns of behaviors, thoughts, feelings related to current symptoms, and problems leading to difficulties in functioning (Monson & Schnaider, 2014). Relatedly, cognitive therapy aims to interrupt disturbing thought and behavioral patterns that interfere with an individual's life via modifying negative evaluations of traumatic memories (Ehlers et al., 2014). Prolonged exposure is a specific type of cognitive behavioral therapy that teaches individuals to confront fears through gradually approaching trauma-related emotions, memories, and situations (Foa, Hembree, & Rothbaum, 1998). This cognitive behavioral therapy involves individuals working with their therapist to face stimuli and situations in a safe and graduated manner to evoke fear reminiscent of the trauma in order to ultimately reduce their fear and increase their comfort (e.g., Schnurr et al., 2017; Powers et al., 2010). This therapy is helpful for those whose traumas activate the fear response; however, this may be less helpful for those with subclinical experiences of trauma. Cognitive processing therapy (CPT) is grounded in cognitive behavioral therapy and information processing theory and includes components of psychoeducation, imagined exposure, and cognitive reprocessing (Resick, Monson, & Chard, 2014; Resick, Monson, & Chard, 2016). Notably, CPT does not require activation of the fear response and, therefore, may be helpful for those with subclinical experiences of trauma. Early support for the efficacy of CPT was provided by Resick and Schnicke (1992) in the treatment of PTSD in rape victims and military-related trauma (Monson et al., 2006). When compared to a minimal attention condition, CPT was highly efficacious and superior in reducing PTSD symptoms to the minimal attention condition, comparable to prolonged exposure (Resick, Nishith, Weaver, Astin, & Feuer, 2002).

Cognitive processing therapy (CPT) has been effective in treating posttraumatic stress, including trauma related to CSA, and has been adapted for a range of problems. Originally developed to treat the symptoms of posttraumatic stress disorder in rape victims, more recently Resick et al. (2008) reported on the relative efficacy of the components of cognitive processing therapy in effecting clinically significant reductions in trauma symptoms. Owens, Pike, and Chard (2001) reported that CPT for sexual abuse was associated with significant reductions in severity of cognitive distortions, which maintained through 1 year of follow-up. CPT has also been effective in reducing symptoms of PTSD more broadly related specifically to sexual abuse that maintained for up to 1 year (Chard, 2005). In addition to its application to treat victims of sexual assault, CPT has been successfully adapted for specific application to treat PTSD in combination with comorbid depression (Nishith, Nixon, & Resick, 2005) and comorbid panic disorder (Falsetti, Resnick, & Davis, 2005; Falsetti, Resnick, & Lawyer, 2006). Further, CPT has been shown to be an efficacious treatment for PTSD among incarcerated adolescent males (Ahrens & Rexford, 2002) and in men with acute stress disorder who had been the victims of anti-gay violence (Kaysen, Lostutter, & Goines, 2005).

Existing Trauma Interventions for SMM Though trauma treatment has been well researched in the general population—including empirically tested techniques such as trauma-focused cognitive behavioral therapy, cognitive reprocessing therapies, prolonged exposure therapy, and CPT—many of the proposed treatments have not been applied to sexual minority populations and the unique interrelated trauma experiences they face (Cohen, Mannarino, & Beblinger, 2006; Foa, Hembree, & Rothbaum, 2007; Resick & Schnicke, 1992; Shapiro, 1989). One reason for this dearth may be the possibility that trauma is underreported in sexual minority populations, as certain types of victimization may not be identified or conceptualized as traumatic by clients (Hardt & Rutter, 2004; Littleton, Rhatigan, & Axsom, 2007). Furthermore, clinicians may hesi-

tate to assess trauma directly in SMM clients, despite the prevalence for multiple traumas and re-victimization experienced by this population (Ard & Makadon, 2011; Pantalone et al., 2012; Pantalone et al., 2014; Sweet & Welles, 2011). The work we present here, including proof of concept and pilot results, is perhaps the strongest evidence in favor of the suitability of components of cognitive therapy and CPT to treat childhood sexual abuse symptoms in SMM with current sexual risk for HIV.

Cognitive Behavioral Therapy for Trauma and Self-Care (CBT-TSC) Treatment Rationale

Conceptual Model: How Developmental Trauma Vulnerabilities Lead to Adult Vulnerabilities for PTSD and Other Disorders

We put forth a conceptual model, informed by previous work, to convey how vulnerabilities associated with developmental trauma may lead to adult vulnerabilities for PTSD and other disorders disproportionately experienced by SMM (e.g., depression, substance use disorders, and HIV). The EXPLORE intervention, which included some skill-building but was predicated on participants' perceptions that they could change their behavior, indicated that these strategies might not have been robust enough to change patterns of internalized anger, depression, and lack of self-efficacy that may have been longstanding in the participants who experienced CSA (Exner, Meyer-Bahlburg, & Ehrhardt, 1992; Kelly et al., 1993; Quadland & Shattls, 1987). EXPLORE demonstrated that depression was significantly more prevalent among SMM with a history of CSA compared to those without. In addition, SMM with a history of CSA versus those without were more likely to use illicit substances and alcohol. Further, as the EXPLORE intervention had less effect than hypothesized in reducing HIV infection rates, we surmised that the presence of CSA history in SMM may interfere with their ability to derive benefit from traditional HIV prevention interventions (Mimiaga et al., 2009). These results suggest that additional effort may be needed to go beyond traditional HIV prevention interventions with this population to reduce HIV incidence, as sexual risk-taking among SMM with a history of CSA is the result of syndemics, or synergistically interrelated issues including mental health and substance use disorders among SMM (Stall et al., 2003).

This work provided several specific insights that influenced the proposed conceptual framework. Specifically, it indicated that future behavioral interventions for SMM with histories of CSA may need to incorporate counseling and skills-building that together address the traumatic memories and coping strategies that ensue after young men are abused. Addressing these together is especially important given the high prevalence of these childhood experiences and their role in potentiating sexual risk-taking behavior.

Therapeutic Rationale and Logic of the Integrated Treatment The experience of being sexually traumatized during childhood or early adolescence may substantially interfere with adult sexual development later in life in a way that places SMM at increased risk for HIV. The four symptom clusters of posttraumatic stress disorder (PTSD) highlight how this may occur. They include (1) highly distressing intrusive thoughts, memories, and flashbacks of the sexual trauma; (2) avoidance of emotions, thoughts, and situations related to the trauma; (3) negative cognitions and/or mood; and (4) hyperarousal—inconsistent and chronic triggering of the biological alarm system.

The intrusive thoughts and negative emotions contribute to very high levels of fear and distress, which may be particularly salient in sexual situations. The intrusive thoughts are often related to negative cognitions about one's self as a result of having been sexually abused (i.e., self-blame, self-loathing, disgust, guilt) which are avoided either through dissociation, substance use, or other avoidant coping strategies. This avoidant

stance, in adult sexual situations, can compromise self-care generally and sexual health specifically by interfering with the ability to identify risk, negotiate safer sex, and assert safety behaviors.

Hyperarousal, a maladaptive attempt to cope with repeated distressing intrusions, leads to chronic activation of the startle response, feeling on guard, irritable, and angry, and interferes with the ability to distinguish safe from unsafe situations. In sexual situations, the symptoms of hyperarousal impede the ability to make accurate and realistic sexual risk appraisals. This leads to loss of self-efficacy as the individual doubts his ability to identify risk or his ability to take steps to offset it.

The purpose of CBT-TSC is therefore to retrain individuals to adequately think through the childhood sexual trauma in a more adaptive way (i.e., change appraisals, identify thinking errors, restructure negative cognitions about self) and to participate in behavioral experiments to practice self-care and to restructure problematic thoughts in the functional contexts in which they occur. We hypothesize that after successful cognitive restructuring of the childhood sexual trauma combined with active rehearsal of healthful behaviors the individual will be bothered less by intrusive thoughts and emotions, be better able to cope with those intrusions when they occur, and so be less likely to engage in avoidance in sexual situations. In addition, as distress and intrusions subside, so will the symptoms of hyperarousal which are no longer needed. Thus, the natural cues for safety and risk will become more accessible to the participant, and he will be able to make more accurate sexual safety and risk appraisals. When this is combined with behavioral rehearsals of safety behaviors in sexual situations (as specified in the treatment protocol), the participant will be better able to achieve benefit from the specific behavioral skills training for reducing unsafe sex that is integrated into each session of the intervention. Hence, the successful outcome of this intervention will be improved sexual health behavior though more adaptive management of sexual risk for HIV and STIs and improved general mental health though the reduction of symptoms of PTSD.

The CBT-TSC Intervention The purpose of this integrated cognitive behavioral intervention, adapted for HIV-uninfected SMM with histories of CSA, is to retrain individuals to develop more realistic appraisals of the childhood sexual trauma, identifying thinking errors, restructuring negative cognitions about self, and increasing self-efficacious behavior. As such, the intervention integrates sexual risk reduction counseling with some components of cognitive therapy and cognitive behavioral therapy for trauma and self-care (CBT-TSC) strategies to address trauma symptom severity and sexual risk for HIV. CBT-TSC has been specifically piloted on SMM with CSA histories and sexual risk to reduce interfering negative CSA-related thoughts about self, to appraise sexual risk more accurately, and to decrease avoidance of sexual safety considerations through rehearsals of sexual safety behaviors. The intervention is designed to address the three pathways to sexual risk. Risk reduction counseling targets the direct pathway by specifying an implementation plan for sexual behavior change. CBT-TSC addresses the cognitive pathway (changing appraisals, restructuring negative cognitions) to risk by generating more realistic risk estimates and increasing self-efficacy. By reducing intrusion-related distress, we impact the behavioral pathway by reducing the need for avoidant behaviors (avoidant coping, drug use, dissociation). Through more realistic evaluations of self and less distress in sexual situations, the participant can approach the realities of sexual risk appraisal and implement plans for sexual safety with increased self-efficacy and without avoidance.

Description of CBT-TSC Modules

Module 1: Psychoeducation/Resource Building The goal of this module is to educate the client with respect to posttraumatic stress reactions and increase distress tolerance. The therapist interactively reviews posttraumatic symptom clusters with the client and normalizes trauma reactions and other anxiety feelings. This includes a review and specification of the client's

distress coping strategies and plan for use of adaptive strategies. During these initial therapy sessions, the patient is educated about the symptoms of PTSD and identifies the sexual abuse event(s) in addition to initial problem areas. Concurrently, the patient learns how to identify and describe both thoughts and feelings as well as understand the relationships between them. This phase of treatment aids patients in the generation of a written account of the meaning and interpretations he places on the abuse event, consistent with impact statements described in cognitive processing therapy (CPT; Resick et al., 2002; Resick et al., 2008; Resick & Schnicke, 1992).

Module 2: Cognitive Restructuring During this module, the client is supported to increase confidence around identifying cognitions in sexual situations. The therapist maintains a safe environment for the client to discuss CSA. Specific therapeutic tasks include reviewing impact statements and working interactively with the client to identify and specify cognitive distortions about self that were present during sexual situations, consistent with CPT (Resick & Schnicke, 1992; Resick et al., 2002; Resick et al., 2008). If necessary, the therapist addresses avoidance related to completing the impact statement as homework and works with the patient to generate an impact statement in session through interactive dialogue. In this phase of treatment, the therapist also introduces the broader rationale, which involves completing a worksheet with the patient that requires the patient to identify a situation that elicits a cognitive distortion and related emotions. This requires the patient to evaluate critically their cognitive distortions, which often involves referencing the range of cognitive distortions often endorsed by people with developmental trauma histories. In collaboration with the therapist, the patient then generates alternatives to the cognitive distortions with the goal of generating realistic, measured, and qualified alternative thoughts. The patient then identifies the emotions associated with these thoughts. The general strategy is not just to restructure or relearn specific distorted thoughts but to identify distorted thoughts more generally in order to be able to apply this skill across multiple thoughts and situations. The focus on sexual (health) situations and related cognitions in nonsexual situations is maintained. During this phase of treatment, the patient also learns how to identify cognitive distortions, particularly with respect to distortions about self (e.g., self-blame, self-guilt). The patient learns strategies for challenging and reprocessing these distortions.

Module 3: Behavioral Experiments In this module, the patient learns the rationale for behavioral experiments, works interactively with the therapist to identify specific relevant behavioral experiments, identifies behavioral and cognitive barriers to the behavioral experiment, and makes plans to offset behavioral barriers and restructure cognitive barriers in session. The inclusion of behavioral experiments is designed to provide a functional learning context in which the patient will most appropriately apply cognitive restructuring skills. This is an important step in learning to apply cognitive restructuring strategies in the actual situations where these interfering and distressing thoughts are elicited. Work is done antecedent and consequent to the event, which involves the anticipation of the experience and debriefing afterward. The treatment plan allows for three behavioral experiments to be planned and debriefed.

Module 4: Intimacy/Relationship Issues The final sessions focus on consolidating the patient's cognitive therapy skills, with a particular focus on areas potentially disrupted by the sexual abuse experience. These content areas are largely informed by and modified from the insightful work completed by Resick and colleagues in the specification and efficacy tests of CPT (Resick et al., 2002; Resick et al., 2008; Resick et al., 2014; Resick et al., 2016; Resick & Schnicke, 1992). These content areas have been adapted specifically to be relevant and applicable to SMM with developmental trauma and sexual risk behavior. These sessions were designed to be modular, whereby the therapist and patient together identify areas that are especially relevant and focus the final sessions on addressing those

issues. This allows for individualizing the intervention while staying within the confines of the treatment manual.

CBT-TSC Pilot

The CBT-TSC intervention was initially conducted with four participants in a proof-of-concept study (O'Cleirigh, 2010) and then piloted in a small randomized controlled trial (n = 43; O'Cleirigh et al., 2019; Taylor et al., 2017), both conducted at Fenway Health, a community health center specializing in sexual and gender minority healthcare in Boston, Massachusetts. The methodology and detailed results are described elsewhere (O'Cleirigh et al., 2019). Eligibility for both included identifying as a man who has sex with men, experienced CSA (i.e., sexual contact before the age of 13 with an adult or person 5 years older or sexual contact with the threat of force or harm between the ages of 13 and 16 inclusive with a person 10 years older), being HIV-uninfected, and engaging in risky sexual behavior (operationalized as two or more episodes of condomless anal intercourse with serodiscordant partners in the past 6 months). Participants were not required to meet diagnostic criteria for PTSD. The ten-session CBT-TSC intervention, which included HIV testing and counseling, was compared to a two-session HIV testing and counseling-only approach with immediate, 6-month, and 9-month follow-up visits.

Across both the proof-of-concept study and the pilot study, participants reported reductions in condomless sex post-treatment. In the pilot RCT, participants in the CBT-TSC condition had significantly greater reductions in condomless sex, trauma symptoms, and specifically avoidance compared to those in the control condition. Further, the reductions in condomless sex were maintained at follow-up visits for those in the CBT-TSC condition. Together, these pilot results provided initial evidence for the efficacy of integrated cognitive behavioral trauma treatment for populations, specifically sexual minorities, who are vulnerable to multiple, intertwined mental health concerns. A full-scale multi-site randomized controlled trial was recently completed (The THRIVE Study, R01MH095624, PI O'Cleirigh; Boroughs et al., 2015; Batchelder, Ehlinger, et al., 2017; Batchelder, Safren, et al., 2017). Further, a version of this intervention adapted for SMM living with HIV is currently being piloted at Fenway Health and Ryerson University (O'Cleirigh, 2018; O'Cleirigh & Hart, 2018). Together, CBT-TSC, which leverages psychoeducation related to sexual health and existing evidence-based trauma-treatment approaches, offers a promising intervention for SMM with histories of CSA.

Implications of Pilot Data This body of work presents the utility for addressing interrelated, or syndemic, psychological challenges to offsetting new HIV infections and improving sexual health self-care among gay, bisexual, and other men who have sex with men. Cognitive behavioral therapy for trauma and self-care (CBT-TSC) not only works to address health behaviors but also addresses the impediments to those health behaviors. By working to improve sexual self-care as well as treating trauma symptom severity among SMM with developmental trauma, CBT-TSC has the potential to be more effective within a real-world context where syndemic or interrelated psychosocial problems perpetuate HIV acquisition and poor engagement in HIV self-care (Singer, 1996; Stall et al., 2003). This is consistent with the increasing emphasis on transdiagnostic flexible interventions being used to address presumed underlying psychological processes (e.g., Barlow et al., 2010; Pachankis, 2015). Transdiagnostic treatment aims to address basic underlying processes thought to be common across syndemic, or synergistically interrelated, issues including mental health and substance use disorders among SMM. Both Barlow et al., (2010) and Pachankis (2015) have tested transdiagnostic interventions to address such processes hypothesized to be linked to causative or maintaining variables. For example, Pachankis has aimed to address processes linking minority stress to HIV risk behavior, including maladaptive emotion regulation, negative thinking styles, low levels of self-efficacy, and avoidance coping

(Pachankis, Hatzenbuehler, Jonathon, Safren, & Parsons, 2015). Pachankis has utilized the Unified Protocol (Barlow et al., 2010), a transdiagnostic cognitive behavioral therapy that can be applied to a range of different psychological disorders and problems (e.g., various anxiety disorders as well as depression). In addition to interventions consistent with the minority stress theory as expanded by Hatzenbuehler and Pachankis, future interventions may benefit from addressing other underlying vulnerabilities common across mental health and substance use diagnostic categories, such as distress intolerance, interpersonal rejection sensitivity, posttraumatic reactions, and internalized stigma (Hatzenbuehler, 2009; Pachankis, Rendine, Restar, Ventuneac, & Parsons, 2015).

Although the encouraging findings for the trials reported here are preliminary, they may suggest the importance of ensuring that there is sufficient treatment dose (in this case ten 1-hour individual treatment sessions) to address sexual behavior that may place our clients at risk for HIV, in the context of childhood sexual abuse histories and in many cases additional adult mental health and substance use concerns. More traditional brief sexual risk reduction programs may lack sufficient dose to change patterns of internalized anger, depression, and lack of self-efficacy that may have been long-standing in participants who experienced CSA and underlie unhealthy patterns of sexual behavior. While more work is needed to determine the ideal combination of skills-building and psychoeducation needed to provide maximum impact on behavior change, by leveraging existing evidence-based trauma-treatment approaches in conjunction with psychoeducation related to sexual health, CBT-TSC may have provided a sufficient dose of treatment to address the underlying trauma necessary to enable improving sexual self-care.

The protection afforded to SMM from pre-exposure prophylaxis (PrEP) (Chou et al., 2019; Dimitrov et al., 2019; iPrEx Study Team, 2010) identifies it as a key component for safeguarding the sexual health of SMM. However, as histories of childhood sexual abuse may interfere with the ability of SMM to modify their sexual behavior to protect their sexual health, it is likely that posttraumatic stress responding may also interfere with their access and adherence to, and sustained use of, biomedical HIV prevention options including PrEP (Centers for Disease Control and Prevention, 2019; iPrEx Study Team, 2010; Nikolopoulos, Christaki, Paraskevis, & Bonovas, 2017). The emergence of streamlined PrEP delivery models (Coelho, Torres, Veloso, Landovitz, & Grinsztejn, 2019), increased availability of PrEP (Hoornenborg, Krakower, Prins, & Mayer, 2017; Sullivan, Mena, Elopre, & Siegler, 2019), and increased availability of programs that support its use nationwide (Carnevale et al., 2019; Hoth et al., 2019) will all help to minimize structural, systemic, and clinic-level barriers to PrEP use. Cognitive behavioral interventions that address the posttraumatic and other mental health barriers to PrEP uptake and use among SMM can help support delivery of PrEP and improve the sexual health of this vulnerable group.

Implementation and Dissemination

Encouragingly, there are now several protocolized treatments with initial evidence supporting their use specifically designed to promote the mental health of sexual minority men (Mimiaga et al., 2019; O'Cleirigh et al., 2019; Pachenkis et al., 2019). The work to provide full efficacy support for these innovative programs is currently under way. The important implementation science work that will support the uptake of these evidence-based treatments into the community and mental health centers where sexual minority men can access them must then be undertaken. The extent to which this work will be successful will be determined by the extent to which these treatments are evaluated using culturally competent therapists, working in community settings, with treatments that are cost-effective to the settings in which they are offered and sustainable within the context of the supports available with the healthcare system.

These implementation hurdles are also complicated by the fact that sexual minority men may

experience additional barriers that interfere with their access to, and uptake of, mental health services (Batchelder, Ehlinger, et al., 2017; Batchelder, Safren, et al., 2017; Ferlatte et al., 2019). Many of these barriers are best understood in terms of sexual minority specific stress. Although, encouragingly, there have been recent attempts to provide guidelines and recommendations for both clinical training programs and professional certifications (Boroughs et al., 2015) for psychologists and other clinicians working with sexual and gender minorities. Nevertheless, the availability of appropriately trained clinicians, with cultural competency for providing behavioral health services to sexual minorities, is very limited (Lyons, Bieschke, Dendy, Worthington, & Georgemiller, 2010).

Conclusions

The development and initial testing of this integrated treatment for PTSD symptom severity and self-care (CBT-TSC) among SMM with histories of childhood sexual abuse are presented here as an innovative treatment platform. This treatment recognizes both the complexity of the mental health problems facing SMM and the devastating health disparity for HIV that they experience. The development of these effective integrated treatments that are also sensitive to the settings and contexts in which they will be implemented has the potential to significantly improve the mental health of SMM and also to help offset new HIV infections.

Acknowledgements R01MH095624-01 and R34MH0 81760-02 from National Institute of Mental Health supported the projects noted in this chapter.

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12

Minority Stress, Stigma, and Violence: Affirmative Counseling for Bisexual Individuals

Taylor E. Mefford and Eric C. Chen

Abstract

Bisexual individuals face unique challenges in terms of mental health, discrimination, and violence, much of which are rooted in the invisibility of sexual orientation in broader society. This invisibility contributes to greater risk of violence (e.g., bullying, intimate partner violence, workplace discrimination, and macroaggressions) across many contexts throughout the lifespan, as well as a lack of resources for clinicians serving bisexual clients in these contexts. Grounded in theories of minority stress, developmental contextualism, concealable stigmatized identity, and psychological sense of community, this chapter provides recommendations to clinicians working with bisexual victims of violence to promote positive bisexual visibility, increase access to community resources, and enable self-affirmation. Recommendations are also given for clinicians to advocate for bisexual individuals outside of clinical practice to increase bisexual visibility, educate others on bisexual issues, and further bisexual advocacy in professional contexts.

It has long been understood that lesbian, gay, and bisexual (LGB) individuals face greater challenges to optimal health than their heterosexual counterparts (Bogart, Revenson, Whitfield, & France, 2013). Much of the research literature, however, has focused on lesbian and gay persons exclusively or erroneously grouped bisexual participants with lesbian and gay participants (Berg, Mimiaga, & Safren, 2008). In recent years, psychological research has revealed key differences in the experiences of bisexual individuals that set them apart from other sexual minority individuals. A 2018 meta-analysis of studies on sexual minority individuals, for instance, found higher rates of depression and anxiety among bisexual individuals (Ross et al., 2018) than in lesbian and gay individuals, as well as greater risk for suicidality (Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002). It is also notable that gender differences exist in these mental health outcomes – bisexual men are more likely to be diagnosed with a panic disorder (Warner et al., 2004), and bisexual women have higher rates of depression and anxiety than lesbian women and bisexual men (Ross et al., 2018).

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E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_12

The higher rate of negative mental health outcomes in bisexual individuals suggests that they also experience stressors at higher rates. Bisexual individuals report poorer physical health and increased substance use (Feinstein & Dyar, 2017) compared to their monosexual (lesbian, gay, and heterosexual) peers. In addition to these intrapersonal stressors, interpersonal stressors also play a role in poor mental health, with higher frequency of workplace harassment (Tweedy & Yescavage, 2015) and sexual violence, especially among bisexual women (Walters, Chen, & Breiding, 2013). The focus of this chapter is on external stressors related to violence and the clinician's role in the prevention and mitigation of violence against bisexual persons as a unique population within the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community.

In this chapter, our recommendations for counseling bisexual individuals with regard to experiences with violence draw mainly upon the minority stress theory (Meyer, 2003) and the literature on concealable stigmatized identities (Chaudoir & Fisher, 2010; Quinn & Earnshaw, 2013), as well as principles of affirmative counseling for LGBTQ individuals. The subject of violence is explored from a developmental-contextual perspective, examining the major types of violence commonly experienced by bisexual individuals across the lifespan. The clinician's role as an advocate for the bisexual client is highlighted, with recommendations for affirming counseling that strengthens the client's ability to cope with violence.

Violence and Bisexual Identity

The World Health Organization (WHO) defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (Krug, Mercy, Dahlberg, & Zwi, 2002, p. 1084). Of note in the context of violence against bisexual individuals is the inclusion of "use of power" in the definition, as much violence against bisexual individuals is more than just physical; much of the violence and discrimination experienced by bisexual individuals is also psychological in nature. Though much harder to detect, verbal attacks on bisexual individuals related to their identity are also a form of violence.

When considering violence against those with concealable stigmatized identities such as LGBTQ individuals, an expanded definition is required. Because WHO specifies that violence must be intentional, this definition is limited in that it does not account for microaggressions, a common form of violence that may or may not be intentional (Sue et al., 2007). Thus, when considering violence against bisexual persons, it is vital to consider violence as taking overt and covert forms, as well as having intentional and unintentional motivations. Furthermore, it must be noted that this violence can be perpetrated by not only heterosexual individuals but also the gay and lesbian communities, which is commonly referred to as "double discrimination" (Ciocca et al., 2017). Experience of double discrimination involves not only a risk of violence from both heterosexual and gay/lesbian communities but also a lack of social support from other queer-identified individuals.

This broader conceptualization of violence – one that includes both overt and covert forms and involves both intentional and unintentional motivations – is sensitive to the perceptions of the victim and the impact on physical and mental health violence can have. Violent acts include microaggressions, sexual violence, bullying, intimate partner violence, and physical violence, all of which occur in a myriad of settings. Regardless of the intention of the perpetrator, the harmful effects of the violence on physical and psychological health cannot be underestimated.

Definitions of Bisexual Identity

One of the complications of addressing bisexual issues in research, practice, and advocacy is the diversity of definitions related to the bisexual identity (Swan, 2018). For clinicians seeking to

work with LGBTQ clients, it is necessary to recognize this diversity and to respect the definitions and labels clients choose to use to describe their own sexual identity. Especially with the advent of social media, a plethora of definitions have been proposed. Just as our proposed definition of violence is broad in order to capture a variety of experiences, so must a definition of bisexuality. Bisexual activist Robyn Ochs defines bisexuality as "the potential to be attracted – romantically and/or sexually – to people of more than one sex and/or gender, not necessarily at the same time, not necessarily in the same way, and not necessarily to the same degree" (quoted in Shelton, 2017, p. 109).

Regardless of the specific definition which is adopted by the client, bisexuality typically encompasses an attraction to two or more genders, and an emphasis on the individuality of their experience – no two bisexual individuals experience attraction in the same way, and even within an individual, that attraction can look and feel different depending on the gender of the individual they are attracted to. Additionally, a bisexual individual may be generally more attracted to one gender than another gender (as opposed to the stereotype that bisexual people are attracted to men and women equally). Though similar, the term *pansexuality* refers to attraction regardless of one's gender identity or expression (Belous & Bauman, 2017); in other words, gender is a component of bisexual attraction while it is not a component of pansexual attraction. Research on the differences between bisexuality and pansexuality in terms of experiences with violence and health outcomes is still in the emergent stages.

Furthermore, research on sexual fluidity – situation-dependent flexibility in individuals' sexual responsiveness – supports the view that the current conceptualization of sexual orientation as distinct categories may not be sufficient in capturing the dynamic nature of sexual attraction and its tendency to change over time and across circumstances, especially for women (Diamond, 2008, 2012). Heterosexual or lesbian women, for example, may experience desires for either men or women or both under certain circumstances though may not change their identity descriptor (Diamond, 2008). Likewise, a bisexual man may find himself more attracted to men, but at a later point in life he may find that he is more attracted to women. These varied attractions to different genders across time also are a different process for each bisexual individual; as such, understanding the nature of bisexuality and bisexual identity requires exploration on an individual level.

Gender Differences in Experiences of Violence

Vital to the conversation of violence against bisexual individuals is an acknowledgment of gender differences in experiences of violence, especially regarding intimate partner violence and sexual violence. According to the Center for Disease Control and Prevention's 2010 National Intimate Partner and Sexual Violence Survey, the risk of sexual intimate partner violence was highest for bisexual women – 61.1% of bisexual women reported rape, physical violence, or stalking by a romantic partner, whereas 37.7% of bisexual men reported the same (Walters et al., 2013). These proportions were similar for bisexual women versus bisexual men when considering sexual violence regardless of perpetrator (i.e., a family member or stranger). The prevalence of physical violence experienced in intimate relationships was also higher for bisexual women – 56.9% of female participants reported physical violence, compared to 37.3% of the male participants.

The reasons for these gender disparities in experiences of violence within the bisexual community remain unclear. Johnson and Grove (2017) offer several plausible explanations, which include, among others, hypersexualization in media and biphobic harassment. In pornographic media, bisexual women are rendered invisible as their sexual activities with both men and women are fetishized. This creates a perception that bisexual women in particular are more sexually available, increasing the risk of unwanted and forceful sexual advances. Violence against bisexual women may also be the product of biphobic perceptions that bisexual women are

more promiscuous and less trustworthy, and such violence is a method of establishing dominance or ownership in reaction to those perceptions.

Minority Stress, Violence, and Concealable Stigmatized Identity

The minority stress model conceptualized by Meyer (2003) examines health risk among LGBTQ individuals by attending to the interactions between members of sexual minorities, on one hand, and the norms and values within the social context, on the other. According to Meyer, minority stress differs from general stressors (e.g., job loss, death of a parent) commonly experienced by all individuals. Because of their minority status as a group in society, sexual minority individuals experience chronic and socially based stressors, and their health problems are often a function of an excess of social stressors related to stigma and prejudice. Meyer describes four different types of minority stressors along a continuum from the proximal, subjective, and direct to the distal, objective, and indirect. Distal stressors tend to be less dependent on one's perception, but proximal stressors tend to be more closely linked to one's identity as a sexual minority group member.

First, on the distal end is the stressor type related to external, objective occurrences or conditions where sexual minority individuals may experience stress more commonly in relation to chronic daily hassles such as hearing antigay jokes. The second type of stressor involves the response to the possibility of violence or rejection from others, as they maintain vigilance as a self-protective strategy in their interactions with others. The third type of stressor pertains to concealment of one's sexual orientation where they engage in the continuous process of assessing risks and benefits of disclosure in each social situation. Constant efforts toward sexual identity concealment contribute to internalized stigma within the sexual minority individual, a proximal and the fourth stressor. Research has further supported links between minority stress and mental health problems, depression, and high-risk sexual behaviors among gay and bisexual men and excessive cigarette smoking and heavy alcohol consumption among lesbian and bisexual women (Grossman, 2006). There is also evidence, however, that LGB individuals demonstrate resilience to negative health outcomes despite – or because of – minority stress (Russell, 2005). In a sample of gay and bisexual men, for instance, Szymanski (2009) found self-esteem – as an indicator of resilience – mitigates the impact of heterosexist discrimination on psychological distress. Thus, when working with bisexual individuals, mental health professionals need to examine complex dynamics of the linkage between minority stress and health outcomes as well as the factors that affect these relations.

While the minority stress model (Meyer, 2003) offers insight into the stress and health risks among sexual minorities in general, continued understanding of the role that stigma plays in increasing risk of violence against bisexual men and women is also necessary. In Herek's (2009a) view, the distinctions among four types of sexual stigma shed light on the unique experience of sexual minorities exposed to violence. First, structural stigma refers to how society values different characteristics, features, or group identifications. Enacted stigma is the local translation of structural stigma, representing overt and interpersonal aspects of stigma because acts of discrimination, bullying, and violence are directed at an individual based on the individual's stigmatized status. Felt stigma occurs when one is aware of the contextual factors that influence structural and enacted stigma and of the likelihood of stigmatizing behavior against the stigmatized individual. For this reason, felt or perceived stigma may lead individuals to conceal actively their stigmatized identities. Finally, internalized stigma refers to an individual's acceptance of stigma as a part of the individual's value system and self-concept. Both felt and internalized stigma pertain to the intrapersonal aspect of stigma.

Similar to their gay and lesbian counterparts, when bisexual individuals internalize society's negative messages about one's bisexuality, their experience of internalized binegativity

(Potoczniak, 2007) emerges as a concealable stigmatized identity (CSI). CSI refers to a central part of one's identity that is socially devalued and invisible to others in social interactions (Chaudoir & Fisher, 2010; Quinn & Earnshaw, 2013), and examples of CSI include an HIV/AIDS diagnosis, learning disabilities, and immigration status.

In Pachankis' (2007) view, individuals with a CSI experience most difficulty in situations where their stigmatized identity is particularly salient, likely to be discovered, and when that discovery would lead to significant challenges for that individual. Pachankis describes a number of cognitive challenges that arise from these situations, including preoccupation with thoughts of the stigmatized identity, increased vigilance of the stigma being discovered, and suspiciousness; individuals concealing stigmatized identities often expect more negative evaluations from others and may protect themselves by more closely monitoring their social interactions. This constant vigilance in social interactions can negatively impact interpersonal behavior of those with CSIs.

Concealment is of particular concern to bisexual individuals, as their sexual orientation is not readily apparent to others within and outside the LGBTQ community. When they are dating individuals of the opposite sex, bisexual individuals are assumed to be heterosexual. When they are dating same-sex individuals, they may be mistakenly perceived as either gay or lesbian. As such, in contrast to the disclosure process of gay and lesbian individuals, managing their CSI as bisexual individuals is a more complicated and stressful process that involves both risks and benefits (i.e., while identity disclosure may result in a sense of relief, it also may increase risk of experiencing violence). That is, in addition to the stress common to sexual minority members, bisexual individuals may encounter additional stress related to anticipated stigmatization – real or perceived – from within the LGBTQ community as well (Monro, Hines, & Osborne, 2017). Perhaps for this reason, bisexual individuals are more likely to conceal actively their stigmatized identity than their lesbian and gay counterparts (Barringer, Sumerau, & Gay, 2017).

The level of stigmatization increases further when bisexual individuals' disclosure results in violence against them, creating a vicious cycle of increased concealment and ingrained binegativity (MacKay, Robinson, Pinder, & Ross, 2017). In addition, their CSI concealment increases their sense of marginalization because they are unable to seek support freely through the identity development process. Furthermore, feeling marginalized may be accompanied by increased resistance in seeking help from health professionals (Durso & Meyer, 2013), as the bisexual individual may be wary of working with someone who doesn't understand their experiences. When addressing experiences of violence with bisexual clients, it is thus important for clinicians to be aware of the concealable nature of their minority identity, as it affects their ability to cope and seek help. In short, as bisexual individuals, the ongoing need to decide when, whether, and how to disclose their CSIs would negatively affect health outcomes and interpersonal relationships (Bostwick, 2012). While such concealment can provide an advantage in that the individual may not be immediately targeted for their identity (as with many racial and ethnic minority individuals), concealment is also shown to be correlated with poor mental health outcomes for bisexual individuals (Schrimshaw, Siegel, Downing, & Parsons, 2013).

Despite potential risks, bisexual individuals' disclosure of their sexual identity facilitates their access in and connection with the bisexual community. Their membership in the supportive community enhances their personal and group identity, providing opportunities to affirm their experiences as bisexual individuals. Social connection through healthy and satisfying relationships can positively impact the mental health and overall psychological well-being of bisexual individuals, countering the debilitating effects of discrimination (Seppala, Rossomando, & Doty, 2013).

It should be noted that, from a developmental-contextual perspective, bisexual individuals' negotiation of their CSIs may vary depending on their developmental stage and contextual factors. Meyer's (2003) minority stress perspective helps

deepen our understanding of LGBTQ experiences of discrimination and victimization as a group of sexual and gender minorities. When they are constantly exposed to or anticipate prejudice and harassment within a larger social and cultural context, these stressors, individually and collectively, lead to mental and physical health complications (Meyer & Frost, 2013). Contextual factors, such as structural conditions, laws and policies, and societal norms/attitudes, thus exacerbate the stress and stigma bisexual individuals experience.

Violence and Developmental Outcomes for Bisexual Individuals

Just as one's identity and context changes across the lifespan, so do the types of violence experienced by bisexual individuals. In adolescence, much of the discrimination and violence experienced is in the school setting. As the bisexual individual approaches adulthood, these settings become much more varied, with the risk of violence occurring with intimate partners and in the workplace. In addition, bisexual adults face a greater variety of discriminatory behavior, including microaggressions. This section briefly explores these four areas – adolescent bullying, intimate partner violence, workplace harassment, and microaggressions – to better equip clinicians with information on the experiences of violence that bisexual clients face.

Bisexual Adolescents and Bullying

A major concern of LGBTQ adolescents is the risk of bullying in the school setting, as evidenced in a cross-sectional analysis of national samples of school-aged adolescents revealing that lesbian, gay, and bisexual youth experience higher frequency of being bullied than their heterosexual peers (Berlan, Corliss, Field, Goodman, & Austin, 2010). Though these analyses generally indicate that gay and lesbian youth are at higher risk for bullying than their bisexual peers, such results are unsurprising – because of the invisibility of bisexuality in broader culture, it is more common for bullies to target gay and lesbian adolescents. Bisexual individuals, however, are also negatively impacted by negative messages directed at their gay and lesbian peers, particularly with regard to homophobic epithets (Evans & Chapman, 2014).

The various forms of bullying experienced by bisexual youth are important for clinicians to be aware of, especially with the increased use of the Internet and social media platforms among young people (Elipe, Muñoz, & Del Rey, 2018). One survey of school-aged children indicated that the most common forms of bullying were social (e.g., teasing or leaving out of social events) and physical (e.g., pushing or hitting) in nature, with online bullying also having a high frequency (Evans & Chapman, 2014). The content of verbal bullying and cyberbullying may include homophobic epithets (e.g., "You're so gay!"), comments about the perceived gender nonconformity of the bisexual individual (Hart et al., 2019), or remarks about the perceived sexual history of the victim (Dank, Lachman, Zweig, & Yahner, 2014).

The impact of bullying is both short- and long-term and may be moderated by the level of bisexual identity disclosure. In LGBTQ adolescents, those who are out to no one or to everyone have the best academic outcomes, while those with more complex patterns of disclosure (i.e., only out to certain friends or family members) have the worst academic outcomes (Watson, Wheldon, & Russell, 2015). Because bisexual adolescents are more likely to have complex patterns of disclosure (i.e., bisexuality cannot be determined from behavior or appearance alone, meaning the bisexual individual engages in a continual process of disclosure), they are particularly at risk with regard to academic challenges. Long-term effects of bullying include persistent fear of victimization in adulthood and internalized binegativity (Greene, Britton, & Fitts, 2014), non-suicidal self-injury and mood disorders (Rivers, 2004), and increased risk of suicidal behaviors and substance abuse (Fedewa & Ahn, 2011).

Though many schools throughout the United States are making concerted efforts to address bullying, especially as online bullying becomes a more common concern, few anti-bullying initia-

tives address the needs of bisexual students (Swearer, Espelage, Vaillancourt, & Hymel, 2010). However, increased efforts have been made to establish LGBTQ resource centers and groups in public schools, which have been shown to decrease minority stress in bisexual adolescents (Kosciw, Bartkiewicz, & Greytak, 2012; Poteat, Heck, Yoshikawa, & Calzo, 2017). For counselors in school settings, an awareness of these resources is vital, and if they do not exist, efforts should be made to create these resources for all LGBTQ students.

Bisexual Adults and Violence

Two of the primary settings of violence for bisexual adults occur in intimate relationships and the workplace. Much of the experiences of violence in these settings are visible and extreme, such as sexual violence, while other experiences are covert, such as microaggressions. Though intimate partner violence (IPV) was briefly addressed earlier in this chapter (Walters et al., 2013), it is worth noting the effects of IPV on bisexual individuals. In a study of gay and bisexual men, bisexual men were found to be more likely to experience IPV, and higher rates of physical (e.g., HIV, heart disease) and mental (e.g., depression, anxiety) illness were found among those who did experience IPV (Houston & McKirnan, 2007). Experiences of IPV also increase internalized stigma and efforts of identity concealment (Carvalho, Lewis, Derlega, Winstead, & Viggiano, 2011).

Workplace discrimination, which can be defined as unfair or negative treatment for reasons unrelated to job performance, is also a common experience of bisexual individuals. Though many states have laws in place which criminalize discrimination based on sexual orientation, these laws have generally failed to protect bisexual individuals (Tweedy & Yescavage, 2015). Research on bisexual-specific workplace discrimination is minimal, as most studies group bisexual men and women with their gay and lesbian peers, respectively, or group all LGB participants together. However, the existing research on the subject indicates that while bisexual individuals report discrimination at a lower rate than lesbian and gay individuals, this is likely due to their invisibility in the workplace (Herek, 2009b), as only 11% of bisexual individuals are out to work colleagues (Pew Research Center, 2013). One study reported that while 15% of bisexual participants reported having experienced workplace discrimination, only 44% of this same sample reported working in an environment that was accepting of their sexual orientation (Pew Research Center, 2013).

Tweedy and Yescavage (2015) suggested that the disparity between lesbian/gay and bisexual employees in terms of discrimination may be due to microaggressions being a more prominent issue for bisexual individuals, as microaggressions do not meet legal requirements of workplace harassment and discrimination. Microaggressions refer to "the brief and commonplace daily verbal, behavioral, and environmental indignities...that communicate hostile, derogatory, or negative racial, gender, sexual orientation, and religious slights and insults" (Sue, 2010, p. 5). Bostwick and Hequembourg (2014) identified six types of bispecific microaggressions: (a) hostility (e.g., being harmed by lesbian and gay attendees at a "pride" event); (b) denial/dismissal (i.e., questioning the validity of bisexual identity); (c) unintelligibility (e.g., "I just don't understand how you could be bisexual"); (d) pressure to change (e.g., a romantic partner wishing that the bisexual individual could change their sexual orientation to "match" the relationship); (e) sexual orientation legitimacy challenged in lesbian, gay, and transgender spaces (e.g., being told that the bisexual individual is "not gay enough"); and (f) dating exclusion and claims of hypersexuality (e.g., potential partners being wary that the bisexual individual would not be faithful).

To date, no published literature exists confirming a link between bispecific microaggressions and mental health, though research on LGBTQ individuals as a whole demonstrates that microaggressions are correlated with poor mental health (Nadal, Whitman, Davis, Erazo, & Davidoff, 2016). In working with bisexual clients, it is

important to be sensitive to the different ways in which the client's identities may be invalidated by both interpersonal and systemic forces in their lives. This may also involve some psychoeducation on microaggressions and exploring with the client how these experiences may shape their own self-esteem and self-awareness.

Affirmative Clinical Practice Grounded in Developmental Contextualism

Recent training competencies, ethical considerations, and practice guidelines (e.g., American Psychological Association, 2012) in counseling LGBTQ individuals have translated to affirmative clinical practice for LGBT individuals. Affirmative mental health practice for LGBTQ clients is often characterized by some common principles, including gaining insight into the ways in which stigma-related stress compromises one's mental health, addressing internal shame and internalized stigma, promoting individuals' resilience and connection to the community as a buffer to stigma-related stress, and the clinician as a social justice advocate (American Psychological Association, 2012; Pachankis, 2018). Similar to affirmative therapy for gay men to recognize and embrace their gay identity and human dignity (Chen, Stracuzzi, & Ruckdeschel, 2004), affirmative counseling for bisexual clients is likewise aimed at validating, respecting, and embracing their experiences and exploration of their bisexual identity, on one hand, and at demarginalizing their stigmatization, on the other.

When working with bisexual clients, mental health professionals need to be equipped with affirmative knowledge, skill, and competency to recognize their distinct experiences and needs. Clinicians need to examine their own common stereotypes and misconceptions about bisexuality and monitor their own assumptions and biases by utilizing appropriate language and behavior. Clinicians who unconsciously endorse negative attitudes or stereotypes about individuals of minority groups may act in accordance with these judgments in their clinical work, contributing to the client feeling isolated or misunderstood (APA, 2003; Hays, 2009). In counseling bisexual clients, clinicians thus need to gain familiarity with bisexual identity development models (e.g., Bradford, 2004; Brown, 2002) vis-à-vis other lesbian or gay identity development models. They can also disseminate accurate information about bisexual individuals as a particularly vulnerable sexual minority group. They can normalize and validate the experience of bisexual individuals by educating them that their feelings of identity confusion are not necessarily the result of uncertainty about their sexuality but rather a completely healthy reaction to the negative messages of a society dominated by binary and heteronormative values (Hays, 2009).

Because bisexual individuals' negotiation of their CSIs may vary depending on the developmental stage, contextual factors, and their exposure to stigma and violence, clinicians' affirmative practice should be grounded in developmental contextualism. A developmental-contextual perspective (cf., Ford & Lerner, 1992) contends that human behavior changes over time and the meaning of behavior is embedded in and inseparable from contextual factors; an individual's needs, goals, and identities change across the lifespan and often in response to contextual (e.g., family, work, community) change. The individual, however, is viewed "as an active agent of change and plays a major contributory role in shaping the surrounding environment across time" (Chen, Kakkad, & Balzano, 2008, p. 1272). Bisexual adolescents, for instance, are subject to a unique form of stigmatization regarding the prevailing, dichotomous view of sexual orientation, the expectation of socially appropriate dating behaviors, and the view that sexual orientation may be more "fluid" during adolescence (APA, 2012). Consequently, these views and expectations can lead bisexual adolescents and young adults to conceal their identity or avoid social interactions altogether. By focusing on their clients' individual experiences and varying degrees of stigmatization, mental health professionals can appreciate how these experiences have come to shape their bisexual identity and relationships within the personal and social contexts.

Disclosure and Consequences of Concealable Stigmatized Identities

Disclosure of one's CSI is an essential aspect of social interaction with far-ranging advantages (Chaudoir & Fisher, 2010), and the consequences, both positive and negative, within each domain (cognitive, affective, behavioral, self-evaluative) may diverge from one person to the next. Clinicians should thus consider the complexity of the disclosure process for bisexual clients, particularly when they have experienced violence and victimization, and the profound impact that disclosure (both beneficial and damaging) can have on their well-being on multiple levels. While individuals who disclose their bisexual orientation may encounter more biphobic prejudice and violence, they may also experience an increase in psychological well-being due to a greater access to support (Brewster, Moradi, Deblaere, & Velez, 2013). As such, feeling connected to the sexual minority community may be beneficial in offsetting some of the harmful effects of antibisexual discrimination (Craney, Watson, Brownfield, & Flores, 2018). Nonetheless, clinicians can assist clients in exploring their goals for identity disclosure and evaluating the potential advantages and risks resulting from this decision. That is, although disclosing one's traumatic experiences or bisexual identity constitutes an important step in the process of developing a positive sense of self (Herek, 2009a; Pachankis, 2007), bisexual individuals would benefit from clinicians' assistance in discussing their goals for identity disclosure, the complexity of stigma and coping strategies, and evaluating the potential advantages and drawbacks this may have on their lives. A counseling plan may then be developed and implemented to help them determine if and how they will engage in the process of selectively disclosing their stigmatized status to supportive individuals.

Bisexual Individuals' Intersectional Identities

Central to the developmental-contextual perspective is a recognition of intersectional identities and stigma. An individual's sense of self also includes social identity, namely, membership in different social groups, such as gender, social class, religion, and age. Although there exist similarities between individuals within each social group, intragroup differences exist, and, depending on one's cultural context, the intersection of personal, social, and cultural identities can result in experiences of either privilege or oppression. Across the human lifespan, bisexual individuals' CSIs interact with and are influenced by individual developmental pathways within a society impacted by prevailing norms, expectations, and stereotypes. It should be noted, however, an individual's sense of self is not shaped solely by one's sexual identity but also by membership in different social groups. Although all individuals maintain membership in multiple groups that reflect their identity, bisexual individuals may experience identity oppression as additive (double oppression) or interactive (simultaneous oppression). In short, clinicians attend to psychological, interpersonal, developmental, and sociocultural factors salient to bisexual individuals' navigation of life transitions and intersectional identities in response to discrimination (e.g., racism, sexism, binegativity) and unresolved trauma from violence exposure.

When bisexual individuals experience trauma from violence exposure, they may be confronted with a terrifying reality that shatters their assumptions about themselves and others, accompanied by shame and internalized stigma. As Pachankis (2007) noted, "[s]ecret keeping, by nature, is shameful. The mere act of hiding information about a stigma may lead an individual to believe that the stigma-related information is shameful simply because it is worthy of being hidden" (p. 234). When bisexual individuals' concealment is rooted in shame, fear of rejection, or discrimination from others, significant cognitive, affective, and behavioral consequences of concealing a stigma should not be underestimated, and, as such, intervention efforts in the counseling process should be directed at addressing their shame and internalized stigma and help reconstruct their meanings for their realities, their resilience, and their intersectional identities as bisexual individuals and as violence survivors.

Effective clinical strategies and techniques include consciousness-raising, self-affirmation, emotion awareness and acceptance, restructuring minority stress cognitions, decreasing avoidance, and assertiveness training (Pachankis, 2014).

Resilience and Interpersonal Support

Given that bisexual individuals' sexual identity is more easily concealed in opposite-sex romantic relationships, they may encounter challenges with disclosure that lesbian and gay individuals do not experience. Perhaps for this reason, bisexual individuals have been found to be more likely to conceal their identity from their family, friends, and coworkers when they have encountered structured and enacted stigma, as compared to lesbian and gay individuals (Herek, Norton, Allen, & Sims, 2010).

There is evidence that bisexual individuals face challenges with self-acceptance, lack of acceptance from partners in mixed-orientation relationships, social alienation, and isolation related to limited bisexual visibility and community (Ross, Dobinson, & Eady, 2010). For bisexual individuals who have experienced violence, clinicians need to help bisexual clients to draw support eventually from interpersonal relationships, despite challenges to negotiate their CSIs in interpersonal relationships. With bisexual identity affirmation at the core, clients need to be supported as they strengthen their bisexual identity in the face of challenges or obstacles such as invisibility and bisexual erasure. Affirming partners and friends can provide a support network where bisexual individuals could safely and comfortably express their bisexual identity; this may ultimately increase their confidence and willingness in disclosing to others their bisexual identity (Pachankis, 2014). For those who experience conflicts associated with their bisexuality, their disclosure to their partners may help to strengthen their relationship and reduce a negative self-perception.

For clients who possess avoidance-focused goals, the work for clinicians may include helping them explore, strengthen, and integrate their sexual identity or helping them to identify alternative outlets of sexual identity expression. As bisexual clients become more confident in embracing their sexual identity, intervention efforts that aim to assist clients in developing greater communication and coping skills may allow bisexual individuals to feel better equipped to disclose their sexual identity to their partners or close others and better prepared for their felt or enacted stigma they may experience from others.

Resilience and Psychological Sense of Community

Stigmatization and rejection from the LBGTQ community may make disclosure particularly difficult, further isolating bisexual individuals. The development of close peer relationships and connection with the LGBTQ community have been viewed as critical aspects of resilience for bisexual individuals providing support and affirmation and acting as a buffer against disapproval, discrimination, and rejection (LeBeau & Jellison, 2009). When bisexual individuals are reluctant to disclose their sexual identity, they presumably lack some of the resources and support that are usually available to lesbian and gay individuals, including a visible community with which they can affiliate (McLean, 2008). For bisexual individuals exposed to violence and trauma, their ability to find support within the heterosexual and LGBTQ communities is further limited because of their increased need to conceal their CSIs.

Concealment of one's bisexual identity restricts the access to group-based protections, such as attributing negative feedback to one's stigmatized group membership rather than one's personal deficiencies (Pachankis, 2018). For bisexual individuals who have been exposed to violence, particularly when they are in adolescence, reaching out to the online bisexual community may be an important and consistent source of validation. The online bisexual community provides a context for exploring various aspects of their identities and relationships. In other words, bisexual individuals may experience a psychological sense of community (PSOC),

defined as "a feeling that members matter to one another and to the group, and a shared faith that members' needs will be met through their commitment to be together" (McMillan & Chavis, 1986, p. 9). PSOC has been linked to psychological benefits, such as an increased sense of connection, confidence in social support, acquisition of problem-solving skills, improved functioning, and psychological empowerment (Omoto & Snyder, 2002).

The concept of PSOC is similar to the therapeutic value of instillation of hope and universality in the group therapy context (Yalom & Leszcz, 2005). The counseling group as a social microcosm provides opportunities for bisexual individuals to explore their potential fears of harassment and discrimination, gradually demarginalizing their stigmatized identities in cultural diversity (Chen, Thombs, & Costa, 2003). In discussing group dynamics, Brabender and Fallon (2018) highlight the use of Herek's (2009a) four types of stigma (structural, enacted, felt, and internalized) to produce group work. To address stigma within group dynamics, for instance, Brabender and Fallon suggest that group therapists can assist members in exploring the experiences of interpersonal interactions within the group by deflecting the aggression directed at a member to the therapist, examining the function of enacted stigma, and helping members to develop cohesion based on shared issues.

In conclusion, clinicians need to provide evidence-based practices in a manner that is affirmative of bisexual identity and sensitive to the bisexual client's challenges with violence across the lifespan. Mental health practitioners can develop, study, and offer bisexual-specific mental health services and interventions, foster a psychological sense of community, and attend to intersectional identities in relation to discrimination. Exploring intersecting forms of oppression (e.g., sexism, racism, antibisexual discrimination) and stigma (structural, enacted, felt, and internalized), for instance, may be beneficial due to the fact that bisexual women often experience various forms of eroticization in multiple contexts (Craney et al., 2018). It is incumbent upon clinicians to explore bisexual clients' experiences and assist them in expanding their network of social support as a means to affirm their bisexual identity.

Counseling Practice Incorporating Social Justice: The Clinician as an Advocate

Because invisibility of one's sexual orientation is a major contributor to bisexual distress, part of the clinician's task in supporting and advocating for the bisexual client is to challenge that invisibility in public settings. Israel (2018) provides suggestions for what this advocacy should look like, which comprises of three components: educating others on bisexuality, increasing bisexual involvement and inclusion, and promoting intersectional bisexuality in professional spaces. What follows is a summary of the suggestions provided.

Because much of the violence against bisexual individuals is due to invisibility and misunderstanding about the nature of bisexuality (i.e., assuming bisexual people are promiscuous), education about bisexuality in broader society is important. Challenging the misconceptions mentioned in this chapter in public spaces and acknowledging past and present contributions of bisexual individuals are functions of increasing visibility. By extension, clinicians must also amplify the voices of bisexual individuals through ensuring they have opportunities to lead in LGBTQ spaces as well as make space for them to form their own groups and develop their own community. It is also important for the work of clinicians to include bisexuality in a way that acknowledges the specific challenges bisexual individuals may face. Because of the specific needs of individuals, mental health services, interventions, and outreach must be specifically targeted to meet the needs of bisexual individuals. This is particularly important for LGBTQ outreach, which tends to capture only lesbian and gay individuals – opportunities must be made specifically for bisexual individuals in order to engage with them.

Finally, bisexuality today is being recognized as being more diverse than ever. Israel (2018)

acknowledges that there is no limit to the aspects and qualities of human attraction and that exploration of the complexity of human sexuality began in the bisexual community. One facet that adds richness to this discussion is the intersectionality of other identities such as race, ethnicity, religion, gender diversity, nationality, and family structure. Most of the research supporting the theories presented in this chapter touch on bisexuality but do not fully explore the rich tapestry of interwoven identities that make up a person. These other identities also contribute to one's experiences with violence, often in an additive manner, increasing the risk for negative mental and physical health outcomes. Researchers and clinicians alike must consider how individuals with specific intersecting identities experience violence in unique ways and tailor their research, clinical, and advocacy practices to those intersections.

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Violence Against Asexual Individuals

13

Emily M. Lund

Abstract

Asexual individuals—people who experience little or no sexual attraction to individuals of any sex or gender—comprise approximately 1% of the population but are often left out, medicalized, and dehumanized in both sexual and gender majority and minority spaces. This chapter introduces the concepts of asexuality and the asexual spectrum and discusses key forms of violence and marginalization that asexual individuals experience: medicalization and pathologizing of asexuality, isolation and erasure, and unwanted sexual experiences and corrective rape. The importance of validation and intersectionality in working with asexual individuals is also discussed.

Asexuality, or the lack of sexual attraction to people of any sex or gender, is an often ignored and misunderstood sexual orientation. Asexuality has been acknowledged since the work of Alfred Kinsey (The Kinsey Institute, n.d.) in the 1940s, who described a sexual orientation of "X" for people who had "no socio-sexual contacts or reactions." Despite the early acknowledgement of asexuality as a variant of sexual orientation, asexuality was largely ignored in psychological research until the turn of the millennium. Bogaert (2004) examined the presence of asexuality, defined as lifelong lack of sexual attraction to individuals of any sex, in a British population sample, and found that approximately 1% of the population could be classified as asexual. Similarly, in a smaller, online American sample, approximately 1% of participants identified as having sexual attraction to neither sex (Lund, Thomas, Sias, & Bradley, 2016).

In 2001, the Asexuality Visibility and Education Network (AVEN, n.d.; www.asexuality.org) was developed to provide an online forum for asexual-identified and questioning people to discuss asexuality-related issues and build connections and community. Because of the rather small number of asexual people and the historic lack of research on asexual people and their experiences, most research and discourse on asexuality has emerged within the past two decades via web-based sources, often using samples from AVEN forums (Hinderliter, 2009). Another issue that may contribute to the underclassification or misclassification of asexual people in research is the idea of an asexual spectrum that includes individuals with some limited sexual attraction (e.g., demisexuals—people who are sexually attracted only to individuals with whom they have formed a close personal connection—and "gray asexuals"—people who experi-

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E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_13

ence sexual attraction very rarely) (Hille, Simmons, & Sanders, 2019). Given that earlier definitions of asexuality might have excluded such individuals, it is unclear how common or rare these other asexual-spectrum identities might be and if and how their experiences differ from individuals who meet the more classic definition of asexuality (Dawson, Scott, & McDonnell, 2018).

Further complicating matters is the distinction between sexual attraction, romantic attraction, and sexual behavior. Individuals who are asexual (i.e., do not experience sexual attraction) may still experience romantic attraction. Sexual attraction refers to the desire to engage in sexual intercourse with another person, whereas romantic attraction refers to the desire to form a loving, romantic relationship with another person; this relationship may, but does not always, include nonsexual physical intimacy, such as hugging and kissing. Similar to sexual orientation, romantic orientation may indicate the genders or sexes to which a person is romantically attracted (e.g., biromantic, heteroromantic, homoromantic, aromantic) (Chasin, 2011; Pinto, 2014). Many asexual individuals will describe and identify with both their sexual orientation and their romantic orientation (e.g., biromantic asexual, heteroromantic asexual, gay asexual, etc.), using a variety of terminology (Chasin, 2011; Hinderliter, 2009; Lund & Johnson, 2015). Other individuals may identify as being "aromantic," meaning that they do not experience romantic attraction to people of any sex or gender. Aromantic individuals may or may not also identify as asexual; some individuals who report no romantic attraction also report feeling sexual attraction to individuals of one or more sexes (Lund et al., 2016). Thus, our understanding of the "asexual community" and subdivisions within it is still in its infancy, as the language surrounding asexuality and the asexual spectrum is in a state of growth (Chasin, 2011; Hinderliter, 2009). Accordingly, participant samples from different studies may capture and combine different swaths of the asexual community (Chasin, 2011; Gupta, 2017; Hinderliter, 2009).

Pathologizing and Medicalization as a Form of Violence

Nonheterosexual sexual orientations have long been subject to pathologizing. Homosexuality was famously classified as a psychological disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM) until 1973 (Drescher, 2015). As Drescher (2015) notes, the de-pathologization of homosexuality leads to a gradual shift away from attempting to "cure" homosexuality to a greater focus on understanding the lived experiences of sexual minority individuals and providing them with legal and social support and protection, although these pathologizing and curative attitudes and approaches do still exist despite a lack of empirical and ethical support for their use (Flentje, Heck, & Cochran, 2014).

Perhaps echoing this historical theme, discussion of asexuality has often questioned if it is a physical or psychological pathology, rather than a "legitimate" sexual orientation (Bogaert, 2006; Brotto, Knudson, Inskip, Rhodes, & Erskine, 2010; Lund & Johnson, 2015). In particular, asexuality is often differentiated from hyposexual drive disorder (HSDD; American Psychiatric Association, 2000, 2013; Brotto, 2010), a disorder marked by a lack of sexual attraction, desire, or fantasy that causes clinically significant distress or impairment (American Psychiatric Association, 2000, 2013). Scholars have generally used the distress criterion to distinguish asexuality from HSDD, with asexuality considered to be a lifelong lack of sexual attraction that does not cause marked distress or impairment (Bogaert, 2006).

However, the distinction between distressed and non-distressed individuals in and of itself can be troubling; although researchers have found that most asexual people do not experience distress as a result of their lack of sexual attraction (Brotto et al., 2010; Prause & Graham, 2007), it is certainly possible that some asexual individuals may experience minority stress or identity integration stress as a

result of their asexuality and the resulting marginalization (Cuthbert, 2017; Gupta, 2017; Pinto, 2014). Ironically, the pathologizing and medicalization of lack of sexual attraction may itself contribute to distress among asexual individuals (Gupta, 2017). This distress then may be mistakenly seen as causative of one's asexuality, rather than the other way around, thus creating an ironic and vicious cycle. Although researchers have found that identification as asexual is not consistently indicative of either medical or psychological pathology (Brotto et al., 2010), we must be careful to avoid assuming that distress in sexual minority individuals causes their sexual orientation (Gonsiorek, 1991) rather than examining possible mediating factors, such as minority stress (Meyer & Frost, 2013), that may better explain the relationship between sexual minority identification and distress and thus provide accurate and affirming avenues for intervention.

Indeed, this medicalization itself may act as form of violence against asexual people. They may face, for example, chronic invalidation of their sexual orientation, including assertations that it "must" be a medical or psychological issue (Gupta, 2017). They may face accusations of sexual repression, immaturity, or other psychopathology due to their lack of sexual attraction (Gupta, 2017). Additionally, asexual people with disabilities may face pressure to defend their asexuality as a legitimate sexual orientation in light of their disabilities and the already prevalent social tendencies toward the medicalization of asexuality (Cuthbert, 2017; Lund & Johnson, 2015). Regardless of disability status, the experience of such pervasive social doubt may cause asexual people to hide or attempt to change their sexual orientation, creating shame, doubt, and distress, as seen in other individuals who have attempted to change or obscure their sexual orientations (Flentje et al., 2014).

Isolation and Erasure

As noted earlier in the chapter, AVEN was formed, in part, out of a desire to reduce isolation and erasure among asexual individuals (AVEN, n. d.). Researchers have found that asexual individuals often feel isolated or "left out" in social situations and conversations that presume some sort of sexual attraction (Dawson et al., 2018; Gupta, 2017). Similarly, asexual individuals may or may not be welcomed in the larger sexual and gender minority community or feel that they belong in sexual and gender minority spaces (Dawson et al., 2018) while also feeling "left out" of heterosexual spaces (Gupta, 2017). This may create a deep sense of isolation and disenfranchisement among asexual individuals, leading them to seek asexual-specific spaces. Such asexual-specific spaces, as with all community spaces, have the potential to be both helpful and harmful (Dawson et al., 2018). They may provide a sense of recognition and shared experience and respite from feelings of "otherness" (Dawson et al., 2018). On the other hand, these spaces can, at times, be iatrogenic, especially for individuals with multiply marginalized identities (Cuthbert, 2017; Dawson et al., 2018) as they feel pressure to "prove" both their legitimacy and their value as a member of community. Thus, individuals may break from a large group to form smaller community spaces that are more welcoming to certain subsets of asexual people or they may break from the asexual community entirely (Dawson et al., 2018).

Along with isolation, erasure of asexuality identity remains a considerable and potentially harmful threat to asexual identities. Asexual individuals report that their identities are often doubted. For example, they may try to identify as asexual only be told that they will change their mind with time due to being a "late bloomer" or not having met the "right person" yet (Gupta, 2017). Similarly, asexual people may feel and be told that they are not "truly" oppressed and therefore do not fit into the larger narrative and history of the gender and sexual minority community (Dawson et al., 2018), although it is important to note that many asexual people also identify as being homo- or biromantic, transgender or nonbinary, or both (Miller, 2012) and thus may experience oppression and discrimination due to those aspects of their identities as well. This sense of erasure from within and outside of the gender and

sexual minority community can be harmful and lead asexual individuals to believe that their experiences are invalid and that their stories are not worthy of being told. It may also lead to pressure to continually assert both one's asexual identity and the legitimacy thereof, leading to fatigue and burnout (Dawson et al., 2018). Indeed, because sexuality is often considered core to being human, asexual people are often dehumanized (MacInnis & Hodson, 2012) or assumed to be inherently unfulfilled and missing out on a core pleasure in life (Prause & Graham, 2007).

Unwanted Sexual Experiences and Corrective Rape

Despite their lack of sexual attraction, many asexual individuals report having engaged in sexual behavior with a partner (Prause & Graham, 2007). This behavior can be positive and wanted, such as engaging in sexual behavior to bond with a romantic partner (Prause & Graham, 2007), but it can also arise from intense, unwelcome pressure to have sex into to appease someone or appear "normal" (Gupta, 2017). Although this unwanted sexual behavior may be *consensual* (e.g., if someone is willingly engaging in sexual behavior in order to please a partner despite a lack of innate sexual attraction), it may sometimes turn coercive or otherwise nonconsensual and thus enter the territory of possible sexual assault (Gupta, 2017). Additionally, the experience of trauma may be further used to delegitimatize the victim's asexuality, as a lack of interest in sexual behavior may be seen as a pathological reaction to trauma, even if the said lack of interest was long-standing and predated the sexual trauma.

Asexual individuals have also reported being the victims of "corrective rape"—alleged attempts to "cure," "turn," or "disprove" one's stated asexuality via sexual assault (Mosbergen, 2017). Corrective rape is a well-documented phenomenon among lesbian women, especially in Africa (Thomas, 2013), although the term "homophobic rape" is sometimes preferred due to the implied—and false—rehabilitative connotation of the term "corrective rape" (Chabalala & Roelofse, 2015). Corrective or phobic rape of asexual individuals has not yet been well-studied in the scholarly literature despite reports of it occurring within the asexuality community (Mosbergen, 2017) and is an area in need of substantial further study.

Conclusion

As often misunderstood, medicalized, and forgotten members of the gender and sexual minority spectrum, asexual individuals may face considerable isolation, erasure, prejudice, and even violence as they seek to navigate, understand, and embrace their asexual identity and experiences. Despite the potential challenges faced by asexual individuals—up to and including sexual violence—many asexual people report finding considerable comfort and even pride in accepting their asexual identity as a benign and positive part of their humanity and as a way of explaining and validating their experiences and finding community (Brotto et al., 2010; Cuthbert, 2017; Dawson et al., 2018; Gupta, 2017). It is vital that professionals understand and validate the experiences of asexual clients as well as the intersections of asexuality identity with romantic orientation, gender and gender identity, disability, and race and ethnicity (Dawson et al., 2018; Gupta, 2017; Lund & Johnson, 2015; Pinto, 2014) and provide an affirming, non-pathologizing environment for asexual clients, including those who have experienced violence and marginalization.

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Invisibility and Trauma in the Intersex Community

14

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Abstract

Much misinformation and myth surrounds members of the intersex community. Intersex is the most often ignored and misunderstood letter in the panoply of the queer community. Indeed inclusion of intersex in the queer lexicon is a still much-debated topic within the intersex community itself. This chapter untangles some of the mystery of what is intersex and what it means to be intersex. The history of treatment and, more importantly, mistreatment of intersex individuals by the medical establishment is discussed. The impact of the violent and systemic erasure of intersex bodies is examined on the societal, familial, and individual levels. How an individual's other identities, such as race and sexual orientation, intersects with their intersex identity is explored as well. This chapter looks at the history of intersex activism, its outcomes, and ongoing work.

Falling outside the staunchly held sex binary results in different traumas for intersex individuals. This chapter delves into the various spaces these traumas occur. The ways intersex individuals and communities have fostered healing, empowerment, and support for themselves are explained. Suggestions for how mental health providers can align themselves with and support these practices are provided.

On Being Invisible

The "I is for Intersex not Invisible" has been a recent motto of the intersex support and activism movements. Much of the mythology surrounding intersex relies on the belief that it is incredibly rare. Many intersex individuals have reported feeling isolated and alone often as a result of being told by doctors and caregivers that they are the only ones like them. Some are even unaware of their own status as intersex or have been advised not to reveal this to others. These circumstances contribute to the persistent narrative that being intersex is an extraordinary and therefore alarming occurrence. Using somewhat conservative methods, it is estimated 1.7% of the population is intersex (Intersex Society of North America (ISNA), 2008a), although some believe that number could be much higher (Davis, 2015). Because intersex identities and, quite literally, intersex bodies are being erased, it is difficult to know a true count.

The medical term for intersex is Disorders of Sexual Development or DSD. For reference,

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E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_14

DSD is listed as a specifier to Gender Dysphoria in the DSM-5 (American Psychiatric Association, 2013). For this chapter, the term "intersex" is used. There will be more on terminology later. For now, it is important to know these different terms also contribute to intersex invisibility.

I See You

I'd also like to take a moment to directly address anyone who is intersex (if you don't know you are intersex until later in this chapter or in life, I encourage you to come back to this paragraph): Hello, I see you. You are real. We are real. This is not just about you, but also for you.

What Is Intersex?

The term intersex literally means between sexes. To be intersex means that a person has genitals, reproductive organs, secondary sex characteristics, hormones, and/or chromosomes that fall outside the commonly known binary definitions of either male or female sex. As a refresher: sex is not the same as gender. Sex is based on karyotype, such as XX or XY chromosomes; genital presentation, such as a penis or vulva; organs used in reproduction, such as ovaries or testes; and the production or use of hormones such as testosterone and estrogen. Gender is society's or an individual's concept of man/masculine or woman/feminine. Gender is much more expansive than this explanation, and I only give this truncated version to highlight its difference from the concept of sex. As it turns out, sex is much more expansive also and intersex falls within this expanse.

A common misconception about intersex is that it means a person has two sets of "opposite" genitals. While this may happen in a sense in certain cases, it is the exception and not the rule. This belief may persist, because an outdated and derogatory term for intersex is "hermaphrodite." This term is based on the myth of Hermaphroditus, a Greek god whose story was used to symbolize the union of the masculine and feminine. This god is often portrayed with two sets of genitals. Some intersex people have reclaimed the term hermaphrodite, but unless an intersex person has specifically asked you to use the term for them, it should not be used.

Intersex can manifest in many different ways in different people. One of the things about intersex that sets it apart from other queer identities such as gay or lesbian is that it is traditionally medically defined. In this sense, it is similar to transgender identities. Though transgender is often defined in psychological terms, whereas intersex is defined in bodily terms. This isn't to say persons are defined as intersex by the medical establishment, but rather certain medical disorders (as defined by the medical establishment) or variations fall under the intersex umbrella. For this reason, there is some controversy over what is or isn't intersex. This also contributes to the debate over the number of intersex people in the population. It is also important to note that not all intersex people believe intersex should be considered part of the LGBTIAQ+ panoply. Because intersex is defined in medical or bodily terms, some believe that it is separate from other sex and gender minorities. Others see how the struggles of intersex people match those of other sex and gender minorities or LGBTQ+ community and believe alignment with this community is mutually beneficial in a combined struggle.

Table 14.1 below from interACT (2018), an intersex youth advocacy organization, gives an idea of some intersex variations and how they might present in a person and in the population. There is not enough space in this chapter to detail every possible intersex variation nor is it necessary in order to understand intersex experiences. This table highlights some of the vastly different permutations to intersex variations that exist. The term "virilize," in this instance, means to be considered what is commonly thought of as masculine in attributes. The term streak refers to tissue that might comprise an organ, but does not actually take the form of a particular organ.

The above table does not even come close to compromising a comprehensive list of variations that might fall under the category of intersex. That being said, even within some CAH

Table 14.1 Common intersex variations with their associated sex characteristics

Common parts of intersex variations	CAIS (complete androgen insensitivity syndrome)	Swyer or gonadal dysgenesis	CAHCAH (congenital adrenal hyperplasia)	Klinefelter's (47 XXY)
Karyotype	XY	XX or XY	XX	XXY
Gonad type	Internal testes	Streak	Ovaries	External testes (smaller than average)
Sex hormones naturally produced at puberty	Testosterone from testes	None	Estrogen and above average testosterone	Below average testosterone (may have breast development, infertility)
Androgen response	Convert to estrogen	Virilize	Virilize	Virilize
External genital appearance	"Typical" labia, may have vagina that is short	"Typical" labia	May be considered "ambiguous," e.g. large clitoris	Often "typical" penis, smaller than average testes
Frequency	1:20 k–100 k	1:150,000	1:20 k–36 k	1: 1100–1500

Adapted from interACT (2018). Intersex 101. Sudbury, MA: interACT Advocates for Intersex Youth. Published with permission of © interACT 2018. All Rights Reserved

(Congenital Adrenal Hyperplasia) circles, there is a belief a person shouldn't be considered intersex unless a person presents with "ambiguous" genitals. The controversies over the diagnosis of intersex, the counting of the population, and a comprehensive listing of any and all possible intersex variations could and has taken up more than one book's worth of information. Please check the Resources section below for more information.

Some Terms

As mentioned earlier, the term Disorders of Sexual Development or DSD is the medical term for having intersex variations. The use of DSD was established in 2006 as part of medical nomenclature. Before that time words such as intersex, hermaphrodite, and pseudo-hermaphrodite (to clarify that these persons did not indeed have two sets of genitals) were used almost interchangeably (Fausto-Sterling, 2000). The term DSD was set forth as part of a movement to try to regulate and have oversight over medical treatment of people, particularly children, with intersex variations. Beforehand, this treatment was determined by the doctors or medical facilities to which a person was admitted or born with little standardization of care across the board. The use of the term DSD was seen as a way to help doctors feel more comfortable with the concept of standardization of care. While this cause had good intentions, many in the intersex community find the term "disorders" to be stigmatizing or pathologizing. Although the term was adopted and some standardization in care did occur, this standardization did not include eliminating unnecessary surgeries or medical interventions. The term DSD furthers the concept that this is a condition that needs to be repaired or prevented, not that these conditions are naturally occurring variations. Some intersex variations do co-occur with other conditions that do need medical interventions, such as salt wasting/adrenal gland issues or interruptions to the flow of urine safely out of the body. However, the variations that define one as intersex are often cosmetic or conceptual and do not require treatment of any kind.

Some prefer the term "Differences of Sexual Development," which still uses the abbreviation of DSD. A minority are fine with the use of disorder and think of it as no more stigmatizing than a diabetic might think of their condition as a disorder of the pancreas. Most prefer the term "intersex." Others use intersex and DSD interchangeably. Within that, some use it as an identity, as in "I am Intersex"; some prefer using it as a description: "I have an intersex variation" or "I have a Difference of Sexual Development. Again a minority will use their specific diagnosis, such as "I am a CAIS woman." or "I am a woman

with CAIS." There are a rare number who have what they consider a Disorder of Sexual Development that they may or may not have sought treatment for and do not consider themselves intersex at all (which is different than those who know they have a particular DSD, but are unaware of intersex as an identity or description exists). Given the above, intersex is the most commonly used and accepted term. The word "intersexed" is incorrect and should be avoided. If possible, it is always best to ask a person their preferred term.

History

Much of the history of intersex treatment covered here is based on Western documentation of European and American origin, also known as the Global North. It is necessary to hold that other cultures and communities might have had widely different responses, histories, and advocacy movements.

As mentioned earlier, intersex variations are often seen as something that needs to be responded to medically. This was not always the case. Previous to the 1950s, if a person was born with an intersex variation, little was done medically. Babies were generally assigned a sex and gender, just like any other baby, based on the best guess of the adults in charge. Sometime later in life, a person might find that assignment to not be a good fit and adjust that accordingly, sometimes with little effort, sometimes with great difficulty, depending on their circumstances. Most of the intersex history previous to the 1950s has stories of a person discovered "to really be" a man or women (having lived a partial or full life as a different gender). At some point, medicine was able to provide some options for physical change in individuals if they wanted to do so, but adults took on these changes.

Some things shifted in the 1950s. The use of psychology to determine the differences between gender and sex was being explored. One particular psychologist, John Money, determined that gender had more to do with nurture than nature. Through a famously now discredited study of twins who were both assigned male at birth, but one raised as a girl and another a boy, he put forth the theory that if you raise a child as a certain gender, they will become that gender (Colapinto, 2000). This theory was applied heavily to children born with intersex variations (although the original case did not involve children with intersex variations). The concept was that if you determine a sex for them, change their genitals to match that sex through surgery, raise them as the gender that matches that sex and never, ever tell them what happened, then they would grow up psychologically sound. If you swayed from this path in any way, the child was predicted to grow up with a whole host of psychological issues. Although Money was the one to put forth this theory, its widespread use speaks more to the discomfort most of society had with variations in sex and gender. This took hold during a time when homosexuality was still considered a mental illness. Transgender was not even in our language yet, but its predecessors in language were also considered mental illnesses. Even when intersex variations did not include variations in genital appearance, other medical interventions, such as removal of gonadal tissue and hormone therapies, were used to "normalize" or reduce/remove intersex variations and move bodies toward binary presentations of male or female. Utilizing these options was seen as a way of preventing psychological issues couched as distress in the person over gender and sexuality. It can be argued that the continued use of surgery and medical interventions on intersex variations is still used as a preventative measure to the perceived issues of homosexuality and transgender identities. (Meyer-Bahlburg, Dolezal, Baker, & New, 2008).

Intersex individuals started to find each other and organize in the 1980s and early 1990s. They were children in the 1950s and 1960s who started to mature and learn the truth about their bodies and their lives. The Intersex Society of North America, ISNA, was formed in 1993 (Intersex Society of North America (ISNA), 2008b). On October 26, 1996, members of ISNA, some calling themselves "Hermaphrodites with Attitude," along with members of the group Transsexual

Menace, protested the American Academy of Pediatrics annual conference in Boston, MA, marking the first Intersex Awareness Day (Beck, 1997). With the advent of the internet, intersex individuals gained the ability to better find each other and organize. Many other intersex advocacy and support organizations formed, both in the USA and abroad. Internationally strides were made to ban intersex genital surgeries on children, also known as Intersex Genital Mutilation or IGM. In 2013, The United Nations Special Rapporteur on Torture classified IGM as an injustice, and ruled that such surgeries are always in violation of international law, arguably meeting the criteria to be classified as torture (Human Rights Watch, 2017). Both the countries of Malta and Portugal banned these surgeries. Even with these advancements, much of the treatment of children with intersex variations still involves surgeries and/or hormone therapies and continues to be shrouded in secrecy and shame. The legacies of those previous treatment protocols still live on in the current circumstances intersex individuals face.

Mental Health and Intersex

Medical Trauma

A specific concern to people who have received medical interventions for their intersex variations is the trauma incurred from these interventions. These interventions can involve the reduction of the glans or clitoris/penis and in some cases complete removal of the portion of the organ outside of the body. Other surgeries could be vaginoplasty: the creation or expansion of a vaginal canal. Another possibly is for hypospadias repair: closure or adjustment of a urethral opening that is not located in the tip of the glans, or penis, or larger than deemed suitable for a person considered male to urinate standing up. Other surgeries could involve removal of internal gonadal tissue or testes. Many of these surgeries are presented as medically necessary in order for a child to be "normal" or to prevent cancer. It is also important to note that "normal" is viewed through the lens of cisgender, heterosexual terms. In many cases, the urgency or danger is not true or not something that needs to be addressed in a young child. However, there are some cases in particular with hypospadias in which some interventions need to be made to ensure that urine can leave the body safely. All of these surgeries can lead to scaring and loss of nerve sensation. Not to mention the confusion and pain caused by having a surgery that a child does not fully understand, has not consented to, or has been misled about in areas of the body that feel particularly vulnerable. Some of these surgeries, such as vaginoplasty and hypospadias repair, require maintenance and possible further medical interventions or surgeries that can be further confusing and hurtful to children too young to understand fully. Removal of gonadal tissue is the removal of tissue that creates androgens such as testosterone. This tissue is often, though not always, removed unnecessarily under the guise it will become cancerous if it is not removed. The result is a person needing to be on some sort of Hormone Replacement Therapy for the remainder of their life, often without the full explanation of this consequence. Even when a person with an intersex variation does not receive surgery, they often receive other medical interventions such as androgen blockers or other hormone adjustments without their full knowledge or understanding of what it is or why it is being administered.

An important factor to recognize in medical interventions is the system of oppressions that might impact an intersex person and their family. Issues of language or cultural differences could prevent parents and children from communicating or accurately understanding the medical interventions, possible surgeries, and their outcomes or consequences. If medical providers do not hold a measure of cultural humility around working with patients with different cultural or language needs, they might not provide the same level of consultation and care as they would to someone with a similar language or cultural background (Dogra, Reitmanova, & Carter-Pokras, 2010).

Another circumstance to consider is that because intersex variations are seen as such a rare occurrence, many individuals are referred to

research and teaching medical facilities for care. This is so medical students, interns, and instructors can study them. With this study often comes the offer of free or reduced fee treatment. For a family with lower socioeconomic capitol, who does not possess medical insurance, and/or whose citizenship status is in question, there might not be any other choice, particularly if the intersex variation is co-occurring with a more serious medical need. This could also be the case if a child is considered in the care of the state. In these cases, the intersex person feels they must submit to possibly unneeded exams and tests, sometimes in the presence of many attendees. They may feel pressured to submit to surgery. Not submitting to exams, treatment, or surgery, particularly for a child, could be seen as neglect and could put the suitability of a parent into question.

Within the context of intersex variations being the subject of research is the matter of medical photography. There is a long history of photographing medical conditions for study; intersex variations have always been of particular interest. Often the subjects of these photographs are children; moreover, the photographs themselves are close-up images of genitals. In some cases, adults are photographed. The process of being photographed in this manner is invasive, dehumanizing, and traumatic (Creighton, Alderson, Brown, & Minto, 2002). The children being photographed cannot and do not consent to these photographs. In some cases where the parents/guardians of child subjects or adult subjects themselves give permission for the photography, they are often not informed correctly or completely about how these photographs may be used. Many do not realize these images could end up in textbooks for areas of study such as Human Sexuality or Human Development. The images could be used extensively and for years often without regard to the impact the use of these images can have. For intersex people finding these images in textbooks, often while in a classroom of their peers, as their conditions or the conditions of those similar to them are discussed in pathologizing and dehumanizing ways, can be traumatic. It can also invoke memories of previous traumatic events.

Another aspect to examine is the ways in which people of color, particularly black people, are assessed in medical settings. It is well documented medical providers tend to perceive black patients as having higher pain thresholds than other patients (Hoffman, Trawalter, Axt, & Oliver, 2016). Historically, people of color, again black people in particular, fall outside the standard concepts of gender, are often hypersexualized, and are seen as needing to be controlled (Arjini, 2018). These beliefs and prejudices could lead to more invasive and unnecessary treatment and surgeries on black and brown intersex children.

A case to consider highlighting many of these factors is that of M.C., a black, intersex child who received surgery to make his body have what is considered a more feminine appearance. This surgery happened while the child was under the care of the South Carolina Department of Social Services. Later this child identified as male and their then adoptive parents filed and won a malpractice suit arguing the surgery was unnecessary and caused both psychological and bodily harm (Ghorayhshi, 2017). This case is unique and the first to find this degree of success in fighting unnecessary treatment and surgeries on intersex children. However, it does show the many complicated layers of systemic oppression that could potentially affect the care of an intersex child.

Widespread studies on the psychological impacts of medical interventions on persons with intersex variations have not been conducted; however, much anecdotal and qualitative information has been reported to advocacy and support groups (Human Rights Watch, 2017). Studies have been conducted showing that trauma in childhood can have negative outcomes in adulthood (Copeland et al., 2018). There is contention among medical providers on whether medical interventions on intersex variations are traumatic. Many medical providers believe that if patients had issues, they would have heard back from them. Since they have received no such feedback, or they are easily able to dismiss the feedback they do receive as a disgruntled minority, they propagate the idea that those who have received medical interventions are happy with the results. In addition, they conflate the satisfaction of the

parents or caregivers with the satisfaction of the children themselves. The children's satisfaction or lack thereof is often absent or not considered. There is also sometimes a conflation of identifying with the gender assignment as satisfaction with the medical interventions. Just like non-intersex people, most intersex people identify with the gender they are assigned at birth. This does not mean they are as equally satisfied with the medical treatment they have received as intersex people.

Though disputed by some medical professionals, one of the most common concerns for intersex people is medical trauma. Nearly every intersex person, regardless of diagnosis or lack thereof, has had some sort of medical intervention they consider traumatic. Each story and history is unique, but they all seem to carry that same thread; so much so that many consider medical trauma a part of the intersex identity. Most intersex people start experiencing medical interventions when they are in childhood. Children, because of their lack of agency over their bodies, are particularly vulnerable to the negative impact of medical interventions. These could show up as an aversion to receiving medical care, dissociation during medical exams, a distrust of medical providers, anxiety, and depression as well as somatic responses such as freezing and muscle tension. There are many ways to manage and help alleviate medical trauma responses. Because medical providers often still pathologize, dismiss the concerns of, withhold information from, and are heavy handed in their treatment of people with intersex variations, it is essential to acknowledge and work with, but not minimize the trauma an intersex person may still be experiencing.

Gender, Sex, and Sexuality

Many intersex people report issues with intimacy and sexuality, especially since most medical interventions involve genitals or hormones. Not all intersex people have issue with sex and sexuality and one should not make assumptions. While most people, regardless of intersex or not, have anxieties around the appearance of their genitals, for persons with intersex variations, it can be particularly anxiety producing. Years of secrecy and shame can create hypervigilance around sex and sexuality. If a person had genital surgeries, there could be pain or a lack of sensation that can prevent a person from experiencing sexual pleasure whether with a partner or alone. Sexual desire and pleasure could be affected in cases where hormones have been manipulated. It is important to validate these anxieties and the harm a person might have received. It is also important to meet people where they are at and not to add pressure to the concept that they need to reach some societal concept of what is normal sexuality.

While most intersex people align with the gender they were assigned at birth, some do find that the gender assigned to them is not a comfortable one. Each intersex person often has their own concept of their sex and gender. Some people identify, for example, as an intersex man or woman. Some find that both their sex and gender are non-binary. For some, an examination of their sex and/or gender can happen when they learn of their intersex variation, while for others they may begin examining their gender and then find that they have an intersex variation later on. Sometimes, learning of their intersex variation can be anxiety producing and difficult. For others, it might feel like the feelings they have been having about their gender and bodies finally make sense. When an intersex person was assigned to a sex and subsequently a gender via surgery, the emotional and physical ramifications can be particularly devastating when they find they are not that gender. These sorts of discoveries can lead to feelings of anger, grief, rage, and depression, even suicidality. Even when surgery was not performed but other medical interventions happened to make an intersex person's body conform to a particular sex and gender binary, there can still be feelings of resentment, anger, and grief. Again it is important to validate their feelings and help them explore concepts of sex and gender outside of the confines of the binary model.

Another factor to consider is when an intersex person finds they want children and are unable to: either due to their particular intersex variation or

due to medical interventions they received. While not all intersex people want children and not all intersex people are infertile, it is a concern with which some intersex people grapple. The additional layer of being intersex can add to feelings of inadequacy, particularly within the gendered context infertility can bring to people. It can also highlight possible feelings of having a flawed or fallible body. It can also impact a person's perceived desirability by a relationship partner. Some intersex people choose to adopt children. As with any adoption, the accessibility of adoption can be affected by situations such as cross-cultural, cross-racial adoptions, and other forms of systemic oppression. Also, there are some intersex people who are adopted specifically from countries in the Global South into countries in the Global North. These children are often people of color adopted into white families. Sometimes these adoptive families themselves also have intersex family members, sometimes not. All of these different layers of identity and oppression can add to the texture of emotions involved in adoptions.

Personal Relationships

A concern many people with intersex variations have is around connecting with and trusting others. The root of these issues might be in the secrecy surrounding their intersex variation and the medical care they received. While many parents are advised to spare their children the truth, children are highly perceptive and will often determine something is being withheld from them and start to distrust whomever did not tell them the full truth. (Gweon, Pelton, Konopka, & Schulz, 2014). This early distrust of primary caregivers could result in difficulty trusting and forming bonds later in life, particularly when intersex people learn the truth about themselves and what has happened to them later. Attachment trauma can result when secrecy combines with disruptions to early attachment opportunities missed due to possible prolonged hospital stays or feelings of discomfort parents might experience with their child's intersex variation. Simultaneously, if a child repeatedly has their wants, needs, or desires unexplored and superseded by their caregiver's desires, these children might grow up to have difficulty determining what their own desires are and setting boundaries around them. Some intersex people report having trouble setting boundaries and determining their own needs and wants. It is important to note that most caregivers or parents are working from a place of wanting to do what is best for the child. While knowing that the intent was meant to be helpful, the result may often be a person who has difficulty making decisions, setting boundaries, and lacking a strong sense of self. Because these actions are centered around bodily integrity and issues of identity in particular, the ramifications can be even more intense.

How To Ally with Intersex People

The most impactful action to be helpful to an intersex person is to educate yourself about intersex issues. Use the Resource section from this chapter to read books, articles, blogs, and other resources. Most intersex people report having to educate teachers, medical providers, therapists, friends, and others about intersex issues. Hold in mind that even though you have gained some knowledge, an intersex person is still going to have the best understanding of their own experience.

Become involved in intersex advocacy. There are many ways to become involved, such as helping fund organizations, participating in protests, advocacy within organizations, business places and/or schools, adopting intersex inclusive language/policies, and spreading the word on social media. Find the intersex advocacy group(s) in the Resources section that aligns with your values and get more information.

If you work directly with intersex clients, remember not everything is about their intersex identity or variation. Do not assume all paths lead back to being intersex. That being said, familiarize yourself with the support groups and organizations listed in the Resources section. Most intersex people and/or their parents/caregivers report wanting peer support and community. Parents and caregiv-

ers should also receive mental health support. Do not assume medical providers have connected people with support or that a person will find support on their own. Some medical providers have been notoriously opposed to connecting people with intersex variations with support or will only connect them to groups who align with their ideas about medical interventions. Other provider are simply unfamiliar with support groups.

Working with Trauma

There is no one way to work with the different traumas an intersex person might have experienced. Familiarize yourself with how to work with presentations such as medical trauma, sexual trauma, and attachment trauma. Understand that a person might experience different traumas and that each distinct trauma may need specific attention. Do not base evaluations and treatment on one case presentation or the history of one particular intersex person. No two intersex people are going to be the same, even if they have the same intersex variation or they have the same gender identity, sexual orientation, or share a similar cultural background. Hold that each person's intersex identity might intersect with a variety of other identities that affect their life.

Resources: Nothing About Us Without Us

Whenever possible, intersex individuals or organizations produce the material unless otherwise noted.

Intersex Resources: interACT

https://interactadvocates.org/

Intersex Youth Advocacy Organization. Includes Political strategy campaigns, resources for Medical Providers, Friends, Family including publications and support resources.

Connected site specifically for advocacy actions: 4intersex http://4intersex.org/

Intersex Hospital Policy: Lambda Legal and InterACT

https://www.lambdalegal.org/publications/intersex-affirming

Includes information for any health provider.

AIS-DSD Support Group

http://aisdsd.org/

Support group for youth, adults, and families of people with AIS or other intersex variations. (in the future, the name of this group will be changing to InterConnect to be inclusive of all intersex folks and to avoid the DSD label).

Intersex Justice Project

http://www.intersexjusticeproject.org/

IG: intersexjusticproject.

Intersex POC lead activist organization.

Organizing End Intersex Surgery Campaign through grassroots efforts and on the ground protests.

Listening to Intersex Voices

There is no one Intersex story. Intersex stories are as various as there are intersex people.

Intersexion A documentary film about Intersex People (created with Intersex people).

Site: https://www.intersexionfilm.com/
To view: https://youtu.be/QQdOp3COfSs

The Interface Project Video project sharing the lived experiences of Intersex people created by intersex people.

https://www.interfaceproject.org/

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15 Interpersonal Violence Against Sexual and Gender Minority Individuals with Disabilities

Emily M. Lund

Abstract

Both people with disabilities and people who are gender and sexual minorities (GSM; i.e., LGBTQ+) experience elevated rates of violence victimization across the lifespan. However, there has been very little research on violence against people who are members of both the disability and GSM communities despite evidence that these individuals may be at even greater risk of victimization as a result of intersecting marginalized identities. In the present chapter, I provide an overview of the research on GSM people with disabilities, explore considerations specific to violence against people with disabilities, review the small body of literature on violence against this GSM people with disabilities, and discuss the challenges inherent in conducting this research. I also provide suggestions for research-supported best practices in working with GSM clients with disabilities.

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It is well-documented that people with disabilities are at increased risk for being victims of violence and abuse in childhood (Jones et al., 2012), adulthood (Hughes et al., 2012), and across the lifespan (Hughes, Lund, Gabrielli, Powers, & Curry, 2011). Similarly, people who are sexual minorities (Katz-Wise & Hyde, 2012) and/or transgender (Effrig, Bieschke, & Locke, 2011; Langenderfer-Magruder, Whitfield, Walls, Kattari, & Ramos, 2016) also experience increased rates of victimization throughout the lifespan. For people with disabilities and people who are gender and/or sexual minorities (GSM; i.e., non-cisgender, nonheterosexual, or both), this increased risk of victimization includes increased rates in peer victimization and bullying (Blake, Lund, Zhou, Kwok, & Benz, 2012; Friedman et al., 2011; Rose, Monda-Amaya, & Espelage, 2011) as well as intimate partner violence, child abuse, and other forms of interpersonal violence throughout the lifespan (Friedman et al., 2011; Hughes et al., 2011; Hughes et al., 2012; Jones et al., 2012; Katz-Wise & Hyde, 2012). Despite the consistently noted increased victimization across both these groups, however, the disability and GSM communities are often treated as separate entities with no overlap in membership, thereby further marginalizing and erasing people with disabilities who are also GSM and making it difficult to gain information on their experiences (O'Toole, 2000; O'Toole &

E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_15

Brown, 2002), especially as they relate to violence and victimization (Brown, 2017).

People with disabilities have been historically assumed to be universally asexual (Milligan & Neufeldt, 2001), thus often denying them the agency to identify as having a sexual orientation of any kind. Because of the erasure of disabled sexuality, people with disabilities are often denied any sort of access to information on sexuality or sexual health at all (Eisenberg, Andreski, & Mona, 2015; Medina-Rico, López-Ramos, & Quiñonez, 2018), leading to a lack of information on what constitutes healthy and unhealthy romantic and sexual relationships and behaviors, potentially increasing the risk for abuse. Furthermore, when the sexuality of people with disabilities has been acknowledged at all, heterosexuality is often assumed as a default, and any expression of same-sex or same-gender sexual attraction or behavior has been seen as inherently confused or deviant (Gomez, 2012; O'Toole, 2000) despite the fact that people with disabilities can and do identify nonheterosexual and/or transgender, experience same-sex sexual and romantic attraction, and engage in same-sex sexual and romantic behavior (Byers, Nichols, & Voyer, 2013; Dinwoodie, Greenhill, & Cookson, 2020; Nosek, Howland, Rintala, Young, & Chanpong, 2001). Ironically, even active identification as asexual—i.e., not sexually attracted to people of any sex or gender (see Lund, 2020, Chapters "Violence Against Asexual Individuals" and "Interpersonal Violence Against Sexual and Gender Minority Individuals with Disabilities", in this volume for further review)—among people with disabilities is sometimes met with resistance and doubt (Cuthbert, 2017; Lund & Johnson, 2015). This suggests that the "myth of asexuality" surrounding disability (Milligan & Neufeldt, 2001) is less about misunderstanding asexuality and sexual attraction and more about a desire to deny sexual identity and agency to people with disabilities, regardless of what form that identity takes. This interpretation is also reflected in the fact that professional discourse about sexuality and disability often focuses on strategies to reduce or eliminate sexual behavior and expression among people with disabilities (Powell, Andrews, & Ayers, 2016). People with disabilities who are also GSM not only have to navigate the stigma and barriers around disabled sexuality but also homophobia, biphobia, and transphobia and other anti-GSM attitudes and policies (Brown, 2017; Caldwell, 2010; Dinwoodie et al., 2020; Gomez, 2012; O'Toole, 2000; O'Toole & Brown, 2002). Thus, they face a level of intersectional and systematic erasure and violence that is not fully captured in either the disability or GSM victimization literature alone.

Violence Against People with Disabilities

People with disabilities face considerable social, physical, and attitudinal barriers to reporting and escaping violence (Lund et al., 2015; Oschwald et al., 2009; Saxton et al., 2001, 2006). For example, they may depend on the perpetrator for care or assistance with major activities of daily living, may not be believed when they report violence victimization, or may not report victimization for fear of losing independence due to being seen as vulnerable. Because people with disabilities face these additional barriers to reporting and escaping violence, they have historically been targeted for victimization by perpetrators who may see someone who is less likely to be believed or to be able to escape as an ideal victim, and violence against people with disabilities may in some circumstances even be seen as understandable or socially sanctioned due to the common conceptualization of people with disabilities as inherently "less than" and "burdensome" (Brown, 2017; Petersilia, 2001).

Additionally, the presence of disability may put individuals at risk for unique forms of violence—known as disability-related violence—that are not typically experienced by individuals without disabilities (Lund et al., 2019; McFarlane et al., 2001; Saxton et al., 2001, 2006). Disability-related abuse is typically conceptualized as taking two possible forms: (1) denial of care or assistance with an activity of daily living (e.g., bathing, eating, dressing, getting out of bed) or (2) destruction or denial of assistive technology

(e.g., wheelchairs or other mobility devices, communication devices, critical medical equipment). Of these two forms, denial of care or assistance is more common (Lund et al., 2019; McFarlane et al., 2001), although denial or destruction of assistive technology, although uncommon, can have massive effects on the victim's health and freedom (Saxton et al., 2001, 2006). Because these forms of abuse occur primarily in people with disabilities, they are often not included in studies, particularly larger and more general datasets (Hughes et al., 2011), and thus are unlikely to be included in studies with a primary focus on victimization of people who are GSM or people in the general population, even if disability status is included as a demographic variable.

In addition to the vulnerability to abuse created by disability status and the resulting marginalization and discrimination, violence and discrimination, including that faced by people who are GSM, can cause or contribute to physical or mental health issues that may become disabling (Foglia & Fredriksen-Goldsen, 2014; Mustanski, Andrews, & Puckett, 2016). Because the deleterious physical and mental health effects of victimization are well-documented, well-known, and can indeed be severe and potentially disabling (Nicolaidis, Curry, McFarland, & Gerrity, 2004), disability, particularly mental health disability, is often assumed to be an outcome of violence victimization rather than a potential risk factor for violence victimization (Coston, 2019). However, when researchers specifically ask whether participants who have experienced violence had a disability prior to the experience of violence, they find that the experience of disability often pre-dates the experience of violence. For example, Bonomi, Nichols, Kammes, and Green (2018) interviewed 27 randomly selected college students with disabilities who had also experienced intimate partner violence, sexual violence, or both in adulthood and found that the majority reported that their disability—most of which were mental health disabilities—was present when violence occurred. Thus, it is important to consider that the relationship between disability and violence, including mental health disabilities, may occur in either direction, with disability both increasing the risk for violence and placing victims at risk for potentially disabling physical and mental health effects. Neither providers nor researchers should assume that this relationship occurs in only one direction and should inquire about if a client's disability pre-dated the experience of violence in order to increase understanding of the issue and of a given client's situation (Bonomi et al., 2018; Coston, 2019).

Furthermore, violence victimization can also have an additive effect, creating new or worsening symptoms in people with preexisting disabilities (Bonomi et al., 2018; Coston, 2019). For example, in a sample of 350 adults with developmental disabilities, Hughes et al. (2019) found that experience of abuse, particularly experiencing multiple types of an abuse as an adult, was significantly related to poorer physical and mental health outcomes, even in this population of individuals with lifelong or early-onset disabilities. Thus, the relationship between disability and violence victimization may also be additive or even cyclical in nature—people with disabilities may be at increased risk for experiencing violence, and this violence victimization may result in additional or more severe disability. The resultant increased level of disability or impairment may then further increase the person's risk for further victimization, potentially creating a vicious and dangerous cycle of continual harm.

Victimization of GSM People with Disabilities

The experiences of people with disabilities who are also GSM are critically understudied, including their experiences of violence victimization. As members of multiple marginalized groups, people with disabilities who are also GSM often make up a small proportion of the sample even in relatively large datasets (Coston, 2019; Hughes et al., 2019). Thus, exploration of these issues is often limited by statistical issues—that is, the number of individuals who are both disabled and GSM in a given dataset is often too small for credible, comparative statistical analysis (Coston, 2019; Hughes et al.,

2019). As multiply-marginalized people, people who are both GSM and disabled may face considerable barriers to participation in many studies, and many researchers may not ask about both GSM and disability status in a single study. Thus, researchers who are interested in the experiences of GSM people with disabilities may have to deliberately seek out datasets that ask about both disability and GSM status and have a large enough sample of participants who identify as both. Additionally, researchers may have to purposefully recruit participants who identify as both GSM and disabled, requiring purposeful and targeted research design and recruitment. As a result, most studies of GSM people with disabilities rely on small sample sizes and are often qualitative in nature (Santinele Martino, 2017; Wilson et al., 2018), making estimates of prevalence or relative risk difficult.

Despite these limitations, there have been a few larger studies of violence victimization in GSM people with disabilities. In one such example, Coston (2019) analyzed data on intimate partner violence and disability in a large national sample of 3542 American bisexual and heterosexual women. She found that bisexual women were four times as likely as heterosexual women to be disabled when they experienced intimate partner violence (14.84% of bisexual women versus 3.37% of heterosexual women), suggesting that disability was a greater risk factor for violence among bisexual women than among heterosexual women. However, Coston also notes that the majority of women in the sample who reported that they had a disability, whether bisexual or heterosexual, were not disabled prior to the experience of intimate partner violence, again providing evidence that the relationship between disability and violence victimization can occur in either direction but that the intersection between disability status and bisexual identity may pose a particular risk for intimate partner violence victimization.

In another large-scale study examining the intersection between disability and sexual minority status, McGee (2014) analyzed a dataset of 7081 Oregon high school students and found that students who were both sexual minorities (lesbian, gay, bisexual, or questioning) and disabled were at the greater risk for victimization. Male sexual minority students with disabilities (adjusted odds ratio of victimization = 10.8) and female sexual minority students with disabilities (adjusted odds ratio of victimization = 4.0) both experienced increased rates of victimization relative to their heterosexual, non-disabled peers, although the increase in risk was greater among male students.

Smaller, qualitative studies also provide evidence of the common and detrimental experience of violence victimization among GSM people with disabilities. In their review of the literature on GSM people with intellectual disabilities, Wilson et al. (2018) found that experiences of vulnerability and marginalization were the most common topic discussed in studies, highlighting the unfortunately prominent place of harm and disenfranchisement in the lives of GSM people with disabilities. As Dinwoodie et al. (2020) highlight, this victimization is often overt, blatant, and frequent, including direct threats and acts of violence as well as more subtle acts of aggression. Combined with the results of the few larger-scale studies of victimization of GSM people with disabilities, these studies, along with the person narratives of GSM people with disabilities (O'Toole, 2000; O'Toole & Brown, 2002), provide preliminary evidence of the seriousness of violence against GSM people with disabilities and the critical need for additional research on this topic to further elucidate both the scope and nuances of this issue as well as to shed more light on the specific experiences of different subpopulations of the GSM disability community.

Interventions with GSM People with Disabilities Who Have Experienced Violence

People with disabilities have been historically marginalized in the development and delivery of services for survivors of violence. Relatively few published interventions exist that specifically address the needs of interpersonal violence survivors with disabilities (Lund, 2011; Mikton,

Maguire, & Shakespeare, 2014). Furthermore, more research, particularly methodologically rigorous research (e.g., randomized controlled trials), is needed in order to further establish the efficacy and effectiveness of these interventions across multiple trials and populations, so that people with disabilities who have experienced violence can access truly evidence-based interventions (Lund, 2011; Mikton et al., 2014). Additionally, more training and collaboration is needed in the field to ensure that both disability service providers and interpersonal violence survivor providers can provide truly culturally competent and accessible services to survivors with disabilities (Lund, Nelson, & Johnson, 2017). Survivors with disabilities have historically been bounced between disability services and victim services, with many providers lacking knowledge or competency across both areas (Chang et al., 2003; Swedlund & Nosek, 2000).

The struggle to find accessible and culturally competent services is even more pronounced for survivors with disabilities who are also members of other marginalized groups. Lightfoot and Williams (2009) found that many survivors of interpersonal violence who were both disabled and people of color reported extreme difficulty in finding services and providers who were competent in both disability and cultural and linguistic diversity issues and reported an implicit pressure to "choose" whether they wanted to receive services that were accessible and disability competent or ones that were racially, ethnically, and linguistically culturally competent. Of course, this dilemma, while real, ultimately forces a false choice—because identities intersect with each other, the experiences and needs of people from multiply marginalized groups are distinct from those of people who are members of only one such group, and different aspects of a person's identity and experiences cannot be compartmentalized nor picked up and dropped at will (Lightfoot & Williams, 2009). Thus, providers must be culturally competent across multiple domains, willing to listen to and center client needs and experiences, and willing and able to consult with experts in other areas as needed (Lund et al., 2017).

Similarly, providers who are working with clients who are both disabled and GSM must be willing and able to gain competence in both GSM and disability issues and to understand the intersection of those identities with others (e.g., race, ethnicity, gender, sex, socioeconomic status, religion, rurality) and how those various intersections shape the client's experiences. A key component of successfully working with clients who are GSM is affirmation of their sexual orientation and/or gender identity, including careful acknowledgment and navigation of the provider's own beliefs and biases and an acknowledgment of the social stigma and discrimination currently and historically faced by GSM individuals (Heck, Flentje, & Cochran, 2013). Likewise, providers also need to approach disability from an affirmative, culturally competent place in which they take into account the client's experiences and level of disability identity development as well as the historic and current context of ableism and disability-related prejudice and discrimination (Andrews et al., 2019). Indeed, both the disabled and GSM communities have faced—and continue to face—considerable oppression and invalidation. Thus, listening to the client's experiences and affirming both their inherent worth and the validity of their identities are key to building a strong therapeutic rapport. Only after developing a strong and affirming therapeutic rapport can the provider build a foundation of trust and openness that facilitates the provision of culturally responsive, meaningful, and effective services to address violence and its effects.

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Violence Against Queer and TGNC People of Color

16

Claire M. McCown and Lisa F. Platt

Abstract

The presence of violence is widespread in the queer/gender minority community. Certain subgroups of this population, including queer people of color (QPOC) and transgender and gender-nonconforming people of color (TGNCPOC), are at a heightened risk of experiencing violence related to their multiple minority identities. Both qualitative and quantitative research have found that queer and transgender POC experience elevated rates of systemic, interpersonal, and identity-related violence. The multiple minority statuses of race, sexual orientation, and gender identity represent compounded minority stressors for queer and transgender POC, indicating that additional minority identities increase an individual's risk for violence victimization.

This chapter illuminates the unique intersections of identity, oppression, and violence across contexts for queer and transgender POC. Additionally, this chapter provides an overview of the domains in which violence is experienced by queer and transgender POCs.

These domains include:

- Systemic violence
- Hate crimes and identity-related violence
- Intimate partner violence
- Family-of-origin violence

The text highlights resiliency factors and addresses the practical and applied implications of violence against queer and transgender POC. In addition, it provides a list of resources for survivors and allies.

Recent research has highlighted disparities in violence victimization and perpetration in the LGBTQ community (Edwards, Sylaska, & Neale, 2015; Hughto, Pachankis, Willie, & Reisner, 2017; Richmond, Burnes, & Carroll, 2012; Stotzer, 2009). However, much of the body of literature on this topic focuses on the experiences of White LGBTQ individuals (Smalley, Warren, & Barefoot, 2018) and fails to account for the unique experiences of people of color (Stotzer, 2009). Little attention has been paid to intersectional discrimination and violence against TGNC individuals, especially queer and TGNC and people of color. Previous work investigating racial/ethnic participant diversity revealed inconsistent findings related to victimization experiences of queer and TGNC racial/ethnic minorities (Sterzing et al., 2017). However, research has demonstrated that the spread of violence impacts queer and TGNC POC across systemic and interpersonal domains.

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E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_16

Systemic Violence

The reach of anti-queer and TGNC violence disproportionately affects communities of color. In addition to navigating daily concerns related to racialized violence and discrimination, queer and TGNC people of color are multiply marginalized due to their gender identities and sexual orientations. Racially diverse queer and TGNC communities are marginalized within dominant White LGBTQ spaces and often experience discrimination and violence within their racial heritage groups. The culmination of multiple minority stressors places queer and TGNC POC at an elevated risk for violence victimization.

Intersectionality and Racial Minimization

Violence against TGNC individuals is often minimized and whitewashed under the assumption of gender identity causality (Lamble, 2008). Transgender Day of Remembrance (TDOR) is observed across the globe annually on November 20 to memorialize those murdered because of their TGNC status. TDOR was established in 1998 to remember Rita Hester, a Black trans woman who was murdered in Boston, MA (Cava, 2014). However, the intersectional focus of TDOR has been lost over the years. While well intentioned, the memorialization practices of TDOR serve to universalize gender-diverse bodies in its causal attribution of violence. Without recognizing identity diversity, TDOR fails to acknowledge the role that White supremacy plays in the murder of TGNC people of color and the structural oppressions that silence the stories of victims (Cava, 2014). Lamble (2008) argues that TDOR memorials deracialize violence, thus producing White witnesses who perpetuate White privilege in their ability to ignore the overrepresentation of POC in TGNC murders. By isolating TGNC as the only identity explaining hate crime victimization, visibility efforts discriminate against TGNC individuals that are not White. The causal attribution of single-identity violence represents a logical fallacy in its incomplete conceptualization of intersectional identity victimization.

Racial discrimination can be especially complicated when sexual and gender minorities are White passing (Ziegler & Rasul, 2014). The marginalization of White passing queer and TGNC individuals perpetuates the erroneous belief that these individuals do not claim racially and ethnically diverse heritage culture groups. Further, many TGNC and queer POC feel invisible in predominately White LGBTQ communities and lament the White-centric nature of mainstream queer activism efforts (Ziegler & Rasul, 2014). Bowleg and colleagues found that Black lesbian participants largely viewed their experiences with sexism and heterosexism through the lens of racism, thus highlighting the saliency of racism in their everyday lives (Bowleg, Huang, Brooks, Black, & Burkholder, 2003). The complexities of daily intersectional violence and discrimination negatively impact queer and TGNC POC at the workplace, in school and medical settings, within the legal system, and in housing access.

Discrimination and Harassment

Systemic discrimination disproportionately affects queer and TGNC POC given the societal inequities related to racial, sexual orientation, and gender identity oppression. The National Transgender Discrimination Survey (NTDS) demonstrates high levels of systemic discrimination for TGNC POC (Grant et al., 2011). For example, respondents identifying as Asian American, South Asian, Southeast Asian, and Pacific Islander (API) experience significant discrimination and violence across multiple settings. Findings for Black respondents on the NTDS revealed that, similar to API respondents, almost half of Black respondents reported experiencing workplace harassment. Those self-identifying as multiracial on the NTDS reported staggering rates of school-based victimization (Grant et al., 2011). Violence victimization presents a nearly ubiquitous concern among American Indian and Alaska Native TGNC communities. Of those surveyed, 86% reported being

harassed at school from kindergarten to twelfth grade. These data highlight the multifaceted systemic discriminations faced by TGNC POC in different domains of life.

Healthcare Discrimination

Many TGNC individuals recount instances of discrimination and denial of life-saving healthcare procedures (Feinberg, 1998; Feinberg, 2001). Feinberg identified bigotry, poverty, and provider ignorance as the largest barriers to healthcare for TGNC folks (Feinberg, 1998). Historically, TGNC individuals have been denied treatment and ridiculed by healthcare providers because of their gender-variant expression (Cava, 2014; Gorton & Grubb, 2014; Klemmer, Arayasirikul, & Raymond, 2018; White & Goldberg, 2006). Many do not seek care because of previous negative interactions with the healthcare system, while others are denied coverage from insurers due to their TGNC status (Cava, 2014; Feinberg, 2001; Gehi & Arkles, 2007).

Research indicates that significantly fewer transgender POC have a primary care physician compared to Whites. Female to male (FTM) POC evidenced disproportionately low access to primary care (Kenagy, 2005). In one study, all participants reported receiving biased treatment from their healthcare providers (Elder, 2016). Several participants indicated that their therapists were uninformed on TGNC issues, while others described transphobic and homophobic interactions. Over 20% of American Indian and Alaska Native (AIAN) respondents to the US Transgender Survey (USTS) reported that a professional had attempted conversion therapy with them to "correct" their transgender identity (James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016). The blatant discrimination displayed by clinicians further underscores the need for comprehensive trainings to enable practitioners to better serve queer and TGNC POC.

Given that transgender identity is still frequently contextualized within the medical model, many states require documentation from healthcare providers verifying that an individual is receiving "appropriate clinical treatment" (Broadus & Minter, 2014). While the medical diagnosis of gender dysphoria (GD) enables many TGNC individuals access to gender-affirming care, it also perpetuates the view of gender variation as medical pathology. To access legal gender changes, many TGNC individuals must provide a letter from their healthcare provider documenting a history of care. This barrier disproportionately excludes poor TGNC individuals, those who cannot undergo surgical procedures, and those who do not require medical interventions to live authentically (Broadus & Minter, 2014). The interaction between legal and medical communities represents a distinct barrier for TGNC people of color from low-SES backgrounds (Broadus & Minter, 2014; Gehi & Arkles, 2007). Those who are unable to access gender-affirming care often resort to crimes of survival (i.e., sex work) which further exacerbate their risk of interpersonal violence (Gehi & Arkles, 2007; Nemoto, Bödeker, & Iwamoto, 2011).

Police, Policy, and Legal Protections

Queer and TGNC people of color experience considerable over-policing for misdemeanor and felony crimes in addition to targeted persecution related to their gender expression and sexual identity (Broadus & Minter, 2014; Gehi, 2012; Goodmark, 2013). Nemoto et al. (2011) found high rates of police harassment across racial groups in their study of trans women with a history of sex work. Other research indicates that police officers often fail to take accurate reports of hate crimes, fail to respond to calls for help from TGNC POC survivors, and arrest those reporting assaults (Goodmark, 2013). When incarcerated, queer and TGNC POC are often severely brutalized by inmates and guards alike (Broadus & Minter, 2014; Grant et al., 2011; Hagner, 2010). Further, TGNC people of color are often incarcerated in sex-segregated facilities incongruent to their gender identities and denied medical care (Broadus & Minter, 2014; Cava, 2014; Goodmark, 2013).

Housing and Public Accommodations

Queer and TGNC people of color are disproportionately discriminated against in housing access and public accommodations (Broadus & Minter, 2014; Grant et al., 2011). Many gender and sexual minorities experience homelessness as a result of family rejection, employment or housing discrimination, and poverty (Cava, 2014; Durso & Gates, 2012; Rhoades et al., 2018). Research assessing discriminatory experiences suffered by TGNC communities found that 20% of respondents had experienced homelessness and almost half had been denied equitable treatment in public accommodations, including businesses, restaurants, hotels, courts, and doctors' offices (Broadus & Minter, 2014; Grant et al., 2011).

Across racial groups, nearly one-third of National Transgender Discrimination Survey (NTDS) respondents reported being denied access to emergency housing (Grant et al., 2011). When coupled with racial minority status, this statistic increased dramatically. Across racial groups, nearly half of all NTDS respondents reported that when allowed into emergency housing, they were forced to live as the wrong gender in order to stay in the shelter (Grant et al., 2011). Threats of discrimination and violence may also prevent many people from seeking shelter. Further, when victimized within emergency housing, the burden of reporting crimes serves as an additional barrier for many people with a history of negative interactions with the police or legal system (Broadus & Minter, 2014).

Resiliency

While transgender, gender-nonconforming, and queer people of color evidence disproportionate risk for violence victimization, these groups of individuals also report remarkable resiliency in response to systemic inequities and identity violence. Qualitative research with transgender POC has found that pride in one's racial/ethnic and gender identities promoted resiliency after experiencing trauma and hardships (Singh, Hays, & Watson, 2011; Singh & McKleroy, 2011). Additionally, the researchers learned from participants that engaging in community activism with other transgender people of color enabled survivors of violence to not only access TGNC-affirming services but also provided them with a platform to speak to their experiences of violence and grow from them. Qualitative research with transgender veterans reported similar findings, noting that trans-vets identified community connectedness, activism efforts, and identity pride as resiliency factors after experiencing discrimination and violence (Chen, Granato, Shipherd, Simpson, & Lehavot, 2017).

Quantitative and theoretical work has also explored the importance of resiliency in gender diverse and nonheterosexual racial minority individuals (Bowleg et al., 2003; Hendricks & Testa, 2012; Meyer, 2015). Meyer (2015) noted the importance of identifying resilience as a counterpart to stress in sexual and gender minority health research. Of particular importance, Meyer argued, are the psychosocial benefits of community resilience. Instead of relying solely on the individual's personal agency and self-efficacy in resiliency efforts, community resilience is guided by ecological context, such that groups of individuals experiencing the same stressors bond and grow from their shared tribulations (Meyer, 2015).

A common finding across this line of research was the role of spirituality in resiliency (Bowleg et al., 2003; Cerezo, Morales, Quintero, & Rothman, 2014; Singh, et al., 2011; Singh & McKleroy, 2011). Participants across studies cited religion and spirituality as a source of strength and an effective manner of coping with minority stress. Further, multiple studies endorsed community building and internal characteristics, including self-esteem and optimism, as unique mechanisms of resiliency among sexual and gender minority POC (Bowleg et al., 2003; Forbes, Clark, & Diep, 2016; Meyer, 2015). Given that resiliency serves as a buffer against negative health outcomes associated with stress and identity violence, it is imperative that researchers, practitioners, activists, and educators continue exploring the nuances of resiliency in sexual and gender minority POC.

Hate Crimes and Identity Violence

National and Community Reports

Violence committed against queer and TGNC individuals, especially communities of color, is often underreported due to negative police interactions, perceptions of discrimination, and stigma. Nevertheless, research demonstrates that sexual and gender minority people of color are among the most highly victimized population. Hate crime victimization is particularly severe for TGNC women of color. Several nationwide reports have detailed such hate crime violence, while other studies have assessed victimization experiences of refugees and community reactions to the Pulse Nightclub massacre. Additionally, research has explored the stress of attribution ambiguity associated with intersectional hate crime victimization for LGBTQ POC.

In 2016, the Human Rights Campaign (HRC) and the Trans People of Color Coalition (TPOCC) published a report detailing fatal violence committed against TPOC (HRC & TPOCC, 2016). Multiple variables impact the accuracy of these statistics, including postmortem misgendering by media, police, and the victim's community. The data therefore likely underestimate the number of transgender people murdered in the United States. The HRC and TPOCC report identified 21 transgender people who were murdered since the beginning of 2016. Of those killed, 95% were people of color (POC). In 2017, the number of transgender people murdered in the United States rose to 28, the highest ever recorded in the United States. So far in 2019, 22 transgender individuals have been killed (HRC, 2019; HRC & TPOCC, 2017).

Since its inaugural inclusion of gender-identity biased hate crimes in 2013, the annual Federal Bureau of Investigation (FBI) hate crime statistics report has tracked crimes committed against the TGNC community. In 2013, gender-identity bias violence accounted for 0.5% of cases reported to the FBI, while anti-LGBQ violence comprised 20.2% of cases. Racial hate crimes accounted for 49.3% of cases in 2013. The 2017 publication revealed an increase in racialized violence (59.6%) and anti-TGNC violence (1.6%) but a decrease in anti-LGBQ violence (15.8%). While the FBI reports do not parse apart person variables related to multiple-bias assaults, FBI race-bias statistics indicate a rise in minority race-bias crimes (Hate Crime Statistics, 2014, 2018). This increase in racialized violence, coupled with current research detailing the overrepresentation of violence against TGNC and queer POC (Balsam, Huang, Fieland, Simoni, & Walters, 2004; Balsam, Lehavot, Beadnell, & Circo, 2010; Klemmer et al., 2018), indicates that POC likely comprise a significant portion of those victimized.

An analysis of hate crime victimization in Los Angeles County from 2002 to 2006 revealed 49 reported victimization experiences of TGNC individuals (Stotzer, 2009). Of the crimes reported, nearly half were batteries or assaults. Most reports detail direct attacks on the person, with six cases related to verbal threats and harassment. The majority of hate crimes were perpetrated in areas with high poverty levels and high concentrations of racial minority individuals (Stotzer, 2009).

Refugee Violence

Experiences of identity-related violence can be especially salient for LGBT persons seeking asylum in the United States after being tortured in their country of origin (Hopkinson et al., 2016). The authors found staggering disparities in violence victimization between LGBT and non-LGBT groups. Those identifying as LGBT were more likely to suffer family of origin violence and to have experienced their first persecution during childhood (Hopkinson et al., 2016). Additionally, LGBT asylum seekers reported a history of sexual violence significantly more than non-LGBT respondents (Hopkinson et al., 2016). Findings from this study underscore the unique minority stressors faced by LGBT refugees.

Transgender women of Latin American descent represent a population with heightened risk of interpersonal violence related to gender identity. Due to their multiple minority statuses, Latin American transgender women often expe-

rience discrimination and abuse during their migration to the United States. While seeking asylum for their gender identity, many individuals experienced significant stressors related to their legal status in the United States and discrimination related to their racial-ethnic background (Cerezo et al., 2014). Many transgender Latin American women in the study reported fleeing their home countries for fear of violence and threats of death related to their gender identity (Cerezo et al., 2014).

Pulse Nightclub Shooting

Research has demonstrated the devastating impact of hate crime violence affects immediate victims and community members (Jackson, 2017; Stults, Kupprat, Krause, Kapadia, & Halkitis, 2017). After the Pulse Nightclub shooting in 2016, the second deadliest mass shooting in American history, LGBTQ psychology graduate students reported feelings of anger, sadness, and fear (Jackson, 2017). Racial minorities in the LGBTQ community acutely experienced the impact of this violence as the mass shooting occurred during the club's Latinx Night. Many respondents identified concerns related to intersectional identity-based violence. A spokesperson for Florida's Hispanic community estimated that over 90% of Pulse victims were Latinx (Thrasher, 2016). Equality Florida, an LGBTQ civil rights advocacy organization, reported statistics disseminated from the Florida Attorney General that LGBT hate crimes accounted for 22% of state-wide bias-based violence, second only to race-related victimization (Equality Florida Action, 2018).

However, other research found racial identity to be less predictive of psychological distress post Pulse when compared to respondent gender identity and sexual orientation identity (Stults et al., 2017). In one study, Stults and colleagues reported that gender identity and sexual orientation, but not race, were correlated with elevated safety concern for self and others. Female-identifying and genderqueer respondents expressed increased personal safety concern compared to male participants. Additionally, female, genderqueer, and transgender respondents expressed elevated concerns for peer safety compared to cisgender male participants. Stults and colleagues concluded that cisgender male privilege served as a protective factor related to safety concerns after the Pulse massacre (Stults et al., 2017).

Community responses to the Pulse Nightclub shooting revealed concerns related to intersectionality across LGBT-POC (Ramirez, Gonzalez, & Galupo, 2017). Similar to issues identified by Lamble (2008) regarding the whitewashing of TDOR, Ramirez and colleagues highlighted the lack of intersectionality in sensationalized media coverage of the Pulse atrocity. While the Pulse shooting received extensive media coverage, the majority of stories covering the shooting presented the tragedy as a singular identity attack against sexual minorities. Media coverage failed to provide space for a discussion of racialized anti-LGBTQ violence. Participants expressed that experiences of racialized violence are ubiquitous in the LGBTQ population but are often erased in public discourse. Further, participants reported lack of intersectional support from not only the media but also their communities (Ramirez et al., 2017.

Homophobia, Transphobia, and Attribution Ambiguity

Differences in victim interpretation for perpetrator motivation of violence have emerged across racial backgrounds. Research has reported that, compared to White gays and lesbians, QPOC and TGNC POC attribute their experiences of violence victimization to multiple identities (Meyer, 2008; White & Goldberg, 2006). Additionally, queer and TGNC POC often expressed ambiguity in the rationale for violence committed against them. Within racial minority groups, differences emerged across gender and sexual minority identities regarding the severity and contextualization of anti-queer violence (Meyer, 2012). Meyer attributes the discrepancy in interpretation between White and POC respondents as a result of privi-

lege and intersectional oppression (Meyer, 2008). Queer and TGNC POC hold multiple marginalized identities, thus heightening the complexity of disentangling perpetrator rationale for violence. Female identity, transgender status, and minority race identity culminate in multiple and simultaneous intersectional oppressions. The stress of attribution ambiguity often forces the victim to not only re-experience the victimization scenario to discern meaning but also burdens the survivor in accessing support from a community that truly understands their intersectional oppression.

In a sample of predominately TGNC POC adults, one study found that nearly half (43%) of respondents had experienced physical, sexual, or relational violence (Xavier, Bobbin, Singer, & Budd, 2005). In a sample of Brazilian men who have sex with men (MSM), researchers found that roughly 16% of respondents had experienced sexual violence (Sabidó et al., 2015). Among those surveyed, the majority reported experiencing sexual violence from acquaintances. Another research team reported that compared to White TGNC participants, Black TGNC respondents demonstrated significantly higher odds of experiencing sexual assault (Coulter et al., 2017). Participants in Xavier and colleagues' study reported homophobia and transphobia as the most common motives for violence committed against them. These findings underscore not only the disproportionate risk of violence victimization for TGNC POC but also the alarmingly high correlation between violence victimization and positive HIV status.

Intimate Partner Violence

To fully understand the impact of intimate partner violence (IPV) against TGNC and QPOC, violence victimization and perpetration must be viewed through an intersectional lens (Sokoloff & Dupont, 2005). Experiences of domestic violence victimization are often interpreted through traditional feminist viewpoints. The overrepresentation of White feminists in efforts to combat domestic violence has led to the erasure of lived experiences of women of color. In an effort to unify feminists, the anti-violence movement adopted the stance that IPV impacts cultural groups equally. This viewpoint fails to appreciate how intersectional marginalizations impose systemic barriers and structural inequalities on non-White queer and TGNC survivors of domestic violence. African American women and lesbians, for example, may not report violence for fear of police discrimination and stereotype threat (Sokoloff & Dupont, 2005). The intersections of multiple social identities must guide our understanding of IPV experiences for queer and TGNC people of color.

National Statistics

In 1998, The National Coalition Against Domestic Violence (NCADV) reported that 50% of transgender and intersex respondents had been raped or assaulted by their intimate partners (Courvant & Cook-Daniels, 1998). This statistic is comparable to results of the 2015 US Transgender Survey (USTS), which reported that over half of Black and Latinx transgender respondents had been sexually assaulted (James, Brown, & Wilson, 2017). Latinx individuals with disabilities (60%) reported significantly more sexual assault victimization compared to able-bodied peers (James & Salcedo, 2017). American Indian and Alaska Native (AIAN) USTS respondents also endorsed elevated rates of intimate partner violence, physical violence, and sexual assault. Respondents expressed experiencing coercive control from their partners related to their TGNC status, often in the form of withholding hormones or threats of outing (James, Jackson, & Jim, 2017). Nationwide IPV statistics indicate that roughly one-third of women and one-quarter of men experienced IPV in their lifetime (Black et al., 2011). The overrepresentation of TGNC and intersex survivors of violence victimization is further heightened when compounded with minority race identity.

The National Coalition of Anti-Violence Programs (NCAVP, 2010) gathered data regarding IPV experiences in LGBTQ and HIV-affected individuals. While NCAVP expe-

rienced an increase in IPV reporting from 2009 to 2010, survivors were much less likely to report such violence to the police (NCAVP, 2010). Almost half of all survivors of IPV were people of color, and nearly half were turned away from emergency housing after experiencing abuse. Another study conducted with Brazilian MSM supported these findings, in that over 90% of respondents did not discuss their experiences of sexual violence with a healthcare professional or report it to the police (Sabidó et al., 2015).

Topography of Intimate Partner Violence

Intimate partner violence against queer and TGNC individuals may include physical, sexual, economic, and emotional abuses that are specific toward a person's TGNC status. For TGNC individuals, physical and sexual abuse can include disfigurement and assault toward specific body parts culturally associated with gender presentation (White & Goldberg, 2006). Individuals who have undergone physical changes to align their external appearance with their internal sense of self may have these body parts targeted by their abusive partners. In addition to suffering from trauma-related stress, survivors may also experience an increase in negative emotions related to gender dysphoria. TGNC POC may also experience economic control, including denial of financial support for transition-related medical costs and financial exploitation. Emotional abuse can include verbal harassment and denigration of one's gender-variant appearance and threats of outing an individual as TGNC (White & Goldberg, 2006).

The looming threat of being outed as queer and/or TGNC carries with it a host of possible negative outcomes, including risk of losing employment, housing, and violence outside of the relationship (Ard & Makadon, 2011; Broadus & Minter, 2014; Kulkin, Williams, Borne, De la Bretonne, & Laurendine, 2007). Abusive partners may also control queer and/or TGNC individuals with threats of taking an individual's children away from them if they attempt to leave the relationship. Those who have children may also be disinclined to report IPV because of discrimination from the legal system (Broadus & Minter, 2014; Kulkin et al., 2007). Abusers often capitalize on the minimization of anti-LGBTQ violence by convincing partners that they will not be believed if they report IPV to authorities (Broadus & Minter, 2014). The social and legal stigma associated with LGBTQ identities makes gender diverse and queer people especially vulnerable to domestic violence (Kulkin et al., 2007). These forms of violence are specific to queer and TGNC individuals and, coupled with unequal legal protections and resources in a homophobic and transphobic society, may prevent survivors from seeking help (Ard & Makadon, 2011; Kulkin et al., 2007).

IPV Resource Disparities

Many domestic violence survivor shelters admit residents based on an individual's sex assigned at birth, thus failing to recognize the needs faced by transgender survivors (Broadus & Minter, 2014; Cava, 2014; Goodmark, 2013). Trans women turned away from survivor shelters are often directed to homeless shelters designed for cisgender men. The risk of violence toward trans women in these settings often increases dramatically. When interacting with the legal system, TGNC POC survivors of domestic violence are often not taken seriously given the court's preconceived view that violence victimization is a by-product of any previous experiences with survival sex. This is a fallacious and damaging conclusion that stereotypes all TGNC people of color as sex workers. The daily discrimination faced by TGNC and queer POC when seeking supportive services decreases the likelihood that survivors will engage with a legal system that oppresses many of their identities (Ard & Makadon, 2011; Goodmark, 2013).

Research has highlighted racially based distinctions in experiences of intimate partner violence (IPV) among LGBQ women in same-sex relationships (Balsam & Szymanski, 2005). The

authors noted that queer women of color evinced statistically significantly more violence victimization and perpetration within same-sex relationships. The bidirectional violence is congruent with other research conducted with sexual minorities (Carvalho, Lewis, Derlega, Winstead, & Viggiano, 2011; Lewis, Mason, Winstead, & Kelley, 2017). Given the intersectional marginalization faced by queer and TGNC people of color, these findings support the need for specific services and resources for queer and TGNC POC experiencing intimate partner violence.

Victimization Risk Factors

In a study conducted with racially diverse LGBTQ young adults (ages 16–20 at baseline), researchers found that those endorsing female gender, MTF transgender status, and Black/African American racial identity were significantly more likely to have experienced IPV (Reuter, Newcomb, Whitton, & Mustanski, 2017). Across varying forms of IPV, Black/African American respondents evinced elevated risk of victimization compared to White, Latinx, and other racial groups. These findings build upon prior research in understanding the multiplicative effect of intersectional identities in experiences of minority stress and interpersonal violence. In addition, IPV victimization negatively impacted health behaviors, including increased likelihood of condomless sex acts (Reuter et al., 2017). These findings indicate that IPV survivors not only experience mental health difficulties related to victimization but may also engage in behaviors that increase their risk for subsequent victimization and physical health risks.

There are multiple variables implicated in intimate partner violence victimization for LGBTQ individuals, including immigration status and cultural background (Ristock, 2005). This vulnerability may be especially apparent in the context of White privilege and perceived superiority over racial minority partners. Racist abusers may exert oppressive control over their POC partners and further marginalize them in a society that socially devalues racial minorities. Similar to findings related to bidirectional violence in LGBTQ relationships (e.g., Lewis et al., 2017), Ristock (2005) reported that the cumulative impact of intersectional discrimination can lead to increased vulnerability for violence victimization and perpetration. Given that the size of one's cultural community becomes increasingly smaller with the overlap of multiple marginalized identities, individuals from intersectionally oppressed groups may be less likely than other groups to speak out against or leave their abusive partners (Ard & Makadon, 2011; Ristock, 2005). The discrepancy of resources and public support provided to White female IPV victims and cultural judgments of inferiority relegated to non-White survivors may preclude non-White survivors from reporting violence victimization (Ristock, 2005).

Family-of-Origin Violence

Many LGBTQ individuals experience violence from their family of origin. Family-of-origin violence may begin in childhood with physical, sexual, and emotional abuse. Violence victimization may also stem from revealing one's sexual and/or gender minority status to family members. Coming out to family members can result in familial rejection, violence, and negative psychological functioning.

Balsam et al. (2004) evaluated experiences of trauma in American Indian and Alaskan Native (AIAN) individuals residing in New York City. Participants self-identified as heterosexual, lesbian, gay, bisexual, or two-spirit. Two-spirit refers to AIAN and Canadian First Nations people who embody variations of masculine and feminine spirits (Anguksuar, 1997). Participants in the study endorsed more experiences of sexual and physical abuse compared to heterosexual AIAN respondents (Balsam et al., 2004). Similarly, Lehavot, Walters, and Simoni (2010) found that nearly approximately 80% of LGB and two-spirit respondents had experienced physical and sexual assault, with the majority of respondents identifying family members as their assailants. The existing body of work regarding AIAN health details multiple disparities in men-

tal health disorders between AIAN populations and non-Native peers, including increased suicidality, substance use, depression, posttraumatic stress, and domestic violence (Beals et al., 2005; Gone, 2004; Gone, 2007; Lehavot et al., 2010).

In 2005, Kenagy (2005) published a needs assessment of transgender individuals residing in Philadelphia. Nearly 70% of participants reported lifetime violence victimization across multiple domains (Kenagy, 2005). Over 50% of participants endorsed being forced to have sex at some point in their lives, experiencing violence in their homes, and being physically abused. Male-to-female (MTF) respondents were significantly more likely to have reported each of the aforementioned classification of violence.

Parental rejection upon discovering their child's transgender identity often leads to violence victimization, harassment, and hostility (Koken, Bimbi, & Parsons, 2009). Koken and colleagues reported that 40% of participants endorsed being victims of familial aggression after coming out as trans women. Respondents endorsed myriad forms of abuse, including verbal harassment, physical violence, and forced displacement from the home. Further, many trans women of color reported feeling unwelcome in their childhood homes and chose to leave after they came out as transgender due to perceived threats to personal safety.

The impact of family violence and rejection can be seen in suboptimal psychological functioning. A study conducted with LGBTQ youth found that those who experienced parental rejection or had disclosed their LGBTQ identity to their parents were significantly more likely to experience homelessness (Rhoades et al., 2018). Further, LGBTQ youths with a history of homelessness reported higher levels of depression, hopelessness, and perceived burdensomeness compared to non-homeless LGBTQ peers. Reisner and colleagues found that those endorsing POC identity, high visual gender nonconformity, childhood abuse, and multiple attributions for discrimination evidenced increased everyday discrimination (Reisner et al., 2016). Additionally, higher everyday discrimination, childhood abuse, multiple attributions for discrimination, and social gender transition were significantly associated with higher PTSD scores.

Conclusion and Future Directions

This chapter sought to highlight research findings related to violence victimization in queer and TGNC POC populations. Violence is present in multiple domains of daily life for these populations, including systemic violence and discrimination. Interpersonal violence is also widespread among queer and TGNC POC, including hate crime victimization, intimate partner violence, and family-of-origin violence. The findings reported in this chapter provide a clearer topography of identity-based violence victimization inflicted upon these communities, but additional research is needed to better understand the unique needs of queer and TGNC POC.

Future research should continue to explore resiliency and coping in the context of identity-related violence and trauma. Previous work has elucidated resiliency factors in queer and TGNC POC, including gender and racial/ethnic pride, identifying and negotiating gender and racial/ethnic oppression, community connections, spirituality, familial relationships, and healthcare and financial resource access (Singh & McKleroy, 2011). By building upon this research foundation, future scholarship can illuminate protective factors against identity-related violence.

Forthcoming scholarship should explore stage models of identity development in relation to oppression and violence. Given the relation between racial identity development and recognition of discriminatory violence, scholars should explore how TGNC identity development relates to interpretation of anti-LGBTQ violence. Additionally, future avenues of research should endeavor to understand if and how the recognition of oppression relates to self-esteem, self-acceptance, and appreciation of intersectional identities. Further, future research should explore the relation between activism and resiliency, spirituality and hope, and community connectedness in relation to identity violence. Given the impact

of violence on multiple facets of daily living, research should expand on coping mechanisms and preventive strategies to attenuate negative psychological, physiological, and social functioning outcomes.

Practical and Applied Implications

By better understanding the presentation, scope, and impact of violence committed against queer and TGNC people of color, helping professionals can better serve members of this distinct and heterogeneous population. In healthcare settings, providers should embody an accepting environment through diversity representation in office paperwork and pamphlets, correct pronoun usage, and overarching cultural humility. Additionally, those serving queer and TGNC people of color should engage in thorough self-education regarding community needs, strengths, and specific concerns.

Gender identity and sexual orientation curriculum and continuing education trainings should be incorporated into standard education for healthcare professionals to decrease barriers to care for gender diverse and sexual minority populations. Further, clinicians should also engage in introspective self-examination regarding their own biases and stereotypes regarding racial/ethnic, gender, and sexual orientation minorities. In psychological treatment, clinicians should identify general, community, and counseling supports that can mitigate some of the burden of intersectional minority stress on members of this community (Weir & Piquette, 2018).

The information presented in this chapter can also enable helping professionals to become more authentic, credible, and impactful advocates. Effective advocacy begins with self-examination of biases and responsiveness to community needs. Allies should engage with the community to elicit information related to strengthening and supporting queer and TGNC people of color (Singh, Richmond, & Burnes, 2013). Advocates must be careful, however, to avoid tokenizing and overburdening individuals already afflicted by interpersonal and structural intersectional violence. Those interested in learning more about queer and TGNC POC needs may wish to consider engaging with the following resources:

- Erickson-Schroth, L. (Ed.). (2014). *Trans bodies, trans selves: A resource for the transgender community*. New York, NY: Oxford University Press.
- Singh, A. A., & dickey, lore m. (Eds.). (2017). *Affirmative counseling and psychological practice with transgender and gender nonconforming clients*. Washington, DC: American Psychological Association.
- Skinta, M. D., & Curtin, A. (Eds.). (2016). *Mindfulness & acceptance for gender & sexual minorities: A clinician's guide to fostering compassion, connection & equality using contextual strategies*. Oakland, CA: Context Press.
- Sue, D. W., & Sue, D. (2016). *Counseling the culturally diverse: Theory and practice*. Hoboken, NJ: John Wiley & Sons, Inc.
- https://www.apa.org/pi/lgbt/resources/guidelines APA guidelines for working with sexual and gender minority clients
- https://fenwayhealth.org LGBTQ+ focused health research center located in Boston, MA
- https://www.hrc.org The Human Rights Campaign is the largest LGBTQ+ rights organization in the United States
- https://pflag.org Parents and Friends of Lesbians and Gays provides resources and advocacy tools for allies of the LGBTQ+ community
- https://www.samhsa.gov/behavioral-health-equity/lgbt Research related to behavioral health trends across sexual and gender minority populations
- https://transequality.org Advocacy agency focused on policy change impacting gender minority populations
- https://transpoc.org Social justice organization promoting the concerns, needs, and interests of transgender people of color

Survivor Resources

- For Ourselves: Reworking Gender Expression (FORGE)
  - FORGE is a national, federally funded, transgender anti-violence agency that works with national providers and TGNC survivors of intimate partner violence, sexual assault, and stalking.
  - Website: https://forge-forward.org
  - Telephone: (414) 559-2123
- The New York City Anti-Violence Project (AVP) & National Coalition of Anti-Violence Programs (NCAVP)
  - AVP provides a 24-hour bilingual hotline for sexual and gender minorities to report harassment and assault. AVP also provides support services to violence survivors through advocacy, free legal services, and counseling.
  - Website: https://avp.org (AVP); https://avp.org/ncavp/ (NCAVP)
  - Telephone: (212) 714-1184; (212) 714-1141 (Spanish/English hotline)
- LGBT National Help Center
  - The LGBT National Help Center provides confidential peer support for LGBTQ issues via hotlines, online chat, and referrals to local resources.
  - Website: https://www.glbthotline.org
  - Telephone: 1 (888) 843-4564 (all-ages hotline); 1 (888) 234-7243 (seniors hotline); 1 (800) 246-7743 (youth hotline)
- The Audre Lorde Project (ALP)
  - ALP is a community organizing center for LGBTQ people of color based in New York City. ALP promotes social justice by uniting folks of various identities in the unifying goal of ending oppression and violence.
  - Website: https://alp.org
  - Telephone: (212) 463-0342 (Manhattan); (718) 596-0342 (Brooklyn)
- The Network/La Red
  - The Network/La Red is an organization that provides confidential hotline support and emergency housing for LGBTQ survivors of intimate partner violence.
  - Website: http://tnlr.org/en/
  - Telephone: (617) 227-4911

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17 Culture and Violence Against LGBTQ+ Persons: International Contexts and Issues in Contemporary Societies

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Abstract

Culture has been increasingly recognized as being central to human experience and in understanding intergroup relations, power, social identities and interpersonal interactions in everyday life in diverse societies, with distinct legal, religious, family and social systems. This chapter is grounded on the recognition that discrimination and violence against LGBTQ+ persons are best understood in a cultural context, as culture shapes attitudes toward gender, sexual orientation and gender identities and expressions. It examines the role of culture in shaping violence against LGBTQ+ persons internationally, as well as the literature on LGBTQ+ migrants, refugees and asylum seekers in contemporary societies. It also presents a case illustration of Chechen queer people and multi-dimensional levels of violence. The chapter ends with reference to the facilitation of healing and resilience among LGBTQ+ survivors of violence in international contexts.

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Culture plays a key role when understanding homophobia, lesbophobia, biphobia and transphobia, and all forms of violence against LGBTQ+ people around the globe, since it is increasingly recognized as central to human experience and in understanding intergroup relations, power, social identities and interpersonal interactions in everyday life in diverse contemporary societies (O'Doherty & Hodgetts, 2019). However, this recognition is far from being mainstreamed in the literature on LGBTQ+ people, which is still predominantly Anglo-American and, as best, mostly conducted in Western contexts. This chapter is grounded on the recognition that discrimination and violence are best understood in a cultural context, as culture shapes attitudes toward gender, sexual orientation and gender identities and expressions (Adamczyk & Pitt, 2009).

Culture and Its Role in Shaping Violence Against LGBTQ+ Persons

The concept of culture has received considerable attention within the social sciences, and its definitions are very rich and diverse. Most recent

E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_17

conceptualizations consider culture as a process of meaning-making, which is influenced by multiple facets of a person which combine and intersect to constitute their identity(ies) (Kirmayer, 2012). A few aspects should be particularly emphasized in this understanding of culture and which have implications for this chapter. First, it should be noted that this definition conceptualizes culture as a process, not as a simple and static state or membership based on belonging to one (or more) group(s) (e.g. nationality). It is, thus, consistent with not only the fact that categories are socially construed (see Phillips, 2010, for a critical review), but also potentially fluid across the lifespan. Second, this notion of culture includes all forms of diversity, such as cultural and ethnic background, age, gender, sexual orientation, gender identity, religion, social status, language and ability, among other possible characteristics associated with cultural norms and values, behaviours and practices. These dimensions multiply in each individual's experience, giving rise to the concept of intersectionality (see Crenshaw, 1991). Furthermore, this conceptualization states that, as a process, these multiple facets of identity may become more or less prominent at any given moment, in the presence of some social interactions and contexts, and not others. In other words, being of Syrian origin may be a central feature in a particular interaction, while being a gay man may be more relevant in another, and being a refugee gay man from Syrian origin living in Turkey and seeking asylum in Germany will be prominent in other interactions. Yet another could be being a father, with a wife and child who one has left in Syria.

A few cultural dimensions may be emphasized as far as their possible impact on the literature and research on violence against LGBTQ+ persons.

Diverse Legal Systems

First, at a macro-level, values and norms inscribed in the legal systems have been recognized as playing a central role in systemic and institutionalized forms of violence against LGBTQ+ people. In many parts of the world, individuals experience and encounter persecution and discrimination based on their perceived or actual sexual orientation and gender identity (United Nations High Commissioner for Refugees, UNHCR, 2008). This is often the case due to homosexuality being forbidden by law, as well as within the dominant religious and cultural value systems of many countries (McClure, Nugent, & Soloway, 1998; Pepper, 2005). For instance according to the International Lesbian, Gay, Bisexual, Trans and Intersex Association's (ILGA) latest report on state-sponsored homophobia, 72 countries in the world still criminalize people based on their sexual orientation (Carroll & Mendos, 2017). Punishment can include imprisonment, physical and sexual abuse, and in some nations, even execution (Human Rights Watch, 2009; Pepper, 2005). For example, in most African nations, homosexuality is illegal and same-sex marriage or unions are inconceivable. In countries where persecution on the basis of sexual orientation is not officially sanctioned by law, individuals are still often the victims of abuse, violence and discrimination from varied sources, including members of police, military and religious institutions, as well as from community and family members (Human Rights Watch, 2009; Pepper, 2005). Extreme stigmatization, even in contexts where homosexuality is not criminalized, can result in persecution and alienation from individuals' communities and families, along with restricted access to economic, occupational and educational opportunities or resources (McClure et al., 1998; Pepper, 2005). Given these experiences, many sexual and gender minority individuals feel they must flee to preserve their lives and, in that process, they leave behind friends, family and loved ones, in addition to careers, homes and most material possessions in the hope that they will receive asylum (McClure et al., 1998).

Laws regarding same-sex unions, parenting rights and responsibilities and legal gender identity recognition are also very diverse around the globe, and limit access to aspirations of children, youth and young adults everywhere, with differential impacts (e.g. Bauermeister, 2014). All

these examples capture forms of systemic violence against LGBTQ+ individuals in contemporary societies. Furthermore, intersections of sexual orientation and gender identities and expressions, with race and ethnicity, disability and class, may further exacerbate both the interpersonal and institutionalized violence against LGBTQ+ people and its impacts.

Cultural Dimensions – Individualism vs Collectivism, Religiosity and Gender and Family Values

Another key cultural feature worth underscoring is the individualism collectivism dimension as, historically, literature that addresses the struggles of LGBTQ+ persons tends to come from an Anglo-Saxon perspective. Less research has been conducted in other cultural contexts, including those which have been described as collectivistic (see Hofstede, 1991). Collectivistic cultural contexts are characterized as those where "people from birth onwards are integrated into strong, cohesive in-groups, which throughout people's lifetime continue to protect them in exchange for unquestioning loyalty" (p. 260–261), as opposed to those described as where the ties between individuals are loose. Given the role of family and social support as a key feature into the development of LGBTQ+ individuals, as protective factors, it seems relevant to acknowledge that consequences of self-expression and going against cultural or in-group norms may be different among those LGBTQ+ individuals expected to look after themselves as individuals, with a strong right for privacy and speaking one's mind, and those expected to be loyal to one's group, with a "we" consciousness, stress on belonging and relation harmony – namely, in the family. Take the example of Latin American and Latin European cultures, such as Portugal, Spain, Italy, Puerto Rico, Mexico, Venezuela, Argentina, Peru, Chile or Brazil, to name a few. In fact, in such cultural contexts, family rejection may represent a major risk factor, as Figueroa and Tasker (2014) explored among Chilean young gay men, and Ryan and colleagues (Ryan, Huebner, Diaz, & Sanchez, 2009) among Latinx LGB young adults in the United States. In these cases, family rejection can be a powerful risk factor, with a distinct relevant meaning, as the absence of parental support may signify self-rejection and self-recrimination, alienation from the community, customs and traditions, faith belongings and resulting marginalization. Furthermore, as lesbian and gay communities may be accessible only after coming out or around the initial phases of this process, any in-group support may be absent for these LGBTQ+ individuals.

This is also the case for trans people (or gender non-conforming) living within the Latin American context. For instance some studies have shown that individuals who demonstrate same-sex attraction or cross-gender behaviour during childhood or adolescence can lead to violence from family and community members. This is the case of *jotas* (young men displaying cross-gender behaviour in impoverished sections of Mexico City) (Prieur, 1998; for a large-scale study in Mexico, see Baruch-Dominguez, Infante-Xibille & Saloma-Zuñiga, 2016) and trans sex workers and/or self-identified *travestis* in Brazil (Kulick, 1997, 1998; Silva et al., 2016; for a large-scale study on Brazilian trans health, see Carrara et al., 2019). Due to their cross-gender behaviours, these individuals are often expelled from their homes and detached from their kin networks, leaving them without support structures and often excluded from the educational system and normative working lives. The presence of persistent and extreme structural violence, coupled with lack of family and community support, often challenges and consolidates the vulnerability of trans individuals in Latin America (Padilla, del Aguila & Parker, 2007).

The intersections of multiple identities within so-called collectivistic or family-oriented social groups with religiosity also may present differential impacts on health and well-being. For example, among Italian Catholic gay men, an association was found between internalized sexual stigma and dissociation symptomatology (Nardelli, Baiocco, Tanzilli, & Lingiardi, 2019). Similar findings were reported among Polish Catholic gay men (Pietkiewicz & Kołodziejczyk-

Skrzypek, 2016). Very little is known about the intersections of cultural values and religion among Muslim, Hindu and Buddhist LGBTQ+ persons (Adamczyk & Pitt, 2009).

Notwithstanding, we acknowledge the criticisms to the dimension of individualism-collectivism and its (mis)uses in cross-cultural psychology as a useful explanatory mechanism for cultural differences in human behaviour (see Voronov & Singer, 2002). Since Hofstede's original study, globalization and contemporary media (Nafstad et al., 2014) have markedly transformed ideologies in contemporary societies in an array of domains, such as gender and LGBTQ+ issues. This bears consequences for LGBTQ+ people worldwide.

Undeniably, current capitalist societies in a global era have had to balance between individual independence and collective interdependence (Nafstad et al., 2014). While being aware that individual values have markedly been strengthened by globalizing neoliberalism, it is also recognized that quality of life and well-being are far from being entirely dependent on oneself, resulting in a tension between individual and communal values and practices (Nafstad et al., 2014; Turken, Nafstad, Blakar & Roen, 2016). These forces also participate in how LGBTQ+ people come to terms with their identities and negotiate them (and the degree of outness) with their families and communities, which may have different paths in cultural contexts that are oriented toward in-group harmony and family. An illustration can be depicted within the Latin American and Caribbean context, where family, social and communal values seem to play an important role in shaping the experiences of LGBTQ+ individuals. For LGBTQ+ Latinx, their sexual orientation and gender identities are no longer a simple and private matter of individual sphere, but rather a struggle between proclaiming a non-heterosexual or non-normative gender identity over the apparent social order (Del Pino, Moore, McCuller, Zaldívar, & Moore, 2014). *Familismo* (the valuing of how family relationships should be) (MuñozLaboy, 2008), *Machismo/ Marianismo (*the traditionally and culturally prescribed and fixed male and female gender roles within Latinx culture) (De Vidas, 1999), coupled with the religious and cultural stigmatization of their sexuality (Del Pino et al., 2014), prompt many LGBTQ+ people to accept an imposed *code of silence* concerning their LGBTQ+ identities. LGBTQ+ Latinx often do not disclose their sexual or gender identities as a way to protect themselves and their families from stigma; however, by doing so, they are also isolating themselves from both their ethnic and LGBTQ+ communities. This isolation then leaves many LGBTQ+ individuals without important sources of social support to fend for themselves in the midst of an ongoing conflict among their ethnic, sexual and gender identities, which in turn may leave them vulnerable and exposed to risk factors and victimization from the broader social-cultural context.

Contemporary Issues: LGBTQ+ Migrants, Refugees and Asylum Seekers

Under EU law, individuals persecuted based on their sexual orientation and gender identity qualify for refugee status (European Union Agency for Fundamental Human Rights, 2017). Even though there is increasing awareness of the reality that people run away to avoid persecution based on their sexual orientation and/or gender identity and that they can qualify as refugees in Europe, few EU Member States have specific national guidelines, resources and integration programs aimed at LGBTQ+, migrants, asylum seekers and refugees (European Union Agency for Fundamental Human Rights, 2017).

Studies have shown that LGBTQ+, migrants, asylum seekers and refugees seem to experience severe and prolonged trauma prior to migration, including psychological abuse, physical and sexual assault, property damage, wrongful imprisonment and forced psychiatric hospitalization (Alessi, Khan, & Chatterji, 2016; Alessi, Khan, & Van der Horn, 2017; Kahn, Alessi, Woolner, Kim, & Olivieri, 2017; Shidlo & Ahola, 2013). Victimization usually begins in childhood, continues into adulthood and occurs at the interper-

sonal, community and state levels (Alessi et al., 2016; Alessi et al., 2017). Further, when sexual and gender minority asylum seekers have reached out for help in their countries of origin, either their concerns were overlooked, or they were subjected to further victimization (Alessi et al., 2016; Alessi et al., 2017; Kahn et al., 2017). LGBTQ+ asylum seekers typically must negotiate multiple stressors connected to their identification with multiple intersecting and marginalized identities (Reading & Rubin, 2011). As such, the cumulative psychological effects of repeated exposure to an array of interpersonal violence and trauma manifest additional symptoms of PTSD, including alteration in affect and impulses, severe dissociation, alterations in self-perception and perception of the perpetrator and difficulty in relating to others (Cloitre et al., 2009; Alessi & Kahn, 2017). This symptom profile has come to be known as complex PTSD or complex trauma. The presence of these symptoms warrants close attention when practising with sexual and gender minority migrants, asylum seekers and refugees, as emerging research has shown that these symptoms strongly indicate the experience of severe cumulative trauma in childhood (Alessi et al., 2016). Therefore, conceptualizing mental health issues through the lens of complex PTSD helps mental health professionals to recognize the impact of prolonged trauma among this population and to tailor treatment to manage its effects.

LGBTQ+ individuals often seek asylum with the expectation of improvement in their lives and mental health (Lewis, 2014). However, even after arriving at their destination, it is common for LGBTQ+ asylum seekers to experience feelings of isolation and alienation (Heller, 2009; Reading & Rubin, 2011) due to their migration and sexual and/or gender minority status. Upon arrival, in addition to the challenges and stressors usually faced by straight migrants, LGBTQ+ migrants, asylum seekers and refugees may also be exposed to heterosexism and cissexism, hate crimes and discrimination (Shankle, 2006; Zwiers, 2009). Thus, they find themselves in double jeopardy, identifying with at least a double minority status (Fuks, Smith, Pelaez, Stefano, & Brown, 2018), that is they are exposed to the mental health risk factors associated with being both migrants and members of the LGBTQ+ community (Munro et al., 2013). Double jeopardy can be particularly problematic when social support and social integration are not available (Fuks et al., 2018). More precisely, family, community and religious affiliations, which usually protect the health and well-being of recent migrants, can become primary sources of rejection and discrimination due to sexual prejudices (Boulden, 2009). Likewise, language, cultural barriers and racism within the mainstream LGBTQ+ community itself can make it difficult for LGBTQ+ migrants to integrate into the local LGBTQ+ community (Ibañez, Van Oss Marín, Flores, Millett, & Diaz, 2009).

It is important to acknowledge that migration (a major life event) poses as a challenge that can provoke stress reactions among LGBTQ+ migrants, asylum-seekers and refugees, also known as *acculturative stress* (see Berry, 1997, 2006). LGBTQ+ migrants, asylum-seekers and refugees are particularly vulnerable to this stress due to the possible lack of appropriate coping strategies (due to the experiences of complex trauma) and social support (e.g. being excluded from their families, religious groups, the local LGBTQ+ community, among others). Therefore, such circumstances pose as barriers in securing their safety and stability in acquiring knowledge of the host culture. In order to achieve integration, it is also important to exert agency over which elements of the heritage and host cultures the individual would like to adopt and which they would like to reject (Huynh, Nguyen, & Benet-Martinez, 2011). However, due to the aforementioned double jeopardy related to the identification with at least two minority statuses (Fuks et al., 2018), many LGBTQ+ migrants, asylum-seekers and refugees find themselves in a situation where they are limited to express their sexual and/or gender identities, or expressing their cultural and/or ethnic heritage (Alessi & Kahn, 2017). For these individuals, the process of acculturation seems to involve, simultaneously, their culture of origin, the host culture *and* queer culture (Fuks et al., 2018). Their agency over the acculturation process may be impaired due to experiencing situations such as verbal abuse, physical assault

and discrimination, even after arriving to the country of their destination (Alessi & Khan, 2017), therefore placing them in situations where they have to demonstrate group membership of the host, origin or queer cultures through performing behaviours that align with Western, Western LGBTQ+ and host society prototypes (Alessi & Kahn, 2017). Therefore, these situations may intensify the levels of stress and increase the levels of social isolation, alienation and helplessness (Kahn, 2015; Shidlo & Ahola, 2013) which expose LGBTQ+ migrants, refugees and asylum seekers to an array of mental health risk factors (Munro et al., 2013).

Case Illustration: Chechen LGBTQ+ People and Multi-dimensional Levels of Violence

The infamous "gay purges" that have swept over Chechnya serve as a dramatic and tragic example of multi-levelled violence against LGBTQ+ people. Pogroms have been happening in several "waves," starting from December 2016 (Benedek, 2018) and spiking later in April of the following year when they gained serious public attention after Novaya Gazeta (an independent Russian newspaper) published information about more than 100 Chechen gay people being arrested and severely tortured by the local police, with some killed either by the persecutors or by victims' own families (Milashina, 2017). The homophobic crackdown reported in January 2019 resulted in 40 more individuals detained and claimed at least 2 more lives under torture (Amnesty International, 2019). Reports from Russian Human Rights organizations, as well as international investigations, confirmed unlawful arrests, torture, enforced disappearances and extrajudicial executions of LGBTQ+ people in Chechnya (Benedek, 2018; De Bruyn, 2018; Russian LGBT Network, 2017).

The report by the Russian LGBT Network (2017) discussed several underpinning factors of the homophobic attacks. Among these factors, the special legal status of the Republic of Chechnya inside the Russian Federation should be noted, giving its absolutist governing regime a high degree of autonomy. Furthermore, collective responsibility was enforced by local conservative traditions leading to "honour killings" inside the families and *teips* (Chechen and Ingush family/tribal organizations, united by believed shared ancestry and territory). Also, it is recognized that, generally, there is a high degree of (state-supported) homophobia in Russia. Therefore, it became noticeably difficult for the human rights organizations to intervene, as Chechen queer people suffer(ed) violence and severe discrimination on multiple levels, from their own families and neighbours, to Chechen police and military forces, and to the Russian federal position that denies the crimes and human rights violations in the republic, creating further obstacles for the survivors to flee the country (De Bruyn, 2018).

Lesbian and bisexual Chechen women happened to be even in a more vulnerable position which is explained by traditional gender roles in the republic that leave women to the will of their "guardians": fathers, brothers or husbands (Heinrich-Böll-Stiftung, 2018). As reflected in the Heinrich-Böll-Stiftung's "Queer women of Northern Caucasus" report (2018), many of the interviewed women suffered from forced marriage, "corrective rape," ongoing physical and psychological abuse by their family members and even sessions of "exorcism" in the mosques which were believed to free them from demons provoking their "indecent" thoughts or behaviours. Furthermore, women have generally fewer chances to escape due to economic dependency (many would not be allowed to work and/or would not have access to money) and mobility restrictions from their families (e.g. not being able to leave home without older women/brothers or after a certain hour, and not being allowed to use public transportation), namely, by the men in their parental or spouses' families. The interviewed survivors, even after relocated to safe places, showed very high levels of PTSD and marked depressive symptoms, accompanied by suicidal thoughts; they also reported constant anxiety and fear, loss of meaning of life and high levels of internalized homo- or biphobia (Heinrich-Böll-Stiftung, 2018).

Despite the significant international outcry that involved several political leaders, UN human rights independent experts, the European Parliament and the Secretary General of the Council of Europe (De Bruyn, 2018), only five countries announced they were willing to provide asylum to the survivors of the purge, among which was Canada, Lithuania, Belgium, Germany and France (Eriksson, 2017).

There is a general silence around those who fled, and this is comprehensible, since Chechens, even abroad, run into high risks for their safety should their identity and location get disclosed. According to De Bruyn (2018), the threat is coming from members of the diaspora who might have supported the homophobic attacks. However, from the little information that is available from the interviews with queer Chechens who sought asylum in Europe, it can be observed that the European asylum system poses certain challenges for Chechens' claims to be accepted as credible and it is not fully prepared to help the asylees meet their needs for safety and psychological well-being.

The case of Chechen queers in asylum enters the complexity of Muslim queers in the Western context and probably goes beyond it. Oswin (2006) argues that queer globalization was heavily built on the exportation of Western-type gay identities within local non-Western queer communities, which in turn produced a category of the "global gay" – pushing those who do not comply to it into the category of an "absolutely different" other. Luibheid (2008) points out that most migration scholarship, social activism and asylum systems take the preconception that queers are citizens, while migrants are heterosexual, which created a major exclusion of queer migrants from the main legal and political discourse. Following Manalansan (2006), she further problematizes the labels of LGBTQ+ that are uncritically assigned to queer migrants in an attempt to fit them into the existing frame of Western identities and presents queer migration as a linear story from "repression" to "liberation." Furthermore, the neoliberal racialized heteronormativity, that presumes heterosexuality as an intrinsic characteristic of the migrants, creates a notion of "impossibility" of queer migrant persons (Gopinath, 2005).

This "impossibility" is reflected in the position of queer Chechen refugees, for whom non-normative sexual identities and asylee/refugee status intersect with Muslim religious background, pushing them out of the gay political map, making them "invisible, unintelligible, and unspeakable in both queer and migration studies" (Luibheid, 2008, p. 171).

As argued in Bracke's work "From 'saving women' to 'saving gays'" (2012), the existence of queer Muslims is particularly problematic for the neoliberal political discourse. While Muslim migrants are thought to be intrinsically heterosexual (Giametta 2014), posing a threat to the well-being of Western women and Western gays, Muslim queers, in order to be "rescued" and accepted by the Western asylum system, are expected to get rid of their religious affiliation first, which is comparable to the practices of unveiling toward the Muslim women (Bracke, 2012). Both narratives, according to Bracke, are connected to the understanding of "false consciousness," which in case of non-Western queer persons comes down to successfully reproducing the "coming out" story (El-Tayeb, 2012).

However, the stories told by Chechen asylum seekers in Europe present significant disruptions to these linear "persecution narratives" (Alessi & Kahn, 2017). Four interviews with Chechen asylees available in both Russian and Western media sources support this argument (Gusarova, 2017; Kakissis 2018; Shuster, 2017). All four men report feeling unsafe in refugee camps, being threatened or attacked by their conationals. One of them said: "*Often, when I see a Chechen on the street, everything shrinks inside of me. I am afraid of people of this nationality, and I am afraid of Russ*ia" (Gusarova, 2017). While this statement is expectable from someone who had been tortured by his compatriots, there is evidence that the European asylum system does not do enough to protect queer Muslims. This report is consistent with the report of De Bruyn for the Council of Europe (2018) that highlights the same issues for Chechen queers in German asylum contexts.

Additionally, three of the interviewed men stated they strongly identified as Muslim and prayed daily, which further disrupted the uniform narrative of a queer Muslim refugee, who has to give up his faith in order to be identified as gay and accepted by the secular Western system. However, giving up one's faith was not the case for those men. One of them admitted that, however, he always struggled to accept his sexuality, he believed God loved him nevertheless (Kakissis, 2018).

Another discontinuity lays in the fact that only one of four men addressed his coming out, while the others did not operate with this category at all. Moreover, two of these men did not even refer to themselves as gay, as identifying strongly as LGBTQ+ and "speaking out your true self" was very unlikely for someone who was living in a hostile homophobic environment. Furthermore, two men reported that they wished they could reunite with their wives and children: "*She's my best friend, and I can't live without my children*", one of the refugees said about his family he left behind in Chechnya (Gusarova, 2017). Together with the absence of the coming-out scene in their life stories, this heavily challenges the expected gay refugee narrative and may seriously affect the credibility of their stories for the asylum system. In fact, Movsar Eskarkhanov, one of the asylees whose interview was reviewed in this chapter, was deported back to Russia in September 2017 as his asylum was denied by German authorities (Shuster, 2017).

Facilitating Healing and Resilience Among LGBTQ+ Survivors of Violence in a Global Arena

Research on forced migrants (de Anstiss & Ziaian, 2010), as well as the LGBTQ-focused migrant studies (Kahn, Alessi, Kim, Woolner, & Olivieri, 2018) show that stigma and distrust about the mental health care and its providers can significantly impede seeking for psychological support among LGBTQ+ forced migrants. Expectations of institutionalized violence, homophobia and transphobia often increase reluctance to seek help.

In addition to being uncomfortable with discussing their mental health symptoms with a professional and fearing that seeking mental health help may further stigmatize them (Reading & Rubin, 2011), members of this group may feel intimidated to access counselling or therapy due to the fear of coming out and sexual stigma they are carrying as a result of multi-level discrimination in their country of origin (Alessi, 2016). At the same time, the disclosure of a sexual identity makes an essential part of the "persecution narrative" (Alessi & Kahn, 2017), which LGBTQ+ asylum seekers have to perform multiple times in the interviews with migration authorities, and it can be extremely difficult for those persons who have been hiding their sexuality to avoid persecution (Nerses, Kleinplatz, & Moser, 2015). Therefore, disclosing a non-normative sexuality or gender identity may be connected to strong feelings of shame and fear (Shidlo & Ahola, 2013). Additionally, recounting to migration officials the experiences of abuse in the country of origin, as well as demonstrating the well-founded fear of persecution, necessary for getting an asylum protection (United Nations High Commissioner for Refugees, 2007), can be highly retraumatizing and distressing (McClure, Nugent, & Soloway, 1998; Perez-Ramirez, 2003). The legal requirements mandate that asylum seekers share with different authority figures the traumatic details of the persecution they faced in their countries of origin multiple times, often in settings that they deem unsafe due to past experiences with law enforcement authorities (Reading & Rubin, 2011). Due to shame, avoidance and fear, many have never disclosed the details of their persecution to another individual. However, participating in individual counselling and group therapy mitigate these potential consequences (McClure et al., 1998).

The extent of these complexities may leave mental health professionals and organizations trying to aid sexual and gender minority asylum seekers and refugees grappling how to educate relevant stakeholders (Alessi & Kahn, 2017). The amount of literature focusing on evidence-based practices of intervention and integration of LGBTQ+ asylum seekers and refugees is almost

non-existent. Therefore, some scholars rely on the existing literature of various independent fields of studies such as LGBTQ+ studies migration studies and post-traumatic stress intervention studies. However, this may not provide sufficient preparation for mental health professionals who offer services to sexual and gender minorities in refugee assistance programs, outpatient mental health clinics, community service organizations or independent practice (Alessi & Kahn, 2017). For example frameworks for providing mental health treatment to refugees are not only scarce (K. E. Murray, Davidson & Schweitzer, 2010; Slobodin & de Jong, 2015), but also may ignore issues related to sexual orientation and gender identity (D. Murray, 2014). At the same time, the literature on affirmative psychotherapy may overlook the complexities that surround culture and migration (Alessi & Kahn, 2017). The cultural aspect is important not only for the asylum seekers but for all migrant LGBTQ+ participants of a group or individual psychological services which may lack cultural sensitivity regarding gender and sexual expressions (Kahn et al., 2018; Nerses et al., 2015; see Kirmayer, 2012 for reconceptualization of cultural competence and humility).

In conclusion, pervasive sexual stigma and discrimination are chronic, cumulative stressors that have detrimental health impacts among LGBTQ+ members (Logie, Lacombe-Duncan, Lee-Foon, Ryan, & Ramsay, 2016). While marginalization and behavioural health issues are prominent among LGBTQ+ individuals as a result of the constant exposure to stigma-related stress, for LGBTQ+ migrants, asylum seekers and refugees, the increased risk of marginalization and psychological health detriments may exacerbate upon migration due to experiencing intersecting stigma associated with sexuality, race, gender, class and immigration status (Logie, James, Tharao, & Loutfy, 2011). This intersecting marginalization contributes to significant challenges in realizing the social determinants of health (Logie et al., 2016).

Recognition of the needs of LGBTQ+ survivors of violence and its impact on international policy and professional training has been slow to observe. While some evidence has recently been discussed regarding mental health and psychosocial interventions for asylum seekers and refugees (Stewart et al., 2014; Tribe, Sendt & Tracy, 2019), more research is needed to develop best-practice guidelines and evidence-based protocols in facilitating healing and resilience among LGBTQ+ survivors of violence worldwide. This evidence, as well as on the challenges and resources of distinct groups and populations, will be key in advocacy and development of public policy anchored in science.

Acknowledgements The contributions of Svetlana Solntseva and Gustavo Aybar were partially supported by the Erasmus Mundus Joint master's degree (EMJMD) entitled: European Master in the Psychology of Global Mobility, Inclusion and Diversity in Society – G-MINDS under Grant number 2016-2167.

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18

Sexual and Gender Minority Refugees and Asylum Seekers: An Arduous Journey

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Abstract

A small but growing group of refugees and asylum seekers are members of the LGBTQ+ community. This identity may be separate from their identity as a refugee, or it might be the reason for their refugee status. Many refugees flee countries in which identifying as LGBTQ+ is considered a crime, sometimes punishable by death. The unique challenges of this population concerning forced migration, resettlement, and acculturation to host nations are addressed in the present chapter.

While efforts have been made to increase human rights protections and equality for LGBTQ+ individuals in certain parts of the world (Gartner, 2015), anti-LGBTQ+ agendas are still rampant (e.g., State Equality Index, 2017). Human rights are nonexistent in many nations, where LGBTQ+ individuals live under constant threat of violence. Some members of this community seek protection in other countries, and many report arduous and horrifying experiences in their journeys toward safety (Alessi, Kahn, & Van Der Horn, 2017; Gartner, 2015; Kahn & Alessi, 2017). Compared to other groups of refugees, LGBTQ+ refugees are unique in that they not only face legislative infrastructure criminalizing their sexual orientations and gender identities but may also be violated by their families and communities (Alessi et al., 2017). Unfortunately, they may also be discriminated against by fellow refugees in their attempts to flee and seek safety (Witschel, 2018). These intersecting and doubly marginalized identities create unique burdens and barriers. The purpose of this chapter is to discuss the experiences of LGBTQ+ refugees, address the rights of refugees, and shed light on experiences in resettlement.

Refugees and Asylum Seekers

As of 2019, there are approximately 26 million refugees and 3.5 million asylum seekers around the world ("UNHCR Figures at a Glance", n.d.). In comparison to refugees, the terms asylum and asylum seekers refer to individuals seeking protection from the border or inside a chosen country where they would like to settle and whose legal status as a refugee has not yet been determined (Cepla, 2019). The status of refugee is granted once it is determined that the individual is indeed fleeing violence or persecution. There are no current estimates on what proportion of

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E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_18

these individuals identify as LGBTQ+, but it is clear that the number of LGBTQ+ refugees is increasing. Some of these refugees flee war-torn countries, such as South Sudan and Syria, together with other natives, whereas others flee alone from countries, such as Saudi Arabia, Iran, and United Arab Emirates, where being LGBTQ+ is considered a crime. In about 77 countries, same-sex relationships are considered a crime, and in 7 of those it is punishable with death ("LGBTI People", n.d.).

The definition and rights of refugees were first articulated in the aftermath of World War II in Europe. In 1951, the Geneva Convention on behalf of United Nations defined a refugee as an individual who,

> owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it (Convention and Protocol Relating to the Status of Refugees; UNHCR, 2011).

Based on this definition, LGBTQ+ individuals can seek protection under the clause of having *membership in a particular social group* ("LGBTI People", n.d.). The Geneva Convention also established a list of rights for refugees, such as that they cannot be sent back to their country of origin if there remains a threat to their lives. Additionally, they have the right to the same civil, economic, and social privileges as the citizens of their new host country (UNHCR, 2011).

While some refugees are resettled in host countries, a much larger proportion end up living close to the border of their native country. Most of these countries tend to be low- and middle-income, developing countries, such as Turkey, Uganda, Pakistan, and Lebanon. While the number of LGBTQ+ refugees in these nations is unknown (Portman & Weyl, 2013), many of these nations, which end up hosting the most refugees worldwide, are also likely to be perpetuating the same discrimination and violence that led to these refugees fleeing their homelands in the first place. Only a fraction of refugees resettle in industrialized or high-income countries, and just 20% of the world's nations have formally agreed to resettle refugees at all ("UNHCR Information on UNHCR resettlement", n.d.). Resettlement, or being permanently relocated in a new country, is often the goal and sole existing long-term solution for refugees (UNHCR, 2017). The agency in charge of resettlement decisions, UNHCR, decides whether a refugee demonstrates a priority to be resettled. Reasons for priority can include having unique medical, legal, or physical protection needs, being a woman, or a child at risk, among others.

The Global Response to LGBTQ+ Refugees

Nations differ widely in their views of LGBTQ+ individuals, and this is further shaped by the country's legislation and sociopolitical views on refugees and asylum seekers. While Western European and North American nations are often seen as beacons of progress for LGBTQ+ rights (Gartner, 2015), the legalization of same-sex marriage, the ability to adopt children, and other anti-discrimination protections vary widely. Even though there is an increased number of LGBTQ+ refugees resettled in Western nations, rising anti-refugee sentiment due to populist and nationalist rhetoric has created hostility toward immigrant communities (Dekeyser & Freedman, 2018) and a reduction in the annual number of approved refugees. For example, in 2017 the United States had the sharpest decline in refugee resettlement of any country in the world (Connor & Krogstadt, 2018).

Asia Pakistan and Turkey are currently hosting the greatest number of the world's refugees ("United Nations Regional Information", 2019) but lack the political infrastructure to keep LGBTQ+ refugees safe. Pakistan has criminalized nonheterosexual relationships and is known for its hostility, discrimination, and violence against the LGBTQ+ community (European Asylum Support Office, 2015; Itaborahy, 2012). Turkey, while not criminalizing consensual same-sex acts, offers no protections for LGBTQ+ individuals and has no legal recognition of same-sex

marriage, unions, or adoptions (Itaborahy, 2012). Non-European asylum seekers can live in Turkey while awaiting their claims to be reviewed. It can take several years to go through the application and interview process before resettlement. During this period of waiting, LGBTQ+ refugees stay in "satellite cities" where they undergo various interviews and medical and psychological examinations. They are also required to pay for their living expenses (e.g., healthcare, transportation, and accommodation), despite having fled their country and a scarcity of resources, placing them in a vulnerable social or financial situation often exposed to discrimination from police and local residents (Shakhsari, 2014).

Israel accepts refugees and asylum seekers, the majority of which are from Sudan and Eritrea. It has an LGBTQ+ task force, Aguda, that actively partners with the government to expand the rights of the LGBTQ+ community in Israel, as well as for those that seek refuge. While Israel does not recognize sexual orientation or gender identity as protected identities, refugees in threat of deportation can appeal the deportation by disclosing their orientation or identity; however, Israel has rarely halted deportations for these reasons (Yaron, 2018).

Europe LGBTQ+ individuals from the Middle East, North Africa, and the Baltic and Slavic regions are increasingly seeking refuge in the European Union due to the threat of persecution (Witschel, 2018). European nations often have conflicting legislative and social stances on LGBTQ+ rights. For example, the Czech Republic has both public and legislative support for gay marriage but until recently enforced the sterilization of transgender individuals seeking to change their gender identity on government documents (Transgender Europe and ILGA-Europe v. The Czech Republic, 2018). In Germany, the rights of LGBTQ+ individuals have developed over the last few decades and are considered some of the best in the world (Davidson-Schmich, 2017). While Germany has accepted a large number of refugees recently, refugees that identify as LGBTQ+ are placed in holding facilities with other refugees that are often hostile to them, resulting in discrimination and violence against them in areas that are supposed to be safe. While deportation is not allowed by EU courts when death, torture, or persecution is imminent, these considerations are more often afforded to individuals fleeing wars than to individuals facing the same threats due to their gender or sexual identities, as shown by several recent court cases around Europe (Witschel, 2018).

North America In 1991 Canada became the first country to accept refugee claims based on persecution for sexual orientation or gender identity (LaViolette, 2009) and is one of the most preeminent destinations for those applying for asylum for persecution based on gender or sexual orientation. While Canada's system for meeting refugee needs is not flawless, there are several notable programs that offer assistance to both refugee-serving agencies wanting to provide better care and to refugees themselves (LGBTQ+ Immigration Info: Being LGBTQ+ in Canada and Laws You Should Know, n.d.). The Ontario Council of Agencies Serving Immigrants (OCASI) has started a Positive Spaces Initiative that provides training to area agencies, as well as referrals and assistance to LGBTQ+ refugees (OCASI, n.d.).

In the United States, the number of refugees hosted varies significantly depending upon fluctuating policies and the will of the sitting President and Congress. In the 1990s, this number averaged around 100,000, but this has plummeted in the last 3 years to a record low ceiling of 18,000 admissions set for the year 2020. Prior to 1990, refugees who identified as gays were not allowed to resettle in the United States. In 1994, the United States began to allow LGBTQ+ individuals to apply for asylum on the basis of persecution for their sexual and gender identity (Sussman, 2013). There are currently a growing number of asylum claims from LGBTQ+ individuals hoping to resettle in the United States (Alessi, 2016). Approximately 300 LGBTQ+ refugees are resettled annually, and around 500 are granted asylum (Portman & Weyl, 2013).

South America Brazil recently criminalized homophobia and transphobia and is consequently becoming a more popular destination for LGBTQ+ asylum seekers in Latin America. However, it simultaneously continues to be considered highly unsafe for LGBTQ+ individuals where attacks and murders are routinely reported (Lopez, 2019). Argentina is another country that offers protections for gender identity and sexual orientation. FALGBT is an LGBTQ+ rights group in Argentina that helps refugees fleeing discrimination due to gender identity and sexual orientation. While no official data are collected on LGBTQ+ refugees, requests for asylum have increased fourfold in the last couple of years. While there is still active violence against gay and trans people in Brazil, Argentina has not had reported violence against these groups. Brazil and Argentina are two countries, along with Mexico and Uruguay, offering protection for those seeking asylum due to gender identity and sexual orientation discrimination. These are among the 28 nations in the region that adopted the UNHCR's 2014 Brazil Declaration, which listed gay and trans migrants as vulnerable populations (Lopez, 2018).

Finding Country-Specific Data

An annual report, *State-Sponsored Homophobia* (ILGA, n.d.), can be used to locate information on current sociopolitical and policy changes at the international, regional, and national levels. This report details legislation both criminalizing and protecting sexual orientation and gender identity, as well as cultural shifts toward or away from LGBTQ+ rights. Rainbow Europe also has a country-by-country index of safety for this community in European Nations and includes asylum laws in its consideration (ILGA Europe, 2019).

LGBTQ+ Refugees' Experiences

There is limited research on LGBTQ+ refugees and their experiences seeking and claiming refugee and asylum status, as well as about their resettlement experiences. To provide a more holistic picture of this dual identity, we will provide an overview of what is currently known about LGBTQ+ refugees and asylum seekers together with more general information about refugees' experiences.

Prior to Leaving Refugee status is often associated with traumatic experiences and posttraumatic stress. Traumatic events may include either being the victim of or a witness to war, torture, discrimination, starvation, rape, diseases, and loss of family members among many other possible events (Schweitzer, Melville, Steel, & Lacherez, 2006). Traumatic experiences like these are associated with posttraumatic stress symptoms, depression, and anxiety among refugees (e.g., Anna et al., 2017; Fazel, Wheeler, & Danesh, 2005; Steel et al., 2009).

Outcomes for LGBTQ+ refugees are compounded by these doubly marginalized identities. Internationally, LGBTQ+ children and adolescents are at risk for social exclusion, HIV/AIDS, abuse, and discrimination (Lesbian, gay, bisexual and transgender youth in the global south, 2016). In a study that specifically examined premigration experiences of LGBTQ+ refugees and asylees, participants described hiding their sexual and gender identity even from individuals closest to them. The fear of their identity being discovered kept them in a constant state of hypervigilance (Alessi et al., 2017). Furthermore, Cheney et al.'s (2017) study on transgender asylum seekers reported high levels of pervasive verbal and physical abuse by family and community members.

Given the high risk of abuse and anticipation of danger, LGBTQ+ refugees and asylees utilize various strategies to minimize the risk of violence and persecution. Many conceal their sexual orientation or gender identity by pretending to be heteronormative (Alessi et al., 2017; Cheney et al., 2017; Shidlo & Ahola, 2013). Sometimes these strategies include limiting their day-to-day activities related to job choices and interpersonal communication, such as minimizing their contact with members of the community by working night shifts (e.g., to hide effeminate traits; Alessi et al.,

2017). Despite efforts to hide and remove themselves from dangerous spaces, including moving to an entirely different city, the assaults continued; most participants in Alessi et al.'s (2017) and Cheney et al.'s (2017) studies detailed continuous assaults until they left their country or origin.

Seeking Refugee Status LGBTQ+ refugees and asylees bear the burden of proving their sexual or gender orientation when seeking refugee or asylum protection. They need to provide proof concerning their LGBTQ+ status and the risk of persecution if they return home (Khan & Alessi, 2016; Gartner, 2015). It can be difficult and traumatic to not only reveal but also provide evidence regarding one's sexual orientation or gender identity to immigration officials. Considering this common history of victimization, hypervigilance, and taking pains to conceal one's identity, disclosure to an immigration official may be terrifying (Berg & Millbank, 2009). Not surprisingly, some refugees choose not to readily share this personal information. Kahn and Alessi's (2017) qualitative study of service providers and LGBT refugees and asylees showed that many refugees found it difficult and even retraumatizing to "out" themselves and disclose deeply private and traumatic experiences to support their claims to immigrations officials. In addition, others reported fearing having their claims dismissed and sent back to their countries of origin with their LGBTQ+ identity now documented, while others described fearing abuse and exploitation by immigration officials (Alessi et al., 2017).

It is important to note that some individuals may not be aware of their right to claim refugee status as an LGBTQ+ individual. A lack of knowledge among immigration staff regarding LGBTQ+ concerns creates yet more barriers for this population. For example, immigration and UN officials may impose Western biases on what behaviors or attributes constitute being gay; individuals from non-Western nations use of other cultural terms to describe their identity and experiences (Munro et al., 2013). For example, to protect themselves, some asylum seekers may have engaged in heteronormativity by getting married and having children (Mule & Gates-Gasse, 2012), which some immigrant officials may not understand.

In Resettlement After being granted asylum, the process of acculturation begins. It is important to remember that only a small percentage of refugees are given the opportunity to resettle. The majority of asylum remain in refugee camps for years. Some may migrate to other nations and remain undocumented.

Legislation regarding resettlement varies between countries. In the United States, refugee assistance is divided between the federal and state governments. Refugees granted asylum are the responsibility of the State Department's Refugee Admissions Reception and Placement Program (R&P). The R&P supports refugees financially for their first 30–90 days to cover rent, food, clothing, and other basic necessities. After this time period, other federal agencies and private organizations provide resettlement agencies with additional albeit limited resources. Refugees may apply for permanent residence after 1 year of residing in the United States and may apply for citizenship after 5 years (Felter & McBride, 2018; US Department of State, 2018).

For many refugees, resettling involves a turbulent emotional adjustment combining relief, gratefulness, and hope with grieving the loss of ones' culture, identity, and often family and friends. While some refugees show remarkable resilience during this adjustment (e.g., Hussain & Bhushan, 2013; Schweitzer, Greenslade, & Kagee, 2007), others find this transition more difficult. Both traumatic experiences prior to immigration and post-migration stressors, such as financial stress and cultural and language barriers, are associated with mental health symptoms and acculturation difficulties (e.g., Carswell, Blackburn, & Barker, 2009; LeMaster et al., 2018). In addition to these challenges, LGBTQ+ refugees and asylees often face unique challenges due to their marginalized sexual and gender minority identities.

Munro et al. (2013) interviewed LGBTQ+ refugee youth in Canada and found that many of

their challenges stemmed from a lack of social and financial support due to discrimination. The youth reported experiences of racism, xenophobia, and homophobia, and intersection of racism and homophobia. This discrimination existed even within entities previously thought to be safe: social service providers, immigration authorities, and within the LGBTQ+ community. Many participants also described not feeling believed or having a difficult time "proving" their LGBTQ+ identity. Some youth alleged that service providers did not acknowledge their identities because they did not conform to stereotypical views of a person of the LGBTQ+ community.

Discrimination is unquestionably a significant stressor for some refugees. It interferes with access to employment (Baranik, Hurst, & Eby, 2018), health care, and housing (Chung, Bemak, Ortiz, & Sandoval-Perez, 2008). In Munro et al.'s (2013) study, the participants described sexual and gender discrimination in their workplaces, educational institutions, and ethnic communities. Recommendations from the study showed a need for training by refugee agencies to the awareness of the differing needs and barriers for LGBT refugees. Even in countries such as United States, Canada, and Australia, newly resettled LGBTQ+ refugees can experience oppressive stigma toward heteronormative ideals, coupled with racist and nationalistic sentiments (Shakhsari, 2014). In the United States alone, as of 2019, 22 transgender or gender-nonconforming individuals were murdered (Human Rights Campaign, 2019).

In addition, LGBT refugees and asylum seekers are not excluded from the challenges faced by the overall refugee population. Language barriers and lack of formal education can make certain aspects of acculturation especially challenging, such as learning to drive, use computers, and use different appliances (Cultural Orientation Resource Center, 2014). There may also be difficulties in finding employment and become financially independent. Studies on stressors and barriers among Muslim Arabs refugees showed that their greatest concern revolved around getting access and opportunity for employment (Baranik et al., 2018). Financial hardship and poverty are not uncommon among refugees (e.g., Capps et al., 2015; Vang & Trieu, 2014).

Social, Educational, and Mental Health Support

Many refugees are unfamiliar with the idea of individual therapy and may feel uncomfortable engaging in intimate conversations with a stranger (Bemak & Chung, 2017). Particularly, LGBTQ+ refugee and asylum seekers may find it difficult to trust service providers given their history of trauma and discrimination, even in in LGBTQ+-affirming spaces. Some LGBTQ+ refugees also come from countries that associate gender and sexual minority identity as a form of mental health disorder (Kahn, Alessi, Kim, Woolner, & Olivieri, 2017). Not surprisingly, the stigma and shame associated with seeking mental health services may act as a barrier to receiving traditionally Western forms of mental health services. In addition, mental health providers may not have the knowledge base to understand the needs and experiences of the LGBTQ+ refugee population (Kahn et al., 2017).

In light of this, providers need to understand that building trust and safety is paramount for LGBTQ+ refugees who have experienced discrimination and this may be the first point of contact they have with such services. A few clinics have been noted for their success working with LGBTQ+ refugees and asylum seekers. One example is the Jewish Family and Community Services East Bay (JFCS). JFCS' case managers trained to work with LGBTQ+ refugees and provide support, such as housing, benefits, healthcare, and education. Mental health services and counseling are also offered, along with introduction to other LGBTQ+ individuals and those within the same cultural group ("LGBT Refugee Services", n.d.).

Heartland Alliance is another organization that helps individuals claiming marginalized identities, including refugees. They provide resources such as the Rainbow Welcome Initiative and the Rainbow Response manual. The Rainbow Response manual provides agencies with training

material for case workers and counselors detailing resources helpful for LGBTQ+ refugees ("Rainbow Response", n.d.). In their article on emerging best practices, Portman and Weyl (2013) reported that it may be beneficial to resettle LGBTQ+ refugees in environments where there are a greater population of other LGBTQ+ refugees or in communities where there are allies and support. The manual reiterates that emphasizing tolerance and community support are best practices for individuals who have previously experienced persecution and trauma due to sexual orientation and gender identity.

Conclusion

The current research demonstrates the vulnerability of LGBTQ+ refugees and their risk for discrimination, exploitation, and violence. Domestic and international laws are painfully ambivalent when it comes to protections for LGBTQ+ individuals and certainly toward refugees as a whole. There is a growing need for agencies and service providers, who work with the refugee and asylum-seeker population to be trained and aware of the differing needs and barriers for this population. Additionally, agencies that have been successful in working with LGBTQ+ refugees have found that introducing LGBTQ+ refugees to other individuals who share similar identities (i.e., already settled LGBTQ+ refugees and individuals of the same cultural background) can help provide them with a sense of support and belonging so greatly needed during the resettlement process.

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19 Finding Safety, Building Community, and Providing Hope: The Creation of Pride Healing Center

Rae Egbert and Gina M. DePalo

Abstract

Pride Healing Center (PHC), a trauma-informed specialty clinic for the LGBTQ+ community, opened its doors at Long Island University Post on January 22, 2017. Following the tragic shooting in Orlando at Pulse nightclub and the shift in our political climate, many LGBTQ+ community members were left scared to be themselves and feeling unsafe in their communities. This is when members of the nationally recognized Trauma Response and Research Team at Post decided to act. With the help of local and national experts on trauma and LGBTQ+ cultural competency, student leaders worked to create a space where members of the LGBTQ+ community would feel welcome and their voices would be heard. Each decision from the name to the marketing materials, treatment modalities, and training of clinicians was carefully considered in an effort to ensure both cultural competency and a high level of trauma services. Now in its infancy, Pride Healing Center continues to grow in clientele, community partnerships, and recognition. The PHC continually hears how safe it feels for clients to be themselves in this space. Readers will benefit from a conversation about the creation and development of this clinic, the benefits of trauma-informed treatment for the LGBTQ+ community, and how to take steps toward cultural competency in their own practices.

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Out of the Darkness, Healing Is Possible

Rising Up: Thoughts from Pride Healing Center's Founder, Rae Egbert

Each summer, typically in June, the LGBTQ+ community comes together to celebrate LGBTQ+ Pride Month. This month, which is now full of joyous and raucous parties and parades, commemorates the 1969 Stonewall Riots in Manhattan. The Stonewall Riots were the catalyst for the modern fight for LGBTQ+ rights in America. What started as "Gay Pride Day" the last Sunday in June has grown to be a full month of celebrations for the LGBTQ+ community.

Rae Egbert was 23 years old when they stepped foot into their first lesbian bar. Rae was not yet out to friends or family, just barely out to themself. Rae was in a town where they barely knew anyone. Rae felt they no longer had anything to lose. As soon as Rae sat down, their fears and anxiety washed away. Behind those doors, Rae felt safe. Behind those doors, Rae was with other people like them. Behind those doors, Rae felt they were finally home.

E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_19

It was that year that Rae attended their first Pride event and every year since then Rae has attended Pride in at least one city, if not more than one. The overwhelming love, support, and welcoming community spirit are matched only by the pride felt at these events. The feeling Rae had when they stepped in that bar for the first time is the same feeling they get each year when they attend Pride. For individuals who come from homes and communities where being LGBTQ+ is not allowed, is not acceptable, is shunned, carries the risk of being disowned, and the list goes on, these events put air in their lungs and pride in their hearts.

On June 11, 2016, Rae attended the Pride parade in Washington, D.C. with their wife and several friends. Together, the group watched as members of the nation's government, military, the D.C. community, and many more marched on. The group laughed and reveled in the joy of the day into the late hours of the night. While the group slept, however, a terrible massacre occurred. During the early morning hours of June 12, 2016, a man with hate in his heart took the lives of 49 innocent people and wounded 53 more at Pulse, a gay nightclub in Orlando, Florida, while patrons attended Latin Night celebrations as part of Pride Month.

The LGBTQ+ community lost something that night. It was not just lives lost to this senseless tragedy, but a sense of safety that was irreparably shattered. In the days and weeks that followed, stories of the gay community in Orlando and LGBTQ+ communities all over the United States emerged, with one similar theme – fear. At Pride events across the nation, security was increased (Keneally & Katersky, 2016). Despite the fear, LGBTQ+ individuals, including Rae, and allies showed up in record numbers to support one another and stand tall.

At the time of the shooting, Rae was about to start their second year of a clinical psychology doctoral program. Rae felt an urgency to do something for their program at Long Island University Post and the surrounding community. Rae led a student-based organization at LIU Post, the Trauma Response and Research Team, and, with faculty advisor Dr. Thomas Demaria, the two brainstormed numerous ideas (e.g., vigils, community education, conferences, etc.). With each idea that they explored, similar concerns arose: were they meeting the needs of enough community members? Would the unique skills of the graduate student therapists (GSTs) be utilized? Could the GSTs and a specialized event galvanize the community to attend?

Ultimately, at the suggestion of Dr. Demaria, the two explored the idea of opening a specialty clinic for the LGBTQ+ community. The idea surfaced out of a confluence of factors. First and foremost, many available resources for such a project were already available at LIU Post's Psychological Services Center (i.e., space, GSTs, intake materials, etc.), as well as students' personal and professional knowledge and interest in working with the LGBTQ+ community. As Dr. Demaria once explained to Rae when suggesting the idea, "What we are best at here is providing therapeutic services, do you think we could give it a try?"

The conversation between Dr. Demaria and Rae set in motion the foundation of the clinic. The goal was twofold: to create a space for people who identified as gender and sexual minorities to seek treatment in a safe and affirming environment and to train graduate student therapists (GSTs) to provide competent and affirming therapy. The initial conception for the clinic was in response to Pulse and a desire to provide services to those who suffered from traumatic events, such as those experienced on June 12, 2016. However, it evolved to include those that experienced the ever-present assaults, discrimination, and systemic oppression faced by people who identify as gender and sexual minorities in this country.

Pride Healing Center began as an idea following a horrible tragedy, but it became a reality due to the hard work of a lot of people. After speaking with Dr. Demaria, Rae got on the phone with nearly every person they had networked with, met at a conference, or knew personally who Rae felt might be able to lend some advice. This included psychologists who worked in the fields of trauma psychology, practiced Acceptance and Commitment Therapy, worked with LGBTQ+ Veterans, had

started similar LGBTQ+ practices or clinics, had started practices of their own, and so on. Rae contacted anyone they felt might have a story to share, knowledge to impart, or whose research seemed relevant to the work we hoped to do.

Surprisingly, it worked. People across the country and overseas, who were searching for ways to support the LGBTQ+ community and were interested in what we were thinking about doing, were more than willing to give their time and their insight. Oftentimes the responses came via email, phone calls, and quick conversations late at night or between sessions at conferences. Rae asked pointed questions and remained vitally aware of the time they were asking of others. Rae perfected an elevator pitch – a short blurb about the work being done at LIU Post and what the proposed clinic was hoping to accomplish. Usually, by the time Rae stated their three sentences, people were offering a kind word and a simple suggestion. Rae used it whenever they met someone new and kept a small notebook to write down what people shared. When Rae met with the Student Workgroup, they all talked over suggestions, looked up resources, and called referrals. As a team, they put in a lot of time simply learning.

Rae spent many nights talking over names and marketing with a psychologist in California, Dr. Nicholas Grant, learning about why the clinic shouldn't use the word "trauma" in its name or materials. At conferences in Florida, Rae spoke with Acceptance and Commitment Therapy (ACT) experts on posttraumatic stress disorder, treating LGBTQ+ clients, compassion-based work, and how to structure a clinic (Drs. Walser, Hayes, & Wilson). Those conversations led to calls with Tim Gordon, MSW in Canada, and flurries of emails back and forth on ACT in both psychodynamic and cognitive-behavioral therapy (CBT) settings. Rae learned more in these few months than they ever could have imagined, and most of it was about the kindness of the human spirit. Rae built a tremendous team of students at LIU Post from many different cohorts to support the efforts. Together, the Student Workgroup got to work on creating a brand and logo (with the help of an incredible designer in London), marketing materials, and a training curriculum to ensure cultural competence.

As PHC worked toward an anticipated opening date (Spring 2017), the country's political climate changed dramatically. President Barack Obama's work to support LGBTQ+ Americans was suddenly threatened in ways many never imagined possible. Fear arose anew, and people worried what the next 4 years would hold under newly elected President Donald Trump.

This social and political change was one of the biggest challenges faced as a development team. Pride Healing Center was created for the purpose of providing a safe space despite the presence of uncertainty, oppression, and discrimination. Yet, the clinic was not scheduled to open for another 3–4 months. Several meetings took place with the PHC Leadership Team, and it was ultimately decided that due to our stated goals, and with the rise in uncertainty, Pride Healing Center would open on January 22, 2017. This date coincided with Inauguration weekend. Michelle Obama put it best during her emotional speech at the 2016 Democratic Convention speech, "when they go low, we go high" (Drabold, 2016). The team pushed into high gear to complete all the necessary marketing materials and internal documents (e.g., inclusive intake packets, demographic forms, etc.), complete the training curriculum, and create a safe space within the walls of Pride Healing Center for the LGBTQ+ community.

Since opening in January 2017, Pride Healing Center has surpassed even Rae's wildest expectations. In February 2017, PHC participated in Long Island's first ever Transgender Resource Expo, the only event of its kind to provide medical, psychological, legal, and local resources for the transgender and gender non-conforming community under one roof. Each year since, PHC has again joined groups across the state to participate in the unique event. Pride Healing Center has also formed partnerships with local community organizations Pride for Youth and Northwell Health's Center for Transgender Care. Rae has had the opportunity to speak about Pride Healing Center at events with the Suffolk Psychological Association, the New York State Psychological Association, the American Psychological

Association, and the National LGBT Health Conference, among others. Most importantly, however, PHC has new clients coming in each week for individual and group services. The feedback Rae consistently hears is that Pride Healing Center is a place where people feel safe and welcome and, for many, finally feel that they have someone to talk to who really understands them and "gets it."

The events that took place that tragic morning in June 2016 were intended to induce fear throughout the LGBTQ+ community. Rae believes the intent was to keep members of the LGBTQ+ community from celebrating their collective pride with the people who remind us most that we, as a community, have something to be proud of. When the United States welcomed a new president and set of policies in January 2017, there was renewed fear in the hearts of many in the LGBTQ+ community. Rae believes a similar message was being sent. Pride Healing Center marches proudly forward each day in an effort to show that this clinic is here to serve the LGBTQ+ community on Long Island. It is the mission of Pride Healing Center to be a safe space for everyone and to help our clients and community believe that out of the darkness, healing is possible.

Finding Safety in Something New: The Development of Pride Healing Center

Student Workgroup

PHC originated within Long Island University Post's Trauma Response and Research Team (TRRT). The TRRT works to employ the mission of LIU's Psychological Services program, serving the underserved, by providing off-site counseling responses following large and small disasters, including trauma-informed outreach and intervention to vulnerable community members whose lives have been impacted by trauma. Following the team's mission to foster future psychologists' trauma sensitivity, the team also engages students in the consumption and production of trauma-related research, placing them in a unique position to advance the science of traumatic stress through the study of the psychological, organizational, and societal impact of trauma, the treatment of trauma, the assessment of trauma, the study of multiculturalism and trauma, and the study of posttraumatic growth.

Following the Pulse nightclub shooting, a Student Workgroup was formed to brainstorm a sensitive response to the event. Table 19.1 illustrates the steps taken by students at Long Island University Post's PsyD program to create a specialty community-based mental health clinic for members of the LGBTQ+ community.

In the initial TRRT meeting, students discussed possible event formats, including a community-based event, an event specifically for the clinical psychology doctoral program, a university-wide event, or reaching out to local high schools to offer support services. Rae, the current TRRT student leader, brought these initial ideas to the team's faculty advisor, Dr. Thomas Demaria.

From the initial discussion, Dr. Demaria and Rae began to formulate the idea of creating a specialty clinic for LGBTQ+ community members. At the following meeting of the TRRT, this idea was introduced. Students immediately created a workgroup to discuss the feasibility of such a clinic within the Psychological Services Center (PSC), the training clinic affiliated with Long Island University Post's Clinical Psychology Doctoral Program (PsyD). Students grappled with how to create a safe space where LGBTQ+ people would feel comfortable reaching out and coming in for services in a time marred by violence and uncertainty.

The Student Workgroup expanded quickly, holding weekly meetings to discuss research on other mental health clinics serving the LGBTQ+ community, trauma-informed care, and specific treatment modalities in these settings. Deep and thoughtful conversations emerged about clinic structure, with particular consideration given to how to create something meaningful within the already established structure of the PSC.

While the Psychological Services Center is a graduate student training clinic affiliated with the PsyD program, the PSC serves both the undergraduate and graduate students at LIU Post as

Table 19.1 The developmental process in the creation of Pride Healing Center (used with permission from the Pride Healing Center)

Precipitating event and initial conversations	Following the shooting at Pulse nightclub, Rae Egbert and Dr. Thomas Demaria met to discuss the planned response of the LIU Post Trauma Response Team (TRT).
	Egbert and Demaria ultimately agreed to explore the idea of expanding clinical services at LIU Post's Psychological Services Center (PSC) to include specialty services for the LGBTQ+ community.
Creation of student workgroup	After Egbert pitched the idea to the LIU Post TRT, a Student Workgroup was formed to explore not only the possibility of creating such services but also the feasibility of doing so within a clinical psychology training program.
Exploration of ideas	Members of the Student Workgroup began researching various topics related to LGBTQ+ clinical services, treatment modalities, clinical entities in training programs, affirming practices, and so on.
	Members reached out to experts in the field via telephone and email seeking support and guidance on issues related to the creation and development of the clinic.
	Members met weekly to discuss what they had learned, share resources, and brainstorm new ideas.
Decision-making	Once the Student Workgroup felt they had gathered sufficient evidence to support the opening of a specialty clinic for the LGBTQ+ community at LIU Post, initial decision-making began.
	A name, mission, unifying treatment modality, and leadership team were selected.
	Creation of inclusive paperwork, marketing materials, branding, and other necessary materials were also undertaken at this time.
PHC is born	Pride Healing Center sits within a larger Psychological Services Center (PSC) affiliated with LIU Post's Clinical Psychology Doctoral Program (PsyD).
	As such, PHC was fortunate to have resources available including space, graduate student therapists, etc.
	Updating already existing paperwork, changing bathroom signs, and explaining the importance of a clinic like PHC were some initial hurdles.
	However, these are relatively minor issues compared to those PHC may have faced had it started without a home base at LIU Post.

well as the communities surrounding the university. Graduate student therapists (GSTs) work with clients at the PSC during their first clinical placement in the PsyD program, which takes place during their second year of training. LIU Post's PsyD program is a dual-orientation program, and students receive training in both cognitive-behavioral therapy and psychodynamic psychotherapy. GSTs completing their training year at the PSC are supervised by both a faculty and community supervisor, with one supervising from a CBT perspective and one from a psychodynamic perspective. Navigating the logistics of LIU's dual-orientation training model and the complexities of creating a trauma-informed clinic for the LGBTQ+ community within the pre-existing structures of the PSC were some of the initial challenges faced by the Student Workgroup.

Advisory Council

Consultation on how to actualize such a lofty ambition began, first and foremost, with faculty input. As the Director of the Psychological Services Center and faculty leader of the TRRT, Dr. Demaria gave considerable feedback on how to weave trauma-informed care with LGBTQ+

affirmative services. Dr. Eva Feindler, then director of the Clinical Psychology Doctoral Program at LIU Post, lent her overwhelming support, advice, and knowledge of the program at LIU Post to the Student Workgroup.

The Student Workgroup also relied heavily on outside input. Various consultants were used throughout this creation and development process. At each step along the way, Rae and other members of the Student Workgroup were reaching out to experts in various fields (i.e., trauma psychology, LGBTQ+ health policy and practice, clinic directors, marketing and business professionals, etc.) for advice on how to move forward. Two areas in particular were of significant importance to the workgroup: clinically relevant treatment and selecting a name for the clinic. The main goal of the Student Workgroup was to make informed, educated, and unbiased decisions. As a group of primarily students, the workgroup was aware of blindspots in knowledge, skill, and expertise. Turning to others for input to ensure decisions were made with as much care as possible was a priority for the workgroup, so that the safety of future clients was at the forefront.

In September 2016, Dr. Nicholas Grant, Lieutenant and Clinical Psychologist in the United States Navy, advised on how to begin developing such a clinic. Leaning on previous experiences providing clinical and advocacy services for people identifying as gender and sexual minorities at Palo Alto University and various Veterans Administrations, Dr. Grant impressed the importance of choosing an inclusive yet subtle clinic name, setting up affirming spaces within the clinic, and identifying safe staff members within the larger clinic. He also advised on creating sensitive and affirming marketing materials.

The Student Workgroup also sought advisement in regard to treatment modalities best suited to this unique population. Research on various trauma treatments, including cognitive processing therapy (CPT), prolonged exposure (PE), trauma art narrative therapy (TANT), and other exposure-based treatment models, were discussed to treat acute crises. CPT and PE are the two cognitive-behavioral therapies with the most empirical support and are proven to be so efficacious in the treatment of posttraumatic stress disorder (PTSD) that they are commonly known as the gold standard of treatment approaches (Gallagher, Thompson-Hollands, Bourgeois, & Bently, 2015). However, for some individuals, CPT and PE have not been effective. In recent years, research into newer approaches has expanded. Members of the Student Workgroup were interested not just in these "gold-standard" treatment modalities but also these newer methods that may prove beneficial in working with people who suffered from long-term exposure to sexual orientation and gender identity minority stress. It was the hypothesis of the Student Workgroup that the accumulation of these stressors might produce responses seen in those with stress disorders, and as such these individuals should be treated utilizing trauma-informed approaches.

Throughout the research done by the Student Workgroup, Acceptance and Commitment Therapy (ACT) was often cited as a well-suited approach to this type of trauma-informed care (Gallagher et al., 2015; Walser & Westrup, 2007). The use of values-based living in ACT appeared particularly relevant in working with LGBTQ+ people who were living in an increasingly uncertain world. Matthew Skinta, Ph.D., ABPP, and Aisling Curtin's, MSc, (2016) book, *Mindfulness and Acceptance for Gender and Sexual Minorities: A Clinician's Guide to Fostering Compassion, Connection, and Equality Using Contextual Strategies*, came out shortly after the Pulse nightclub shooting. Many of the themes and ideas within this book helped to set the stage for the clinic, including the importance of self-compassion, gender-affirming care, and trauma-informed approaches.

In September 2016, Dr. Matthew Skinta described his approach to working with gender and sexual minorities via email, "Shy of major assaults like what occurred at Pulse, I think the common background is more like what is referred to as complex trauma." Complex trauma is described by Dr. Christine Courtois as "a type of trauma that occurs repeatedly and cumulatively, usually over a period of time and within specific relationships and contexts" (Courtois, 2004,

p. 412). Individuals who have experienced complex trauma have typically coped with "several forms of interpersonal trauma including abuse, neglect, exploitation, betrayal, rejection, antipathy, and abandonment" (Courtois & Ford, 2016). Such betrayals, particularly when they are experienced by parents or caretakers, can undermine healthy development and lead to "starkly negative beliefs about self and others" (Courtois & Ford, 2016, p.3).

It is through this framework that the Student Workgroup sought to understand how best to frame treatment for the clients at Pride Healing Center. Dr. Skinta referenced several key points to consider in working with this population utilizing the framework of complex trauma, "Work on the small, casual aspects of avoidance of discomfort of uncomfortable situations. Specifically emphasize interpersonal avoidance with warmth and care. Do not neglect the role of shame."

The group also consulted with and attended trainings given by Robyn Walser, Ph.D., and Timothy Gordon, MSW, two leading experts in Acceptance and Commitment Therapy. Dr. Walser is the Director of TL Consultation Services, Associate Director at the National Center for PTSD, and Associate Clinical Professor at the University of California, Berkeley. Rae had the opportunity to train with Dr. Walser in November 2016 and October 2017. During these trainings, Rae spoke with Dr. Walser about the clinic and the use of ACT in the treatment of PTSD, particularly with gender and sexual minorities. Dr. Walser provided advice and consultation on a number of issues related to the creation of the clinic, treatment models, and suggested readings to increase clinicians' knowledge.

Tim Gordon, a registered social worker, peer-reviewed ACT trainer, author, and yoga instructor, is a leader in the ACT community. Rae met Tim at an ACT training in November 2016 and spoke to him about the proposed clinic. From December 2016 through January 2017, Rae and Tim communicated via email on how to integrate ACT into the PSC clinic model, how to collaborate with faculty who did not practice within this modality, and what steps were needed to actualize and sustain this project.

Without the support, guidance, and expertise of these faculty members and outside consultants, Pride Healing Center would not have been possible. Each person that the Student Workgroup researched, identified, spoke to, and met with provided valuable information that led to the construction of a piece of Pride Healing.

Clinic Creation

Through the consultation and advisory feedback process, the Student Workgroup finalized the idea of creating a trauma-informed clinic to serve the LGBTQ+ community located within LIU Post's Psychological Services Center. The clinic would focus on serving LGBTQ+ people in the wake of acute trauma (i.e., events like the Pulse nightclub shooting, physical and sexual assault, etc.), as well as treating the experiences akin to complex trauma described by Skinta of those growing up as gender and sexual minorities in a heteronormative, cisgender world (i.e., familial and societal pressures to conform, rising fears in the political climate, etc.).

In service of Long Island University Post's dual-orientation program and training model, the two primary treatment modalities chosen were cognitive-behavioral therapy and psychodynamic psychotherapy. This remained consistent with the already established treatment modalities, case assignment, and supervisory roles of the larger Psychological Services Center (PSC), in which PHC is housed.

In order to best treat the unique clients and presenting problems within PHC, specific trauma-based trainings were required of those wishing to be PHC clinicians. In particular, GSTs had the opportunity to be trained in cognitive processing therapy (CPT) and prolonged exposure (PE), the two modalities aforementioned as gold standards of PTSD treatment, particularly for acute traumas. GSTs also had the opportunity to attend a training and receive group supervision in ACT.

While ACT was not a formal treatment modality used in the clinic, due to few available ACT supervisors in the community, GSTs were encouraged to think about ACT-informed approaches to treatment when working with PHC clients. This was particularly important in regard to the emphasis ACT places on values-based living. One reason for focusing on the principles of ACT was the common background of many LGBTQ+ people, including familial and societal pressures to conform, bullying, and lack of self-acceptance. Thinking about this minority stress as complex trauma, due to living in a world where their sexuality or gender identity isn't affirmed, tenets of ACT were seen as very useful in helping clients to buy into treatment and begin to focus on leading their own values-driven lives.

Deciding on the name of the clinic was a very difficult task for the Student Workgroup and there were several important considerations. The three main goals of the Student Workgroup were to have a name that drew people in and alerted them that this was a safe space for them to come and receive services. The team also wanted to promote strength and healing, as these were founding principles of the clinic. Finally, the PHC team wanted to address and incorporate the trauma focus of the clinic. In discussing ideas with outside consultants (i.e., clinical psychologists [both with and without LGBTQ+ expertise], marketing and business professionals), many stressed the importance of avoiding increased stigma toward the community with the name. Most warned against the use of the word "trauma" or any such word that created the impression that being LGBTQ+ meant you were by nature mentally ill, traumatized, or unwell. Despite best efforts, many initial ideas were unintentionally offensive, increasing negative attention, and adding stigma.

Many outside consultants also suggested having a name that could be shortened or to give individuals the ability to use an acronym for an increased level of safety in speaking about the clinic and their treatment with others without outing themselves. Students in the Workgroup felt very strongly about being able to use an acronym for this purpose, and it fits well into the culture of the clinic, as the Psychological Services Center was referred to by most in the community as the PSC. As previously mentioned, outside consultants were relied on heavily in making this decision and for good reason, as with each piece of advice the Workgroup learned something new, adapted a possible name or removed one from the list, and adjusted expectations for what a name could be. Having voices from both psychology and business perspectives also helped to give two different lenses in which to view the potential names.

With all of these considerations in mind, students settled on the name Pride Healing Center, as it referenced a sense of community subtly and safely, spoke to a trauma recovery model, but focused on a positive element – healing – and did not stigmatize the community it hoped to serve. The acronym PHC was adopted for additional safety.

After the selection of the clinic name, the clinic logo was designed by London-based designer Chay Sells (https://www.pridehealingcenter.com/what-we-do). The design, which combines the American flag and the rainbow flag, was intended to communicate that, despite recent events, the United States is a place where everyone should feel welcome no matter their gender identity or sexual orientation. The combined flag-based design represents unity, positivity, and challenging negativity of others.

Once the logo was solidified, print materials were made to advertise the new clinic, including brochures, flyers, and signs. The workgroup had two banners made: one small sign for the door of the PSC to help identify the subclinic and one larger sign that hangs inside the PHC space. The larger sign is also transported to community events. Additionally, a website, www.pridehealingcenter.com, was designed to advertise services and start to build a presence in the community. Social media channels on Facebook and Twitter were created, and a member of the Student Workgroup was identified as social media coordinator to monitor the channels and post LGBTQ+-related content.

The availability of gender-affirming bathrooms was an important consideration prior to the opening of Pride Healing Center. The PSC is a multilevel building with two bathrooms on each

floor. On the first floor, there is one single-stall bathroom and one multi-stall bathroom, while the second floor has two multi-stall bathrooms. The single-stall bathroom on the first level was originally designated a men's bathroom. It was subsequently changed to a gender-neutral bathroom and appropriate signage replaced the old sign. This single-stall bathroom is the bathroom closest to the waiting room and is available for any patron of the PSC or PHC.

Most importantly, members of the Student Workgroup collaborated on a clear and concise mission for PHC. The mission of Pride Healing Center is to help LGBTQ+ community members impacted by difficult life experiences or traumatic events to re-establish a sense of safety and predictability in the world by providing culturally competent therapeutic care. Students agreed that all efforts within the clinic should be tied to and driven by this mission.

Building Community

Creating a Structure

Pride Healing Center is unique in being both student-created and student-run. The clinic is comprised of doctoral student clinicians, known as graduate student therapists (GSTs), who have volunteered to participate in the clinical and administrative responsibilities of PHC. This includes completing the 20-h required PHC training, attending a weekly peer consultation group, and any additional continuing education opportunities throughout the academic year.

As previously mentioned, Pride Healing Center operates as a specialty subclinic within the larger Psychological Services Center (PSC) at Long Island University Post, a community mental health training clinic for the program's clinical psychology doctoral students. Distinguishable from PSC operations, PHC clinicians are also overseen by an administrative structure of PHC, including a Director, an Assistant Director, and the Program Director, all filled by students. The initial PHC Director role was filled by Rae Egbert, JD, MS, the founder of the clinic. During the first year, the Assistant Director role was split due to the demand of getting the clinic off the ground and the need for increased support. The two roles included the Assistant Director of Clinical Services, Eva Chiriboga, MS, and Assistant Director of Training, Francesca Rodriguez-Ruiz, M.S. This position was later collapsed into one role, filled by Gina M. DePalo, MS All clinical operations of the PHC are overseen by a faculty supervisor.

While the GSTs are directly supervised on their individual cases by their faculty or community supervisors, they also participate in a weekly peer consultation group led by the Director of the PHC. The group aims to help clinicians confront their own biases about the LGBTQ+ population, support them in the unique clinical questions that arise, and allow for peer feedback. In the first year of the clinic's operation, clinicians were also required to attend a monthly ACT supervision led by Mark Sisti, PhD, a community psychologist with a strong ACT background.

Developing Community Through Safety

The PHC aims to create a safe, inclusive space in the clinic, providing individual, family, and group services. Clients' experience with the clinic begins through one of the referral sources, such as the website (www.pridehealingcenter.com), word of mouth from other clients or providers, or engaging with the PHC at a community event (such as Pride Month events, resource expos, etc.). Each potential new client is screened through a process created by the PHC Administrative Team, which consists of faculty advisors from LIU Post's Clinical Psychology Doctoral Program, the LIU Post Psychological Services Center, and the student director of the PHC. Table 19.2 illustrates the process by which potential PHC clients are screened for admission to the clinic, as well as the responsibilities for each member of the PHC Administrative Team throughout the process.

This initial consultation session is required primarily to explore mutual assessment of fit. During this session, the first set of data is collected on

Table 19.2 Intake screening flowchart for potential PHC clients (used with permission from the Pride Healing Center)

Pride Healing Center **Intake flowchart**
Call or email received by PHC
Member of PHC Admin Team reaches out to schedule initial consultation meeting.
Initial consultation meeting
The primary purpose of this meeting is to create a sense of safety and community.
The first half of the meeting is devoted to introduction to therapy and PHC.
The second half of the meeting is used to conduct a brief screening (using phone screen for PSC and/or agreed-upon questions). Potential client will be asked, "Why now?", and any red flags from paperwork will be addressed.
At the end of consultation meeting, it is made clear to client that if we have further questions about risk, a licensed clinician will be reaching out. All potential clients are asked to go home and think about the fit of PHC for their needs and told we will be in touch within 24–48 h
If there are any red flags from consultation meetings (in either paperwork or screening), the case will be sent to Eva Feindler, PhD, for further assessment.
If there are no prior hospitalizations, suicidal thoughts, self-harm, weapons in home, arrests, etc., the case will go to the PHC Admin Team for assignment to GST.
Once the case has been cleared for assignment, the PHC Admin Team make a decision regarding assigning a PHC graduate student therapist (GST)
Assignments of cases to GSTs will be based on completion of PHC training, attendance at weekly meetings, and current PSC caseload.
Every effort will be made to ensure that those who want a PHC case will receive at least one cause throughout the training year.
PHC team meetings and PHC admin meetings will take place regularly to ensure cases are properly supervised and underlying risk is addressed immediately by licensed supervisors
PHC team meetings will take place weekly.
PHC admin team meetings will take place monthly (or more frequently if needed) to provide faculty and PSC supervisors with case updates and address any issues of risk.

prospective PHC clients. Information gleaned from this consultations session not only helps to assess their current psychological functioning and whether they are an appropriate match for a training clinic but also adds to the research being collected at PHC related to the LGBTQ+ community. The consultation paperwork includes a demographic questionnaire and self-report measures that assess general psychological and PTSD symptoms. The PHC utilizes measures that are reflective of concerns uniquely relevant to the population, assessing for trauma symptoms, progress toward and obstructions to living a life in line with one's value system, and psychological flexibility, a construct involving the ability to see possibilities and remain adaptive in the face of life's difficulties (see Table 19.3).

Potential clients are notified during this initial meeting that should the clinic have any concerns about risk, a licensed clinician will be reaching out. Should elements of risk arise in the consultation, such as previous hospitalizations, suicidal thoughts, self-harm, court involvement, or access to weapons, the case is sent to the faculty supervisor for an additional phone screening. Should a potential client be cleared by this final screen, or a potential client endorses no risk and decides to work with us, they are paired with a trained GST based on their unique needs. Clients are also advised that they can reach out to the PHC Director with any questions or concerns. In this way, the mission of the center is again presented, and transparent communication is always encouraged.

The PHC also offers group services to clients. *PHC Parents* is a parent and caregiver support group in which people can come together to meet other parents and guardians of LGBTQ+ youth, build a community, and discuss the issues that are uniquely relevant to them. *PHC Parents* is a collaborative effort with partner organization Pride for Youth. Their group Pride for Parents meets the first Thursday of each month at their location, while *PHC Parents* meets the third Thursday of each month at PHC. The group is co-facilitated by leaders from PHC and Pride for Youth. Members are encouraged to attend meetings at both locations and create supportive relationships that extend outside of the group setting. A *PHC Parents* Newsletter is also sent out regularly with news for members including meeting times, local events, and news relevant to the transgender and gender diverse community locally and nationally.

Table 19.3 The three branches of PHC

Clinical services	Training a new generation of therapists	Research and development
Individual and family therapy.	All clinicians at PHC are second year students in the Clinical Psychology Doctoral Program at LIU Post.	PHC is a training clinic; as such, data is regularly collected to assess the outcomes of clients and clinicians.
PHC parents.	All students self-select to take part in extra training and supervision affiliated with PHC.	Using this data, the PHC Leadership Team is able to better understand the unique needs of the clients presenting for treatment, as well as the successes and areas of growth for PHC in training. GSTs
Letters for hormones/ surgery.	Training includes self-directed study, in-person training, and continuing education.	
Psychological assessment services.		
Low cost, sliding scale.		
No one is turned away due to inability to pay.		

This table illustrates how PHC was designed with three interconnected branches in mind that each work together to create the unique team-based approach that Pride Healing Center strives to achieve (used with permission of the Pride Healing Center)

Pride Healing Center is currently developing a plan to offer a Creative Arts Space for LGBTQ+ Youth, to meet at the same time as *PHC Parents*. In this group, LGBTQ+ youth will have the opportunity to come and meet others, make friends, and express their creativity. This group will be open to youth of all ages and does not require any previous art or art therapy experience. Though creativity is the medium that is used for expression of self, the purpose of the group is community building and engagement and is being developed in response to community members' request. The group will be facilitated by an art therapist as well as a PHC clinician.

Beyond the therapy room, PHC aims to build a presence within the community and to remain active and engaged. Collaborations have been formed with local community organizations, namely, Pride for Youth and the Northwell Health's Center for Transgender Care, which serve as major PHC referral sources. Additionally, the PHC utilizes these partnerships to assure clients can receive comprehensive care, should they require services beyond what the clinic can provide. Services that these collaborative partners provide include medical care (e.g., hormone replacement therapy, gender affirmation surgery, psychiatric evaluations, transgender support groups, HIV/STD testing, etc.), community-based engagement, numerous support groups, and youth drop-in centers.

The PHC also participates in local events to increase awareness within the surrounding communities. The clinic participated in the Long Island Transgender, Gender Non-Conforming & Non-Binary Resource Expo in 2017, 2018, and 2019. This Expo was a first-of-its-kind event on Long Island that brought medical, legal, and mental health services together under one roof to allow transgender and gender diverse individuals to reach many different service providers in one day. The PHC was also represented at a booth at Long Island Pride in 2017 and 2018 and participated in the Long Island Equality Walk and Pride Picnic in 2018.

Training a Team

Initial Training Curriculum

As members of a stigmatized minority, LGBTQ+ individuals seek counseling services at higher rates than heterosexual-identifying individuals due to increased exposure to minority stress (O'Shaughnessy & Spokane, 2013). However, psychologists and graduate students alike report that they lack skills or believe that they are inadequately trained to incorporate sexual or gender identity into counseling services (O'Shaughnessy & Spokane, 2013). This perceived lack of preparedness may decrease therapists' self-efficacy,

leading to the potential for poor mental health outcomes and the potential for microaggressions and discrimination in the therapeutic relationship (O'Shaughnessy & Spokane, 2013; Riggs & Fell, 2010).

In order to assure the PHC offered culturally informed and sensitive LGBTQ+ care, founder Rae designed a comprehensive virtual training program for GSTs interested in participating in providing services to clients and the community through Pride Healing Center. The initial goal of the training program was to provide an introductory-level education of each community represented within the LGBTQ+ acronym (lesbian, gay, bisexual, transgender, and queer). Through this educational programming, GSTs become familiarized with relevant mental health concerns unique to each community as well as common treatment issues that may arise when working within each population.

At Long Island University Post, the PsyD program participates in SafeZone training. Each first year cohort participates in monthly training sessions to educate students about the LGBTQ+ community. The SafeZone series includes monthly installments of didactics and experiential exercises to familiarize students with relevant research in the area and encourages students to explore their own biases and misconceptions about topics related to the LGBTQ+ community. SafeZone, as well as required multicultural classes taken within the first year of the LIU Post PsyD program, aims to promote sensitive, reflective, and informed clinicians who can practice psychotherapy in an affirmative manner. The PHC training intended to build upon this base-level knowledge imparted during the students' first year.

The initial training utilized a mixed-media approach (e.g., webinars, books, articles, websites). The importance of utilizing various forms of media was twofold: (1) there was no book available that encapsulated all the necessary information and (2) all students learn differently. Asking graduate students to participate in extra training can be difficult, particularly when the second year in the PsyD program at LIU Post involves the first introduction to clinical care with patients. There is already a great deal of training, added responsibility, and stress. Knowing that participation in this specialty subclinic was elective, Rae and the team of students working on creating the PHC knew that they needed to create a training that was adaptive in meeting the learning needs of many students, as well as inclusive of opportunities for learning that went beyond the typical reading of books and articles.

The training, which was initially 10–15 h, followed a self-directed model. Students were presented with the training program (see Appendix A) and instructed they must complete it before they could be assigned cases within Pride Healing Center. Completion of the training program was a contingency for participation in PHC activities, including group and outreach activities. The reason for self-directed study, as opposed to a didactic, single experience with an instructor, was again to accommodate the needs of the GSTs who were working toward beginning their training in the Psychological Services Center. Additionally, it allowed for multiple voices to be involved in the training experience, rather than one single voice. Ultimately, GSTs were exposed to multiple leaders and experts in the LGBTQ+ community through the mixed-media approach of the training program.

The Fenway Institute's National LGBT Health Education Center is a resource that was relied on heavily in the development of the training program. The National LGBT Health Education Center offers free educational programs and resources to healthcare organizations with the goal of optimizing quality, cost-effective care for lesbian, gay, bisexual, and transgender (LGBT) people. The organization had existing concise and comprehensive webinars that spoke directly to topics in behavioral health that were important to our training needs at Pride Healing Center. The training team watched more than 15 webinars to assess the content and relevance to PHC's training needs before deciding on 6 webinars to include in the training program.

In the initial training program, three of the six webinars were identified as core to the education of the clinicians, and GSTs were required to watch. These webinars included Sexual

Orientation, Gender Identity, and Mental Health in Children and Adolescents (1 h); Behavioral Healthcare for Lesbian, Gay, and Bisexual People (1 h); and Mental Health Care and Assessment of Transgender Adults (59 min). Additionally, GSTs had to watch one additional webinar from the remaining three: Structural Stigma and the Health of Lesbian, Gay, and Bisexual Populations (1 h), Providing Care for Addictions in the LGBT Community (1 h), or Same Sex Domestic Violence: Considerations, Suggestions, and Resources (58 min).

In addition to these webinars, the initial training program utilized a number of existing articles and clinical reports. Articles included in the training program were selected for their significance within the psychological community and the ability to educate new clinicians about experiences of LGBTQ+ youth and parents. GSTs were asked to read three of the five following: (1) APA Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients, (2) APA Guidelines for Psychological Practice with Transgender and Gender Nonconforming People, (3) Lesbian and Gay Parenting, (4) Human Rights Campaign – National Coming Out Day Youth Report, and (5) Human Rights Campaign – Supporting and Caring for our Gender Expansive Youth Report.

Websites were also used to enhance GSTs learning about the LGBTQ+ community, particularly the national and local resources available for LGBTQ+ people. For many LGBTQ+ individuals, community building happens online. This can be particularly true for transgender, gender non-conforming, and nonbinary (TGNCNB) people. As the world becomes more technologically savvy, online forums have become the modern way for TGNCNB individuals to connect and form communities, a vital source of support as they navigate their way in a sometimes-unwelcoming society. LGB and TGNCNB people seek connectedness and community to promote healthy coping mechanisms, reduce psychological distress, and validate emotional experiences related to discrimination and other traumas (Pflum et al., 2015). For these reasons, visiting prominent LGBTQ+ websites was also a required part of the training program.

Five websites were selected for their importance within the LGBTQ+ community or for the experience that they may provide the GST in learning about the community. GSTs were asked to familiarize themselves with three of the five websites. An effort to understand these websites would help these GSTs not only to become better allies but also to provide resources for their future clients. The websites included:
http://www.hrc.org/
http://www.thetrevorproject.org/
http://www.wpath.org/
http://www.transequality.org/
http://www.transpeoplespeak.org/

Assessing GST Competency

Multiple measures were used in conjunction with the training program to assess a GST's completion of learning objectives and self-reported feelings of competency in working with LGBTQ+ clients. GSTs were asked to complete pre- and post-tests, designed by Rae, that covered content specifically addressed in the training materials. These two measures assessed learning objectives and knowledge acquired through the completion of the trainings. The purpose of these pre- and post-tests was to ensure that GSTs participated meaningfully in the training experience. In order to work with clients at the PHC, GSTs were expected to show improvement between the pre- and post-test. A score above 85% on the post-test was considered a passing score.

In addition to these pre- and post-knowledge-based tests, GSTs were asked to fill out self-report measures about their perceived competency and attitudes in working with the LGBTQ+ population. Again, these measures were filled out prior to beginning the training and after completion. GSTs completed the Measure of Attitudes Toward Gay, Lesbian, Bisexual, and Transgender Clients (Cochran, Peavy, & Cauce, 2007) and the Sexual Orientation Counselor Competency Scale (Bidell, 2005). An increase in self-reported feelings of competency and attitudes was expected for both measures.

Using Feedback to Make Change: Training Phase Two

The initial training program was used to train the first two cohorts of students and was met with mixed reviews. In the first two cohorts, 11 GSTs elected to participate in Pride Healing Center and completed the training requirements. There were five GSTs in the first cohort and six GSTs in the second cohort. Data, in terms of the abovementioned self-report measures, was collected not only pre- and post-training but also at the end of each year. In addition, feedback was requested about the value of the training experience (initial training, continuing education, supervisory/leadership experiences). All of this information was used by the PHC Leadership Team to make changes to the training curriculum for the following year.

Pride Healing Center opened during the spring semester of 2017. The first cohort of GSTs to work at PHC had the shortest amount of time to work with clients, least access to resources, and received the least amount of training. In many ways, this cohort was the testing ground for many of the training services we would come to offer for future cohorts. However, this group of GSTs was also one of the most dedicated to the development and creation of PHC. Many GSTs who became clinicians were also part of the original Student Workgroup.

Qualitative feedback from these GSTs at the end of the 2017 academic year reflected that these GSTs wanted more in terms of training. They wanted more time to talk about cases and receive feedback, more experts in the field to provide training on relevant topics to the cases we have in the clinic, and more LGBTQ+-specific training. The quantitative data from the knowledge-based tests and self-report measures of competency and attitudes showed the Leadership Team that scores did improve pre- and post-training, as well as over time. These GSTs, many of whom were already versed in LGBTQ+ mental health, also found the training webinars and articles quite helpful. We felt we were on the right track, but knew we wanted to do more.

The second cohort of GST clinicians was the first full year that PHC was open. In this training year, the training curriculum remained the same, but additions were made including weekly consultation meetings with founder, Rae, and Lunch and Learns with Pride Healing Center. These Lunch and Learns featured local and national experts in LGBTQ+ care for 90-min didactic and skills seminars. Again, limited increase was seen in initial pre- to post- assessments from the training, particularly on the knowledge-based test. However, at the year-end data collection, scores increased on the Measure of Attitudes Toward Gay, Lesbian, Bisexual, and Transgender Clients (Cochran, Peavy, & Cauce, 2007) by 18.4 points on average (range 0–33) and the Sexual Orientation Counselor Competency Scale (Bidell, 2005) by 50 points on average (range 43–58).

The significant improvement in feelings of competency over the course of the year showed the PHC Leadership Team that efforts in training students and improving feelings of competency were paying off. The qualitative data from the second cohort of students further solidified these feelings. Gina M. DePalo, MS, Director of PHC 2018–2019, said the following of her training experience at PHC in 2017, "We have taken so many trainings since beginning the program, and I feel none have been as useful, informative, sensitive, and clinically-relevant as our PHC training. It sets a foundation that is more comprehensive than many of us have ever gotten before in other attempts to promote LGBTQ+ competency." Loey Bromberg, MS, agreed, "I was told that there was a 6-h training and I was dreading it because my experience with trainings is that they are dry, redundant, and too long. After 20 min, I had my notebook out, taking notes and was actively captivated because it was the most useful and interesting training I have had."

Following the end of the 2017–2018 academic year, the training curriculum was revised in response to feedback from prior cohorts and to include up-to-date materials. Areas of improvement in the training were identified using a content analysis of the two prior cohort responses on the Measure of Attitudes Toward Gay, Lesbian,

Bisexual, and Transgender Clients (Cochran, Peavy, & Cauce, 2007) and the Sexual Orientation Counselor Competency Scale (Bidell, 2005). Key areas included assessing understanding of institutional barriers to treatment for gender and sexual minorities, GSTs exploring their own privilege and bias, and preparedness for assessment/evaluation/treatment of gender and sexual minorities.

The current training curriculum is divided into five modules, each with a different theme (see Appendix B). The modules build on one another and create what founder, Rae, and 2018–2019 director, Gina M. DePalo, felt was a cohesive starting point for LGBTQ+ competency for beginning clinicians. In conjunction with weekly consultation team meetings with PHC director and Lunch and Learns, this training program provides a comprehensive training throughout the academic year.

The five training modules include (1) Introduction/Issues facing the LGBTQ+ Community; (2) LGBTQ+ Youth; (3) Lesbian, Gay, and Bisexual Adults; (4) Transgender Youth and Adults; and (5) Special Topics. The entirety of the training is estimated to take approximately 15–20 h to complete.

The current training follows many of the same principles as the initial training curriculum. Webinars, videos, articles, book chapters, and websites are used to present the material in a meaningful way. There were two notable changes made to the training for this cohort. One was again made in response to feedback from prior cohorts who asked for more interaction with the PHC Leadership Team during the training process. In response, the training was offered in two formats, independent study (as the training had always been) or group study. The group study (see Appendix C) format would offer the GSTs the opportunity to meet weekly with the PHC Leadership Team and other group study participants to discuss that week's module, ask questions, and engage in relevant conversations. This type of study sparked a lot of initial interest, but due to scheduling conflicts, the group study was not started this year. This type of training will be offered in the coming academic year.

The second major change was in regard to how the Leadership Team assessed GST completion of training. Unlike the two previous cohorts that utilized a pre- and post-knowledge test based on the training, this cohort was asked to be more self-reflective and think more critically about each module (see Appendix B). At the end of each module, each GST was provided a post-test which asked reflective questions (see Appendix D).

The choice to switch to a more self-reflective and critical thinking style post-test was made based on 2 years of sub-par scoring and minimal improvement on the post-test measures. While it was apparent the GSTs were engaged in the material, it felt to the PHC Leadership Team that there was a better way to capture what they were learning, how they were internalizing it, and how they may use it to interact with their PHC clients in the future.

In the third cohort of PHC clinicians, ten GSTs completed the training. This was the largest cohort to take part in the training experience to date. The GSTs showed a great deal of insight, compassion, willingness to learn, and eagerness to serve others throughout their training year.

Analysis of their post-tests from the initial training at the start of the year demonstrated six key themes including the burden on the client to educate the GST should be reduced; educating yourself as a GST reduces microaggressions/mistakes and makes the environment more inclusive and affirming; personal stories remind GSTs that statistics represent real people with real difficulties – these anecdotes often resonated more than academic sources; the therapeutic space should be used as a safe one to explore identity without fear; therapy should be used to help build a client's support system, resources, and safe spaces; and GSTs should continue to educate themselves about issues that impact gender and sexual minorities – including continually assessing their own bias and stereotypes.

The GSTs self-report measures indicated several three key findings. First, there was no significant change in attitudes toward LGBT clients from pre-training to end of training year. The GSTs at PHC began the training year with posi-

tive, affirming beliefs, and those remained relatively consistent throughout the year. Second, the most significant amount of change in self-reported feelings of competency occurred following the initial training modules. This occurred despite feedback from GSTs that self-directed training was "tedious, should be shortened, etc." The gains that were made following initial training held throughout training year or continued to improve slightly. However, there continues to be room for improvement in the continuing education component of the training curriculum, as rates of improvement appeared stagnant from post-initial training to the end of the year assessments.

A hallmark of PHC and the training program in particular has been incorporating feedback from prior cohorts. Each year, the PHC Leadership Team takes time to analyze the year's successes and areas for improvement. Being able to self-reflect is an important way PHC leadership feels the clinic can continue to grow. Using the PHC GSTs to help do so is a strength of PHC's team-based approach.

At the end of this training year, the 2018–2019 cohort gave feedback and suggestions about their experiences at PHC. Many of their suggestions were items that the PHC Leadership Team had already begun to discuss. Most notable was the concept of incorporating more in-person training throughout the training year. In response to the feedback from PHC GSTs, the training for the fourth cohort, beginning fall 2019, will include both self-directed and in-person training. The initial training program will be divided into a 10–12-h self-directed study, including more fact/summary sheets to reference throughout the year, which will be followed by a full day (8-h) in-person training prior to the start of the PHC training year. This training day will include role-plays, exploring bias, and self-reflection.

Continuing Education

In order to assure continued learning and support, GSTs are required to attend a weekly peer consultation group led by the PHC director. As previously mentioned, this consultation group allows GSTs to get additional support and supervision on current cases, as well as psychoeducation on issues pertinent to the LGBTQ+ community. Topics that have arisen in this setting include the current World Professional Association for Transgender Health (WPATH) guidelines for transgender care (https://www.wpath.org/publications/soc), discussing vocabulary for various identities, and how to conduct sensitive risk assessments with LGBTQ+ clients.

In order to supplement the consultation meeting and offer more didactics, the PHC began the Lunch and Learn with Pride Healing Center series. This series introduced local and national experts in the field of LGBT healthcare and policy to the LIU Post PsyD program, benefitting GSTs both working within and those unaffiliated with PHC, as well as faculty. The Lunch and Learns are monthly, 90-min sessions, roughly broken into three 30-min segments, including didactics, skills building, and a Q&A portion. Spring 2018 topics have included HIV and Sexual Health within the LGBTQ Community, Using Emotion-Focused Therapy with LGBTQ Couples, Working with Transgender People: How to Integrate Name and Gender Marker Changes in to Mental Health Treatment, and Affirmative Counseling with Transgender and Gender Diverse Clients.

The response to the inclusion of the weekly peer consultation and Lunch and Learns has been remarkable. GST Sarah Immerman, MS, stated the following: "I have found tremendous value in the continuing education aspect of the PHC, and I appreciate that we are committed to consistently learning and growing." In response to the success and popularity of Lunch and Learns, PHC has partnered with the SafeZone program to offer joint programming to the entire PsyD program.

Providing Hope for Healing: Evaluating Outcomes for Clients and Clinicians

Outcome Measures for Clients

In order to assure the PHC is providing effective treatment, clients are asked to fill out a variety of measures to track their treatment progress. At intake, clients are asked to fill out four self-report

forms to assess symptoms and concerns at baseline. The Outcome Questionnaire (OQ-30: Ellsworth, Lambert, & Johnson, 2006) is used throughout the larger PSC in an effort to track treatment-related outcomes over time. All adult PHC clients are asked to fill out the OQ-30 as well.

Unique to the PHC, clients are asked to fill out the Valuing Questionnaire (VQ; Smout, Davies, Burnes, & Christie, 2014), Acceptance and Action Questionnaire (AAQ-II; Hayes et al., 2004), and PTSD Checklist for DSM-5 (PCL-S; National Center for PTSD, 2012). These measures were selected in an effort to assess psychological flexibility, progress toward values – both Acceptance and Commitment Therapy constructs – and PTSD symptoms. The AAQ-II, OQ-30, PCL-S, and Valuing Questionnaire are repeated every 8 weeks to track a client's progress over time. Additionally, GSTs verbally administer the Mini-International Neuropsychiatric Interview (MINI; Sheehan et al., 1998) at intake. The MINI is a structured diagnostic psychiatric interview that is used as part of diagnostic training of GSTs in the Psychological Services Center. The MINI is not used exclusively in diagnosing at the PSC or PHC. The MINI serves as only one tool used to assess clients at intake.

Current Data

To date, Pride Healing Center has trained 22 clinicians across 3 GST cohorts. PHC clinicians have treated 29 individuals, 2 couples, and 1 family and run 2 groups (PHC Parents and a creative arts space). Not only has PHC done well recruiting clients, but clinicians have done well in retaining clients over time. Only three clients have terminated services by failing to come for sessions or failing to respond to PHC contacts. Four clients from the first two cohorts chose not to return to PHC the following year to continue treatment citing the following: two clients graduated from LIU Post and two clients moved out of state. Three clients have been referred out of the clinic due to their level of risk and their need to be referred to a higher level of care. Pride Healing Center is a training clinic, and at times there are cases that are not suitable for beginning therapists due to the amount of risk posed. When this occurs, every effort is made to refer the client to a provider or treatment center that is LGBTQ+ affirming and a safe space. PHC has had only one client state that they discontinued services due to dissatisfaction with their care.

PHC clients present with a myriad of concerns, often including issues that relate to high-risk behaviors such as chronic suicidality, self-harm, substance abuse, and eating disorders. Other diagnostic considerations among the clients that are treated at PHC include major depressive disorder, anxiety disorders (namely, generalized anxiety disorder and social anxiety), issues with family, gender dysphoria, issues with avoidance (particularly avoidance of others), issues of development, and issues with sense of self. Figure 19.1 illustrates the types of diagnoses clients have presented with to the PHC for treatment by the three GST cohorts.

Notably, many clients at Pride Healing Center present with high levels of PTSD symptomology. On the PCL-S, scores above 35 in the general population and 45–50 in a specialized mental health clinic indicate patterns associated with PTSD symptoms. Of the 29 individual and family clients treated at PHC by GSTs in the first 3 cohorts, 67% had PCL-S scores above 35 (range 35–77), and 42% had scores above 45 (range 45–77). This gives a picture of significant trauma in this population. For this reason and more, continual training on trauma-informed approaches to care are woven into all of the clinical work at PHC. Figure 19.2 illustrates the high percentage of PHC clients who indicate trauma symptoms at intake on a self-report assessment (PCL-S).

Measuring Group Success

In the spring of 2017, Pride Healing Center ran its first group. This group was an 8-week creative arts group for undergraduate students, which ran in conjunction with an undergraduate art therapy student, Veli Sadiku. The purpose of this group was to better understand how LGBTQ+ undergraduate students were experiencing the stress of the Pulse nightclub shooting and the change in

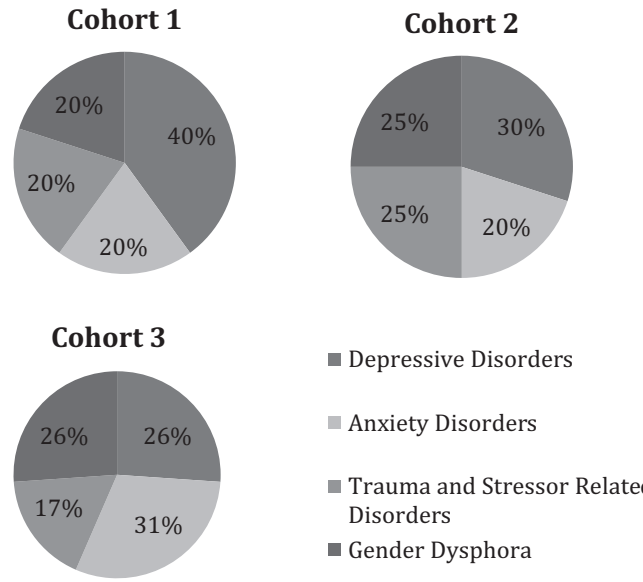

Fig. 19.1 Diagnoses at PHC by cohort (used with permission of the Pride Healing Center)

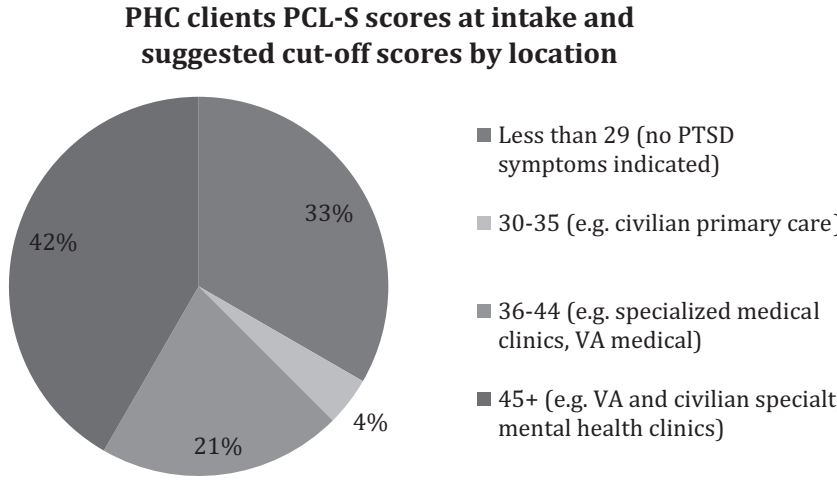

Fig. 19.2 PHC clients PCL-S scores at intake with suggested cut-off scores (used with permission of the Pride Healing Center)

the current political climate. Additionally, this group sought to promote community building among LGBTQ+ students and their allies. This was an open group, and each week had a structured activity which promoted learning and community building. Throughout the 8 weeks in which the group met, there were 17 members who attended at least 1 session. Most group meetings had between 5 and 10 students present.

At the first and last meeting of the group, students were given a self-report measure and questionnaire to assess their feelings of safety and connectedness. The questionnaire was created by Veli Sadiku and Rae to better understand feelings of safety on campus and in the community. The measure used was the Connectedness to the LGBT Community Scale (Frost & Meyer, 2012). At the outset, the majority of the students in the group reported that they did not feel safe as an LGBTQ+ person in America. The members attributed this lack of safety to the political climate (including President Trump and his sup-

porters), the ignorance of people they interact with, reports of gay bashing, seeing others mistreated due to their identity, the shooting at Pulse, hate crimes, a lack of education and acceptance among the general population, and that simply "people are crazy."

At the completion of the 8-week group, student members gave the feedback that their feelings of safety and a sense of community increased in being part of the art group. Most of the group members reported feeling more connected to one another and their community, particularly on campus. One member stated, "Before I didn't [feel connected to my LGBTQIA identity] because I was more enclosed to myself but now I feel more connected." The majority of members also indicated that they had not expected to enjoy coming to the group, but found that having a space to be with other LGBTQIA students was fun, comfortable, and a good space to express their personality. One member put it best, stating, "[This experience] showed me that happiness and pride will forever conquer. It was inviting and welcoming [and] makes me proud of myself."

Future Directions for Pride Healing Center

On January 22, 2019, Pride Healing Center celebrated its 2-year anniversary. In the past 2.5 years, an unbelievable flurry of events has created a fully operational and sustainable clinic for the LGBTQ+ community on the LIU Post campus. New clinical and research opportunities present themselves each day. The outcomes data collected every 8 weeks from the clients drives research about treatment for the LGBTQ+ community, particularly trauma-informed practices. PHC leadership continues to track GST progress in their training and self-reported feelings of competency and regularly collects feedback on how to improve the approach to training.

Additionally, and most importantly for many on the PHC Leadership Team, meaningful relationships and partnerships the community continue to be formed, including LGBTQ+ organizations, clinicians with expertise in the field, LGBTQ+ community members and allies, and so on. Rae is regularly asked to speak at LGBTQ+ events, conferences, and youth centers, opening the doors for connection and community building across Long Island.

As PHC grew, Dr. Eva Feindler's leadership helped it to thrive. She ushered in a new wave of research, supervision, and training initiatives that will ensure the program sees continued success for years to come. Dr. Feindler worked tirelessly to recruit and retain community supervisors with experience treating people who identify as gender and sexual minorities.

Starting fall 2019, seven community-based supervisors with experience working with the LGBTQ+ community will join the PHC Supervision Team. These supervisors will have access to all PHC training resources, including all continuing education experiences. Members of the PHC Supervision Team will also have continued interaction with Dr. Feindler throughout the year so that the PHC Leadership Team can continue to assess the efficacy of this new venture.

In two short years, Pride Healing Center has become a part of the Long Island LGBTQ+ community. The clinic has become a recognizable and safe space for LGBTQ+ community members to receive quality mental healthcare. When the PHC Leadership Team thinks about how to achieve our mission moving forward, community building and partnerships are identified as the place to best meet the needs of the Long Island LGBTQ+ community.

Appendices

Appendix A

PHC Training Plan (Used with permission of the Pride Healing Center)

Watch the following five videos/webinars:

(Accessible through http://www.lgbthealtheducation.org/topic/behavioral-health/ **and** http://www.apa.org/apags/governance/subcommittees/lgbt-training.aspx**)**

- Sexual Orientation, Gender Identity, and Mental Health in Children and Adolescents (1 h)
- Behavioral Healthcare for Lesbian, Gay, and Bisexual People (1 hr.)
- Mental Health Care and Assessment of Transgender Adults (59 min)
- Working on Shame with Sexual Minority Clients (10 min)
- Sexual Orientation and Gender Identity Microaggressions in Clinical Settings (18 min)

Choose one of the following:

- Structural Stigma and the Health of Lesbian, Gay, and Bisexual Populations (1 h)
- Providing Care for Addictions in the LGBT Community (1 h)
- Same Sex Domestic Violence: Considerations, Suggestions, and Resources (58 min)

Visit three of the following websites:

- http://www.hrc.org/
- http://www.thetrevorproject.org/
- http://www.wpath.org/
- http://www.transequality.org/
- http://www.transpeoplespeak.org/

Read three of the following:

- APA Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients
- APA Guidelines for Psychological Practice with Transgender and Gender Nonconforming People
- Lesbian and Gay Parenting
- Human Rights Campaign – National Coming Out Day Youth Report
- Human Rights Campaign – Supporting and Caring for our Gender Expansive Youth Report

Appendix B

PHC Training Plan (Used with permission of the Pride Healing Center)

Thank you for your interest in the PHC! We are thrilled you have decided to take part in this exciting new opportunity, and we can't wait to see what successes and challenges the PHC will present for each of you.

The training protocol will take approximately 15–20 h to complete. We recognize that this is a large time commitment. However, we feel that as a training clinic, it is important to ensure that we, as clinicians, are well versed in the current literature and cultural issues for this population.

Prior to the start of the training, you will be asked to take two self-report measures, which will assess your own attitudes and feelings of competency in working with members of the LGBTQ+ community. Throughout the training, you will be asked to complete five training modules. At the completion of each training module, you will complete a post-test to assess your understanding of the material. After completing the entire training, you will take the two self-report measures again.

All of the training materials you will need, including readings, as well as links to the websites are included in a Dropbox folder (titled PHC Materials) so that you can easily access them. Before getting started please carefully read all of the instructions. You will notice there are several different tasks you are asked to complete.

Training Instructions: The goal of this training is for you to begin to think about your own motivations for working at the PHC, to better understand cultural bias that this community faces (even in therapy settings), and to begin to think about how to approach working with gender and sexual minorities to meet their unique needs. This means thinking critically about yourself and your implicit and explicit biases as you work through this process. It's ok, we all have them, now is the time to explore them! As you watch, look, and read – think about how each of these things resonates with you, what you are learning, and how it is impacting you.

Videos: Watch each video with a *critical* eye. What did you learn? What resonated with you? What questions do you still have? What left you feeling uncertain or left you feeling like you might not be able to do it yourself?

To watch the webinars, you will need to access the following websites:

- http://www.lgbthealtheducation.org/topic/behavioral-health/
  - On the Fenway Health website, you'll be asked to create a login in order to watch the videos. This is completely free.
    - (All of the webinars are located under the Behavioral Health topic should you happen to navigate away from the page and can't locate the videos.)
- http://www.apa.org/apags/governance/subcommittees/lgbt-training.aspx
  - The shorter length videos (10 min, 18 min, and 21 min) are located on this website.

Websites: Unless otherwise noted, look through each website as if you were choosing what sites you might recommend to a future client. What makes this website a good choice? What makes it not so good? What questions are you left with? What resources are offered here? How might this be useful to a particular client/population? Think and look *critically*.

Readings: Each reading was selected for a different reason, some to provide clinical skills, others to educate you about unique aspects of LGBTQ+ culture, and so on. Think *critically* about what you are reading. What did you learn? What resonated with you? What questions do you still have? What left you feeling uncertain or left you feeling like you might not be able to do it yourself?

Feel free to watch the videos, look at websites, and do the readings in any order that you like as long as you complete each piece before moving on to the post-test for the module. Upon completion of all materials in the module, self-study participants should contact Rae Egbert for access to your post-test. Group study participants will be given access to the post-test on the day marked on their group calendar.

Please reach out with any questions or concerns. We are here to help!!

Module #1: Introduction/Issues Facing the LGBTQ+ Community

(Approximate time to complete 4–5 h)

Videos

- Structural Stigma and the Health of Lesbian, Gay, and Bisexual Populations (1 h)
- Addressing Social Determinants of Health for LGBTQ People (58 min)
- Intersectionalities in Psychology: Intersections of Race, Sexual Orientation and Gender (21 min)
- Sexual Orientation and Gender Identity Microaggressions in Clinical Settings (18 min)

Websites

- http://www.hrc.org/
- https://implicit.harvard.edu/implicit/
  - Take the Transgender Implicit Association Test and the Sexuality Implicit Association Test – Think about your results. What do you think they say about you? What do they mean to you? How do they influence how you view the world?

Readings

- Mental Health Care for LGBT People (Fenway Guide to LGBT Health, 2nd Edition, Chap. 9)
- Self-Discovery: A Toolbox to Help Clinicians Communicate with Clarity, Curiosity, Creativity, and Compassion (Fenway Guide to LGBT Health, 2nd Edition, Chap. 15)
- Obama Administration Record for the LGBT Community

Module #2: Youth

(Approximate time to complete 3–4 h)

Videos

- Sexual Orientation, Gender Identity, and Mental Health in Children and Adolescents (1 h)
- Obesity, Feeding and Eating Disorders, and Body Dysmorphic Disorder Among LGBTQ Youth (1 h)
- Out Proud Families – *Proud mom videos series* (early years, elementary years, middle and high school years) (17 min). http://www.outproudfamilies.com/?page_id=25

Readings

- GLSEN – The 2015 National School Climate Survey: The experiences of lesbian, gay, bisexual, and transgender youth in our nation's schools
- Human Rights Campaign – 2018 Youth Report

- LGBTQ Youth of Color: Discipline Disparities, School Push-Out, and the School-to-Prison Pipeline

Websites

- https://www.thetrevorproject.org/
- http://wearetheyouth.org/
- http://youth.gov/youth-topics/lgbtq-youth

Module #3: Lesbian, Gay, and Bisexual Adults

(Approximate time to complete 2–2.5 h)

Videos

- Behavioral Healthcare for Lesbian, Gay, and Bisexual People (1 h)
- Working on Shame with Sexual Minority Clients (10 min)

Readings

- APA Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients
- Lesbian and Gay Parenting

Module #4: Transgender Youth and Adults

(Approximate time to complete 4–5 h)

Videos

- Transgender Competence in the Clinical Setting (90 min)
- Mental Health Care and Assessment of Transgender Adults (59 min)

Readings

- APA Guidelines for Psychological Practice with Transgender and Gender Nonconforming People
- Human Rights Campaign – Supporting and Caring for our Gender Expansive Youth Report
- Non-binary Gender Identities Fact Sheet
- Why Support for Trans Youth Matters
- Why Trans People Need More Visibility

Websites

- https://www.wpath.org/
- https://transequality.org/
- http://www.transpeoplespeak.org/

Module #5: Special Topics

(Approximate time to complete 3–4 h)

Videos

- Providing Care for Addictions in the LGBT Community (1 h)
- Same Sex Domestic Violence: Considerations, Suggestions, and Resources (58 min)

Readings

- Sexual Health of LGBTQ People (Fenway Guide to LGBT Health, 2nd Edition, Chapter 12)
- LGBT Relationships and Family Lives (Fenway Guide to LGBT Health, 2nd Edition, Chapter 6)

Answers to Your Questions about Individuals with Intersex Conditions

Appendix C

PHC Training Plan – Group Format (Used with Permission of the Pride Healing Center)

There will be approximately 2 weeks between each module. You will be emailed the module post-test 24 h before our group meeting, and you will have until 11:59 pm on the day of our group meeting to submit the test. Group meetings will be held on Thursdays, and we will vote as a group on the time. Each group will last 90 min. While it would be easiest to try and remain consistent on the day/time, I understand that we may need to be flexible in order to best meet the needs of the group. You may attend the group in person or via web conference (if you are out of town, etc.).

Module #1: Introduction/Issues Facing the LGBTQ+ Community

(Approximate time to complete 4–5 h)

Group meeting 6/14

Time TBA (90 min)

Module post-test emailed on 6/13 – must be submitted by 11:59 pm on 6/14

Module #2: Youth

(Approximate time to complete 3–4 h)

Group meeting 6/28

Time TBA (90 min)

Module post-test emailed on 6/27 – must be submitted by 11:59 pm on 6/28

Module #3: Lesbian, Gay, and Bisexual Adults

(Approximate time to complete 2–2.5 h)

Group meeting 7/12

Time TBA (90 min)

Module post-test emailed on 7/11 – must be submitted by 11:59 pm on 7/12

Module #4: Transgender Youth and Adults

(Approximate time to complete 4–5 h)

Group meeting 7/26

Time TBA (90 min)

Module post-test emailed on 7/25 – must be submitted by 11:59 pm on 7/26

Module #5: Special Topics

(Approximate time to complete 3–4 h)

Group meeting 8/9

Time TBA (90 min)

Module post-test emailed on 8/8 – must be submitted by 11:59 pm on 8/9

Appendix D

PHC Training Plan – Module 1 Post-Test (Used with permission of the Pride Healing Center)

1. Please talk about what you learned in this module about issues facing gender and sexual minorities. Did anything surprise you? Are there still lingering questions left unanswered? (approximately 500 words)
2. What was your experience of the Transgender Implicit Association Test and the Sexuality Implicit Association Test? Briefly describe.
3. How do you think you will be able to apply the information you learned in this module to potential clients you may see in the PHC next year? Think about what you learned and how you might integrate it in to practice. (approximately 300 words)

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Ethical and Legal Considerations in Clinical Training and Clinical Supervision

20

Colleen A. Sloan, Matthew D. Skinta, and David W. Pantalone

Abstract

Clinical supervision is an integral component of training mental health providers, serving educational, supportive, and administrative functions. The field of clinical supervision has consistently lagged behind psychotherapy in terms of defining competencies, agreeing about the best methods for training clinical supervisors, and in terms of developing a strong evidence base on clinical supervision. In this chapter, we highlight an array of ethical and legal issues that may arise in working with victims of violence and in working with SGM clients. We discuss interpersonal considerations that can arise in supervisory dyads and the impact of those dynamics on therapy-client dyads; legislative and legal system considerations; case management and social considerations; and other unique elements of the clinical supervision experience.

Introduction

Training mental health providers is a multi-faced endeavor. Clinical supervision is considered to be an integral component and, along with classroom-based learning and skills practice, has been one of the primary pillars on which clinical training has rested. Clinical supervision is provided for assessment, intervention, consultation, and other elements of a mental health provider's practice and includes three types of functions—educational, supportive, and administrative (Berger & Quiros, 2014). As defined by the American Psychological Association (APA), clinical supervision is "is a distinct professional practice employing a collaborative relationship that has both facilitative and evaluative components, that extends over time, which has the goals of enhancing the professional competence and science-informed practice of the supervisee, monitoring the quality of services provided, protecting the public, and providing a gatekeeping function for entry into the profession" (APA, 2014, p. 2). The field of clinical supervision has consistently lagged behind psychotherapy in terms of obtaining collective agreement on the competencies

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E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_20

involved in high-quality supervision, in how to train clinical supervisors, and in terms of developing a strong evidence base to undergird the practice of supervision (Kühne, Maas, Wiesenthal, & Weck, 2019). A focus on specialized supervision in working with victims of violence, and in working with SGM clients, is even more elusive (Falender, Burnes, & Ellis, 2013).

Despite the lack of gold standard empirical evidence, there has been a great deal of thoughtful writing over the years that summarizes clinical wisdom and lived experience about the best ways to conduct supervision both when victimization or trauma is involved (e.g., Berger & Quiros, 2014) and when SGM identities are relevant (e.g., Bieschke, Blasko, & Woodhouse, 2014). The considerations raised by these authors provide important guidance to mental health providers who serve as supervisors, and to their supervisees, about unique elements of clinical supervision for SGM clients, those who have experienced victimization, and to instances when both are relevant. This guidance is joined in the literature by some qualitative and quantitative studies of various elements of clinical supervision. For example, a study by Adams and Riggs (2008) examined vicarious traumatization of trainee therapists and found that self-sacrificing defense styles, which may be common among mental health providers, were positively associated vicarious traumatization. The authors called for the necessity of supervisors to orient supervisees to the intensity of working with clients who present with victimization histories and a strong focus in supervision of the trauma recovery process.

Although there are various definitions of "trauma-informed practice," the most comprehensive reflect an understanding that working with victimized clients requires an understanding of the "the sociopolitical complexity of trauma, an aspect that broadens the scope of trauma practice… include[ing an] awareness of the intersectionality of race, class, and gender… and underscores that consideration of such [complexity] is essential for the creation of systems of care that are truly trauma-informed" (Berger & Quiros, 2014, p. 296). This type of definition of trauma-informed practice dovetails well with the tenets of multicultural competence in clinical supervision.

The purpose of this chapter is to highlight some of the ethical and legal considerations that could arise in clinical supervision with SGM clients who have experienced interpersonal victimization. This topic presents a particular type of challenge, which is that there are no empirical data on the topic in its narrowest construal, and there are several field's worth of writing—empirical and scholarly yet not empirical—in the topic's widest construal. Thus, we have attempted to raise important concerns of an ethical and legal nature, and we present them with a clear understanding that, given space constraints, we have omitted depth in many areas. We encourage interested readers to review the publications cited in the reference list as our suggestions for greater depth.

Interpersonal Considerations

A variety of interpersonal dynamics may arise based on the identity characteristics of a supervisor, supervisee, and client. For example, an SGM-identified supervisor may or may not work with an SGM-identified trainee. Even if both members of this dyad possess one or more identities that fall under the SGM umbrella, one may identify as a sexual minority person and the other as a gender minority person which, of course, are experienced differently in the world. Further, gender or gender identity differences (e.g., transgender gay male supervisor and a cisgender lesbian supervisee), racial and ethnic identity differences, and other identity-based differences may exist that influence the provision of training and, likewise, care provision to clients. Relatedly, the therapist-client dyad is also influenced by the concordance or discordance across identities between the supervisor and the supervisee. Identity characteristics notwithstanding, personal histories, such as the victimization and trauma history of all individuals involved, may also exert an influence on the multi-directional interpersonal dynamics and, thus, the provision of supervision and clinical care.

Unfortunately, an inadequate evidence base exists regarding competent clinical supervision broadly speaking, let alone something as nuanced as culturally competent supervision. This absence of evidence poses an obvious challenge to the provision of effective supervision, especially when complicated dynamics exists, like those mentioned above. Although the relevant literature has begun attending to this gap (e.g., Falender et al., 2013; Pettifor, Sinclair, & Falender, 2014), identifying fundamental components of competency and providing guidelines regarding their application, less has actually examined the implementation of such guidelines or examined how this objectively impacts clinical supervision and practice. More recent research, mostly published within psychology training journals, has begun to examine clinical experiences of marginalized trainees and their experiences in supervision. Little empirical resources exist regarding ways in which SGM-specific biases may influence clinical training experiences and clinical practice. Later in this chapter, we will discuss and provide recommendations regarding the provision of supervision to SGM supervisees and when working to address client histories of victimization, which provides useful for directing future research in this area. But, in the absence of empirical data, reliance on judgment is often necessary for action, which may be biased and potentially damaging to clinical supervision and practice.

Regarding the provision of clinical care in particular, Fitzgerald and Hurst (2017) conducted a review of the literature on implicit bias and its impact on clinical care. Findings revealed that healthcare professionals exhibit the same levels of implicit bias as the general population and that these biases influence diagnosis and treatment. More specifically, results showed a strong and significant association between level of bias and lower quality of care (Fitzgerald & Hurst, 2017). It is interesting to consider the finding of nearly identical rates of bias among providers compared to the general population. These data help to dispel what seems to be a common myth that healthcare providers are somehow immune from bias. Perhaps this misconception is related to the notion that healthcare professionals, by nature of choosing a career in a helping profession, are unbiased toward those for whom they provide care. However, the evidence suggests otherwise and, unfortunately, a lack of attention to bias in care provision runs the risk of poor outcomes for clients.

It is important to consider, also, situations when a client may have a biased attitude toward a mental health provider. As discussed in a commentary by Weeks (2017), mental health training programs have failed to provide evidence-based guidance regarding how to engage in effective dialogue when clients have biases against their providers. Weeks suggests that hospitals and other healthcare settings should take an active role in addressing these issues by enacting policies that prohibit discriminatory behavior, providing training about competent provider responses to bias when it arises, and creating support resources for providers to discuss their experiences of navigating bias in workplace interactions. Although Weeks (2017) focuses explicitly on racism and religious discrimination that arise between physicians and patients, it is a thoughtful discussion which raises useful considerations for other types of healthcare providers and other marginalized identities, including clinical supervision of SGM trainees.

Legislative and Legal System Considerations

Provision of supervision when working with marginalized supervisees, and/or clients, who by nature of their identity are increased risk for violence and victimization, warrants increased attention and thoughtfulness of what is considered "standard" practice and training. Social determinants of health (SDH) are well-established and include factors such as economic stability, education, social and community context, neighborhood and the built environment, and health and healthcare (Healthy People, 2020). Countless studies have chronicled health inequities for members of marginalized communities, such as SGM individuals, as they relate to these social

factors. Social factors are, themselves, influenced directly and indirectly by access to equitable legal protections, which should be considered and discussed in training settings, especially when working with marginalized clients. For example, if a cisgender white woman client discloses that she fears her cisgender white boyfriend when he consumes alcohol, a clinical supervisor may encourage a supervisee to discuss safety planning, including but not limited to calling the police when feeling unsafe. Although this recommendation seems very reasonable, it may be less so if the client is a Latino gay man, with a history of discrimination and violence perpetrated by law enforcement officials and who is partnered to another Latino American gay man with a similar history. As such, it is ethically necessary to consider the "culture" of the legal system, especially as it relates to SGM rights and protections, within which a supervision dyad or team is working (Friedman, 1994).

Legal protections are different for SGM individuals as compared to heterosexual and cisgender individuals. Examples of unequal legal protections for SGM individuals include but are not limited to a lack of protection or acknowledgement—to overt discrimination—in the areas of employment, parenting, adoption, healthcare, and military service. Specific legal protections of relevance to SGM individuals in a mental health treatment context are the variable and often inadequate protections against identity-based discrimination and violence. When legal issues arise in therapy or supervision, ethical considerations about ways to manage must be carefully considered and explicitly related to the identities of the clients. For example, in communities in which police brutality against trans women of color has been noted, the question arises about the ethics of calling the police for a "wellness check" when working with a black transgender woman. Determinations about an ethical response in a given situation rest on a determination of the likelihood and magnitude of potential risks versus benefits. In this example, it behooves supervisors and clinicians to consider the real potential for bias events to impact clients, especially those in acute risk. Therefore, approaching issues in the exact same way as with heterosexual cisgender clients may not be consistent with ethical practice.

One legal issue as it specifically relates to victimization of SGM individuals is the classification and legislation regarding hate crimes. A recent FBI report (2018) documents recent increases in hate crimes perpetrated against SGM people, contrasting with an otherwise steady downward trend across the past few decades. These findings elicited attention from SGM advocacy groups, such as the Human Rights Campaign (HRC; Kozuch, 2019). FBI statistics also indicated increases in hate crime reports for members of other marginalized communities as well, particularly racial minority individuals. Given these data, and the current sociopolitical climate of overt hostility toward people with various marginalized identities (e.g., Albright & Hurd, 2019; Ford-Paz et al., 2019), SGM individuals, and especially those with marginalized intersectional identities, may be at exponentially greater risk for victimization. Additionally, given the federalist system of government, there is variability across states and incongruence between state and federal hate crime legislation. Thus, differences in hate crime reporting requirements across entities decrease the validity of hate crime data—however, these differences would most likely result in underestimates of these types of offenses. Both these experiences as well as vicarious learning about them may understandably increases minority stress for SGM individuals. These inequities and system-level issues should be carefully considered and integrated into a treatment approach when working with marginalized clients, especially those with histories of violence and victimization.

In addition to legislative and legal concerns related to individual-level SGM violence and victimization, these considerations also impact work with SGM families. For example, when working with families and/or partnerships where children are involved, considerations regarding custody and legal rights may be different than when working with heterosexual, cisgender partnerships. Is there

more than one parent? Who has legal rights to child? Is the partnership legally recognized? Again, clinicians and supervisors must be well-versed regarding legal rights and protections for marginalized families and thoughtfully consider utilization of legal resources that exist within systems that do not affirm nor recognize these families.

Case Management and Social Considerations

The well-established systemic inequities that exist for SGM people manifest within communities and associated resources. Therefore, when considering case management and community-based resources for SGM clients—such as shelters, housing, assisted living, and public accommodations—supervisors and supervisees must carefully consider options as well as how to effectively engage with resources. Given increased rates of suicidality, minority stress, and other physical and mental health disparities within the SGM community (e.g., Haas et al., 2010; Mereish, O'Cleirigh, & Bradford, 2014), it is necessary for mental health providers to consider how to address and utilize emergency and inpatient resources when they might be structured in ways that further SGM clients' oppression. For example, consider a gay male teenager who lives with a non-affirming family. He presents for therapy endorsing depression and suicidal ideation. His family threatens to "disown" him if he "chooses" to be gay. The gay teen then attempts but does not complete suicide and he immediately is hospitalized. The family requests he be transferred to a faith-based residential treatment center that relies heavily on sexual orientation change efforts (SOCE). The residential facility contacts the therapist, a supervisee, for coordination of care. Provision of supervision will likely include training in coordination of care, advocacy, and communication of evidence-based approaches to addressing suicidality. This last point will likely be in direct conflict with the residential facility's treatment team. Given that differences of professional opinion are common even when working with cultural majority clients, this example highlights unique complexities that arise in the context of societal stigma and discrimination, both of which will increase risk of the gay male teen's suicidality. Therefore, provision of supervision must directly attend to the safety of the client. This might be further complicated if a supervisee is also a sexual minority person, especially if they have other shared experiences with this client.

End of life concerns may present differently when providing care to SGM older adults, as compared to working with heterosexual and cisgender older adults. For examples, same-sex older adult couples have not had access to marriage equality until much later in relationships, thus potentially existing within non-legally recognized relationships. This may also present challenges when one partner dies. For gender minority (GM) elders in particular, unique experiences and healthcare needs exist, which complicate an already challenging developmental stage (Bouchard, Potts, & Lund, 2020, this volume; Williams & Freeman, 2007). Additionally, GM elders are unique from younger cohorts of GM people, by nature of their having lived through a history beginning with almost complete invisibility of transgender experiences to a present time in which transgender identities and experiences are very visible (Cook-Daniels, 2016). With this variability of individual experiences across the life span, GM elders may present at various points during their gender transitions or may have opted to not transition at all, which may manifest as resentment or regret for having not transitioned, or via sense of urgency to capitalize on an opportunity to transition later in life. GM elders may have reasonable fears of discrimination in long-term care facilities (Cook-Daniels, 2016; Porter et al., 2016; Witten, 2017) or that they will die having been disrespected (e.g., buried in a manner that reflects their sex assigned at birth; Witten, 2017) and in some cases may opt to "de-transition." Unique concerns for clients notwithstanding, these concerns also present unique challenges within clinical supervision.

Clinical Supervision

The creation of a supportive and affirming clinical supervision space in which student therapists might feel comfortable to both share vulnerable challenges and explore therapeutic missteps is incredibly important. The second author (MDS) supervised a sexual and gender identity clinic for 4 years that integrated the vulnerable, process-oriented supervision and training style modeled in functional analytic psychotherapy (FAP; Callaghan, 2006). Training incorporated weekly readings on SGM psychotherapy, including research on violence toward SGM people, as well as exercises practicing vulnerable self-disclosure related to one's own history of mistreatment or bias related to sexual orientation or gender identity. The rehearsal of personal disclosure in a warm training atmosphere, as well as the concurrent invitation to explore where one's own experience may lead to discomfort or avoidance in clinical work, has been associated with subsequent improvement in the therapeutic alliance in predominantly heterosexual training groups (e.g., Kanter, Tsai, Holman, & Koerner, 2013). This also created a group history in which trainees could feel supported and may more openly share challenges that arise in practice with those clients whose histories share similarities with the therapist's own. As care was taken to select members for each training group whose own racial, cultural, and sexual orientation and gender identities were diverse, opportunities could be made for supervisees to share different perspectives when the identity of the therapist and client did not match.

Supervision of trauma therapy also merits special attention. Vicarious trauma can contribute to feelings of burnout or personal difficulties for the supervisee (e.g., McCormack & Adams, 2016). The challenges of supervising trauma cases can be compounded by difficulties in developing case conceptualizations, lack of support for the emotional impact of the work, and the infrequent and varied nature of traumas that may pose challenges for the development of flexible yet effective clinical interventions (Lansen & Haans, 2004). It is important that the supervisor have their own competence and experience in treating trauma, as well as a strong framework for incorporating cultural factors into case conceptualization and the course of therapy.

Providing Support Within Supervision

Support can be modeled in supervision through a variety of exercises, including modeling, weekly check-ins during both group and individual supervision, and the presentation of resiliency training into group supervision. For instance, after the midpoint of the training year, the second author's (MDS) supervision group incorporated Compassion Cultivation Training, an 8-week meditation-based course with prior efficacy in reducing burnout among healthcare workers (Scarlet, Altmeyer, Knier, & Harpin, 2017). This protocol allowed for the incorporation of discussions of microaggressions or the stressors posed by challenging therapeutic encounters, ranging from client experiences of police entrapment, or the threat of reporting undocumented partners to federal authorities in a context of domestic violence. This also provided opportunities for mutual support or expressions of difficult emotions, such as sadness or anger related to the experiences of clients who in a pre-contemplative stage of change pertaining to reporting workplace discrimination or past experiences of violence that did not meet the threshold of breaching confidentiality.

Conceptualizing Clients

Although traditional diagnostic criteria for PTSD are met by many SGM clients, others may present with trauma symptoms in the absence of a Criterion 1A event (Bedard-Gilligan & Zoellner, 2008). The concept of complex trauma may be helpful to consider, regardless, as patterns of relational betrayal and rejection, or broader challenges posed by isolation and bias in the client's history, could exist either in the presence or absence of traditional PTSD (Cloitre et al., 2011). Acknowledgement of traumatic responses irre-

spective of Criterion 1a is particularly important, as complex trauma may contribute to patterns of avoidance or therapist distrust that could reduce willingness to participate in effective exposure-based therapies or undermine trust in the clinician necessary for such difficult work. For these reasons, it may be important to include a period of alliance building and further exploration of the client's history to determine not only traditionally defined traumas but also histories of bullying, intrafamilial rejection, and school or workplace encounters with discrimination.

The framework for understanding the impact of daily microaggressions on psychological distress and well-being is well-established (Eldahan et al., 2016; Feinstein, Davila, & Dyar, 2017). The link between SGM microaggressions and trauma symptoms is less developed, although models exist in the broader microaggressions literature with other minority groups and offer a helpful guide for considering the role of microaggressions in the development of trauma or trauma-like symptoms (e.g., Tummala-Narra, 2007). Further, avoidance of conflict and social submission resulting from rejection sensitivity (Pachankis, Goldfried, & Ramrattan, 2008), in the context of biased social environments, may mean that a client is experiencing current daily microaggressions. Introducing problem-solving around those contexts may be an important stage in both alliance building and creating enough safety to proceed with more emotionally taxing trauma interventions.

SGM Trainees Working with Non-affirming Clients

Given the often-invisible nature of a non-majority sexual orientation and gender identities, the possibility is high that a client may make unfiltered comments expressing animus toward SGM people. This can pose certain challenges to a supervisee uncertain about appropriate responses or the degree of institutional or supervisory support. Exercises developed within supervision might range from role-play to the review of recorded microaggressions followed by rapid rounds of peers suggesting possible responses. Responses might range from sharing a sense of discomfort or offense at biased language to coming out and personalizing this response, all in the context of careful consideration of the intended intervention with the client. For instance, a client with a propensity toward offensive language that is generally isolated and struggles with maintaining relationships may benefit from candid feedback. Supervisors and institutions should consider their willingness to allow supervisees to discontinue with clients whose patterns of abuse overwhelm a supervisee's ability to succeed.

Ethical Considerations

There is some literature to suggest the importance of a therapist's disclosure of a non-heterosexual orientation to a sexual minority client (Halpert & Pfaller, 2001; Kronner, 2013). Though somewhat dated, the logic behind the recommendation to use disclosure as a form of modeling, empathy, and decreasing the perception of dishonesty if discovered to be SGM through the community still holds true. As in all instances of disclosure, however, the function should be considered; rather than serving the therapist or supervisor's needs to be seen as similar by a client or supervisee, there should be a clear goal such as responding to an absence of SGM models in the life of a client. The decision to disclose, however, should never be compelled by the individual in a relationship with greater power. That is, a supervisor should not compel a supervisee to behave in such a vulnerable way by requiring a disclosure of identities, though the context should be supportive enough that if a supervisee chose to disclose their sexual orientation or gender identity, the relationship would feel safe to do so. Similarly, a supervisor or therapist choosing to disclose first should be aware of subtle uses of power, such as lengthy silences or indirect questions following a disclosure that signal an expectation that such disclosure be reciprocated, as the decision and process of supervisory disclosure is a model for how therapist disclosure might occur.

Similar modeling occurs in respect to advocacy. From pro bono psychotherapy support at trauma or domestic violence centers to visits to state or federal legislators, there are a range of behaviors in which mental health professionals might engage. This provides another opportunity to provide broad options for supervisees to consider how advocacy might fit each supervisee's vision of their future role as an independent professional. In the second author's past supervision group, evocative articles were selected to challenge preconceptions that a professional identity is incompatible with effective advocacy (e.g., Tsai, Kohlenberg, Bolling, & Terry, 2009). Depending on the supervisor's own values and advocacy behaviors, this may lead to opportunities to engage collaboratively with supervisees. It is incumbent on the supervisor to consider and consult with colleagues regarding any possible multiple relationships that could arise in advocacy work in non-clinical settings, though the risk might be reduced if closer collaborations are reserved for after any formal period of supervision.

Of final note regarding ethical conflicts that arise in SGM communities, multiple relationships are a common risk (e.g., Kessler & Waehler, 2005). Even in large cities, additional variables such as similarity between the client and supervisee's gender identity or sexual orientation can increase the likelihood of encountering a client outside of session, working within historically SGM neighborhoods or businesses, or responding to advertisements to receive SGM clinical services. Not all forms of multiple relationships are unethical, and straightforward discussions of boundaries and expectations may be sufficient in even the smallest of communities. These limits may be particularly taxed, however, by two factors. First, in a small community, a therapist's experience of vicarious trauma may be exacerbated by perceived proximity to a traumatic event—if a client or community member is assaulted leaving the city's lone SGM space, the therapist is more likely to perceive themself as similar to the victim of discrimination. Secondly, higher profile instances of community violence may lead to experiences of vicarious trauma among therapist and client alike, such as in the aftermath of the Pulse massacre when many SGM individuals and particularly Latinx SGM people were deeply affected (Ramirez, Gonzalez, & Galupo, 2018). Most cities held community vigils following Pulse, where both clients and therapists seeking connection and solace may have been likely to not only share physical space but to gain inadvertent knowledge of one another's broader social network and where areas of overlap might occur. Further discussion is needed within the peer-reviewed literature on how such community connections might be negotiated.

Conclusions

Clinical supervision serves an essential and unduplicated role in training mental health providers with a small but growing empirical literature. In the present chapter, we provided an overview of recommended literature informing treatment of victims of trauma (e.g., Berger & Quiros, 2014) and SGM-identified patients (e.g., Bieschke et al., 2014). We noted a dearth of literature exists on the supervision of trainees working with SGM patients who have experienced trauma. Therefore, informing service delivery with SGM patients may involve an understanding of implicit biases and experiences of in-community members (who may include the supervisor or trainee), as well as the ethical and legal considerations that arise with patients who may seek community resources given their status as a minority with special consideration given to older adults. Finally, in reviewing the ethical considerations, we consider that trainees may in fact have non-affirming experiences as minorities in the process of meeting with patients. This chapter serves as an introduction to the increasingly empirically informed dialogues of different factors relevant to working with SGM populations who have experienced victimization.

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Homeless LGBTQ+ Youth in NYC: Violence and Resilience on the Streets and in the System

21

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Abstract

Many New York City homeless LGBTQ+ youth grew up in environments that were violent and abusive, which they had no choice but to endure. Those who spent time on the streets and in emergency shelters experienced having to use violence, or the credible threat of violence, to protect themselves. Those who moved on to transitional living, stable government-supported housing, and other programs offering a real chance at stability had to avoid any association with violence, or they risked losing their housing. Like the LGBTQ+ rights movement itself, youth who have exited homelessness live in a place of relative safety, but they still remember times when they were victims of – and empowered by – violence.

Quentin was already known to the child welfare system when he attempted suicide at age 12. He hated school because he was bullied there, but this seemed to have less to do with his sexuality or gender expression than with his speech and motor control delays, which were due to complex neurological problems. His custodial mother was too burdened with her own difficulties to make him go to school – she had become depressed and alcoholic since Quentin's father had left them and she had lost her job in the aftermath of 9/11. Quentin's suicide attempt prompted New York City's Administration for Children's Services (ACS) to finally remove him from the home, citing educational neglect. Quentin spent a month in a psychiatric hospital, after which ACS sent him to an assessment shelter in the Bronx. Staff made assumptions about his sexual identity before he had a chance to even come out to himself, and they were not supportive. When he tried to play "footsie" with someone who turned out to be a worker, Quentin was hauled into a pantry and beaten. The same worker lost his temper at Quentin while trying to get him to stop talking over a movie and attacked him, breaking his foot. The facility fired the worker, but wrote the incident up to make it look like Quentin's fault, which precluded his mother from suing.

In foster care, Quentin never had any option for dealing with bullying but to endure it, and never had any relationship with an adult male that was not confrontational. All of this changed when he was 16, when his male behavioral specialist became his case worker and advocated for him within the system. That that case worker left the agency when Quentin was 20, and everything changed again. Quentin's new case worker was wholly ineffective. At one point, Quentin saw a judge berate her for it. Quentin had a window of opportunity to go to a private college that could have managed his disability issues. However, his workers wanted him instead to just find a job so that he could be off their caseload. Quentin obtained a temporary exception to policy that allowed him to remain in services past age 21, but his workers told him that, since he was obviously not looking hard enough for a job, he would never

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E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_21

be granted another exception. Tired of being threatened and bullied, Quentin signed himself out of services, giving up rights that he might have kept had he held out and made the system discharge him. He lived with his mother until he could get into a transitional living program specifically for LGBTQ+ young adults, where the upper age limit was 24. At that program, he had access to LGBTQ+ positive psychotherapy, a case manager with expertise in neurological limitations, and a stable environment that allowed him to finally make progress toward self-sufficiency.[1]

New York City's policies toward homeless and housing-insecure LGBTQ+ youth have become more progressive since Quentin went through "the system." NYC's Administration for Children's Services (ACS) established an Office of LGBTQ Policy and Practice in September 2012 (NYC Administration for Children's Services, 2018a). They collaborated with the LGBTQ Community Center and a major foster care agency to create the LGBT Foster Care Project (You Gotta Believe, 2014). On May 30, 2018, First Lady Chirlane McCray and City Council Speaker Corey Johnson announced $9.5 m worth of new initiatives, including 20 new shelter beds for LGBTQ+ youth ages 21–24 (Schindler, 2018). Covenant House, a Roman Catholic organization that provides most of the youth emergency beds in NYC, partnered with the True Colors Fund on an LGBTQ+ inclusion assessment (Ellasante, 2017).

NYC has also made progress in policies that affect the broader demographic to which most NYC homeless and housing-insecure LGBTQ+ youth belong, which is urban poor youth of color. The NYPD ended its stop-and-frisk practice, which disproportionately targeted urban poor youth of color, realizing a drop in crime as a result (Smith, 2018). ACS partnered with NYC Health + Hospitals to provide care for youth in NYC's juvenile detention as part of the implementation of New York State's Raise the Age Law, which abolished the practice of automatically prosecuting 16–17-year olds as adults (NYC Administration for Children's Services, 2018b). These social changes were the results of years of advocacy, during which activists' demands and researchers' recommendations became public policy, and social services provided by grass roots organizations were increasingly resourced by the government.

Years before he went through the system, but still within the living memory of his service providers, Quentin's journey through homelessness would have been very different. During the Stonewall Era, homeless LGBTQ+ youth formed communities on the streets. They supported themselves and each other by any means, legal or illegal. Drugs, sex work, and survival crimes like shoplifting were ways of life (Shepard, 2013). For some, homeless LGBTQ+ street life was a great adventure and their first chance to be themselves, and the experience left them with a powerful skill set (Castellanos, 2016; Lankenau, Clatts, Welle, Goldsamt, & Gwadz, 2005; Shelton, 2016). Their street communities were their families of choice (Weston, 1991), a social construction that has long been part of LGBTQ+ cultures, manifested in the storied drag houses of *Paris is Burning* (1990, see also Netflix's *Pose*) and perhaps also in the custom of calling Fire Island Pines vacation time shares' social organizers "house mothers" (Galtney, 2000). Homeless LGBTQ+ youth did not have so many high-level politicians and advocates standing up for them – they were their own advocates. They were unwelcome most places they went, and many things they did to survive were illegal, so they had little incentive to obey the law or social norms. Activist Sylvia Rivera, namesake of Sylvia's Place shelter in Manhattan (Metropolitan Community Church of New York, 2002), is said to have struck liberal Greenwich Village councilwoman Carol Greitzer on the head with a petition-laden clipboard at a 1970 meeting of the Village Independent Democrats (Shepard, 2013). In an episode of the 1969 Stonewall Rebellion, rioters threw small change at the police, ostensibly to compensate them for the Mafia payoff that must have been missed or the bar would not have been raided. At one point, police barricaded themselves *inside* the bar for their own safety (Carter, 2004).

[1] "Quentin" now works for a homeless LGBTQ+ youth services organization. He agreed to give an interview for this chapter. All identifying information in his case study has been changed.

Quentin experienced the milieu of NYC LGBTQ+ youth homelessness while it was still in transition from the old to the new, a transformation which is still far from complete. Like neighborhoods that NYC real estate brokers describe as "transitional," i.e., gentrifying, the transformation has not been uniform. It has created a system that is a patchwork of the old, the new, and the in-between. There are still LGBTQ+ youth still living on the streets and in shelters that are little safer than the streets. Many youth who eventually move into transitional living programs and government-supported housing have had to adapt to the streets at some point in their lives and, if they expected to be successful in those more stable housing arrangements, they had to adapt all over again to conform to program rules (Ream & Forge, 2014). This arguably parallels the adaptation that the homeless LGBTQ+ youth community as a whole has had to make from their marginalized, street-tough beginnings to their new positionality as objects of public sympathy. As in NYC gentrification, the mere appearance of behavior, clothing, and facilities that are old-school, gritty, and survival oriented can be seen as problematic for the transition toward a newer, more attractive environment. Appearance would not be important except that the transition can only happen with money and political advocacy from outside the community. Other parallels with gentrification are that the transition increasingly becomes a process that is out of the original community members' hands and leaves, in its wake, spaces with norms and rules that original community members did not choose.

Youth like Quentin had to adapt to the written and unwritten rules of many pre-transition and post-transition spaces on their pathway through homelessness, sometimes multiple spaces on the same day. A key difference between pre-transition and post-transition spaces is the likelihood of experiencing violence and appropriate methods of dealing with it (or dealing it). Failure to manage violence correctly according to the norms of a particular milieu could jeopardize a homeless LGBTQ+ youth's safety and their housing. The arc of LGBTQ+ youths' journey through homelessness, as the authors of this chapter described it to many new volunteers, staff members, and interns over years of work in this field, is described below, with specific attention to issues of violence.

Home Life Before Homelessness

The conventional wisdom image of a homeless LGBTQ+ young person is of someone who had a relatively normal childhood until their birth parents turned them out of the family home for being LGBTQ+ (Ream & Forge, 2014). Only a minority actually fit this narrative. Key features of homeless LGBTQ+ youths' home life before homelessness include:

- Most of their families are characterized by poverty, abuse, family substance use, and other stressors (Rosario, Schrimshaw, & Hunter, 2012).
- Many also experienced problems outside of the home, such as bullying in school (Bidell, 2014).
- Some were pushed out because of behavioral issues that no adult working with them knew how to handle. They generally continue to have those issues while participating in services (New York City Association of Homeless and Street-Involved Youth Organizations, 2012).
- Although some youth were made to leave, others left situations that they could no longer tolerate. They might be able to go home if they wanted to, but they choose street or program life (Shelton, 2016).
- Whether and how being LGBTQ+ contributed to their becoming homeless vary widely from case to case (Castellanos, 2016).

Adverse home life experiences that leave youth ill-prepared for life in conventional society also enhance their preparation for life on the streets. For example, drug use in the family teaches them about trafficking and using drugs. Sexual abuse teaches them about the marketability of certain sex acts. Violence in the home prepares them to use violence to defend themselves and their property (Lankenau et al., 2005).

Foster Care

While the conventional wisdom image of an LGBTQ+ young person's path to homelessness involves their having gone directly to the streets after their families turned them out, most actually spent some time in the child welfare system (Berberet, 2006). Gerald Mallon's *We Don't Exactly Get the Welcome Wagon* (1998) describes experiences of LGBTQ+ youth in a system that was not yet doing anything in particular to support them. Foster care workers took no responsibility for cultural competence with respect to LGBTQ+ issues. Sexual and physical violence toward LGBTQ+ youth were common, and verbal homophobic harassment was almost universal. Workers blamed the victim when LGBTQ+ youth experienced harassment, punished LGBTQ+ youth for defending themselves, directly engaged in abuse toward LGBTQ+ youth, allowed LGBTQ+ youth to be pressured into sexual orientation change efforts (SOCE), relegated them to congregate care settings appropriate to youth with much higher needs, isolated them for their own "protection," and burdened them with baseless and inappropriate psychiatric diagnoses (Mallon, 1998; McCormick, Schmidt, & Terrazas, 2017; Ream & Forge, 2014). LGBTQ+ clients found ways to adapt, but they did not experience their placements as parental or homelike (Lankenau et al., 2005). They also felt justifiably betrayed by a system of organizations advertising commitments to the highest ideals of human welfare but which, in reality, contract with funders to provide the most basic standard of care allowable under the law and then, once contracts are signed, provide even less than that, sometimes even breaking the law to abuse and underserve LGBTQ+ youth (McCormick et al., 2017; Shepard, 2013). Roughly half of Mallon's (1998) respondents, at some point, left the system for the *relative safety* of the streets.

The Streets and Emergency Shelters

The narrative about LGBTQ+ street life that developed during the Stonewall Era and for several years afterward was that LGBTQ+ youth engaged in sex work to support hard drug habits acquired through self-medicating the rigors of homelessness (Clatts, Goldsamt, Yi, & Gwadz, 2005; Lankenau et al., 2005). These years coincided with the crack and heroin epidemics, so that narrative might have fit. However, by Quentin's time, most youth who accessed homeless LGBTQ+ services were not involved in either sex work or hard drugs (Ream & Forge, 2014). The classic street life scene of Sylvia Rivera's day still exists, with all of the associated risks of violent victimization, HIV, mental illness, and suicide (Edidin, Ganim, Hunter, & Karnik, 2012; Van Leeuwen et al., 2006). Compared to non-LGBTQ+ street homeless youth, LGBTQ+ street homeless youth are victimized at higher rates and are less likely to be taken seriously by police and others who are supposed to protect them (Snyder et al., 2016; Spicer, 2010). LGBTQ+ street homeless youth have difficulty finding safety in shelters that are not LGBTQ+ specific. Staff there may not be trained to work with LGBTQ+ youth or might just not want to work with them (Shelton, 2015). Other shelter clients, particularly those who are gang-involved, can be intolerant, sometimes violently so (Ream & Forge, 2014).

The dream of LGBTQ+-specific emergency shelters famously began with a deathbed promise that Metropolitan Community Church pastor Pat Bumgardner made to Sylvia Rivera. The promise was to establish a place where LGBTQ+ youth could find comfort and safety away from the rigors of street life and connect to services that would help them toward stability (Metropolitan Community Church of New York, 2002). Other organizations specifically serving homeless LGBTQ+ youth have emerged over the years, and they are now thought of as a necessary part of services to homeless and housing-insecure youth, as described earlier. LGBTQ+-specific services are not without their own specific challenges. Any LGBTQ+ affirming youth service site risks attracting malefactors who wish to involve its clients in things like sex work that will not help them toward stability (Ecker, 2016; Spicer, 2010). Situations can also emerge in which programs position themselves as favorite recipients of LGBTQ+ donor money, which they use to grow

the organization, but they do not attend to meeting standards of care to clients (Thrasher, 2011). Homeless LGBTQ+ youth appreciate LGBTQ+-specific shelters for their symbolic value, and for creating a context where they can be themselves (Castellanos, 2016; Shelton, 2016), but they do not always want to sleep in them. Even the best-resourced emergency shelters have problems with theft and fighting, and members of client populations sometimes decide that they will be better able to keep themselves and their property safe on the street.

Transitional Living Programs (TLPs) and Stable Government-Supported Housing

Transitional living programs and stable government-supportive housing offer comfort, safety, and social services in-house (Nolan, 2006). They can be a reliable bridge from shelter homelessness to stability – for those few youth who can find space in them. Homeless LGBTQ+ youth who are using the system as a path to stability often become mired at this stage, because TLPs are probably the part of the system where capacity is least adequate to the need. To secure a space, youth have to keep a months-long gauntlet of appointments, case managers have to know countless written and tacit rules, and both have to fill out substantial amounts of paperwork. After they move in, youth have to comply with rules about curfews, guests, substance use, saving money, and allowable behaviors in and around the space. If they rely upon sex work or selling drugs for income, have insurmountable substance abuse problems, allow others from their street "family" to pressure them into sharing space, or try to solve conflicts through threats or violence as they would have on the streets, then they can lose their housing. Obtaining stability through TLPs and stable supported housing is only tenable for youth who internalized a great deal of stability prior to moving in (Shelton, 2015).

Even if youth manage to follow all of the rules of a TLP, they must still face the issue that the amount of time that most TLPs give them is fairly short for any emerging adult, even one who was never homeless, to find stability in NYC. Many move on to another program when their time is up (Forge, 2012; Nolan, 2006). Some age out of emerging adult-oriented services, as they aged out of foster care years ago (Shelton, 2015), and move on to the adult system. The prospect of spending years in programs regularly positioning themselves to be acceptable to the next program leads them to develop a specific skill set for being a good client, which may divert bandwidth away from growth toward independent living. They also face the very real chance of a return to street life if they cannot get into another program or their current program discharges them. This possibility means that they cannot leave their street adaptations, including street-specific ways of managing violence, wholly behind them.

Conclusions and Implications

Quentin and other LGBTQ+ young adults who were homeless throughout their adolescence and emerging adulthood experienced a life course that is distinct from both those of homeless non-LGBTQ+ youth and those of stably housed LGBTQ+ youth. One thing that is dramatically different at various moments in this life course is their relationship to violence. Many came from home and school situations where they could not protect themselves from violence, endured street and certain emergency shelter situations where they had to employ violence to protect themselves, then progressed to TLPs and stable supported housing, in which any association with violence could jeopardize their hard-won stability. Their path is often nonlinear, as they go back and forth between chaotic home environments, the streets, and a variety of programs, each of which has different complex stated and tacit rules and is run with various degrees of resourcing, ethical integrity, and competence. Survival skills that they learn in the process can be empowering to them (Lankenau et al., 2005), but every year that they spend focused on survival and being a good participant in the system is a year that they do not spend having normative developmental experiences that prepare them for life in conventional society (Edidin et al., 2012; Zerger,

Strehlow, & Gundlapalli, 2008). Practitioners serving homeless LGBTQ+ youth need to remember this, and also be prepared to address trauma, because the vast majority of homeless LGBTQ+ youth have been victimized on some level even if they do not meet clinical criteria for posttraumatic stress disorder (Snyder et al., 2016).

Systems serving homeless LGBTQ+ youth should evolve toward greater safety at the emergency shelter level, higher age limits at the TLP level, more beds at the TLP level, and more help with transitions to stable government-supported housing. There needs to be advocacy not only to improve child and youth welfare policies around LGBTQ+ youth but to enforce existing policies, because some agencies and workers will break the law if they can get away with it (McCormick et al., 2017; Shepard, 2013). With government grant funding having dwindled to the point where agencies increasingly rely on private donors and foundations that provide little oversight, cancelling government contracts is not necessarily a reliable threat to make them follow best practices. Negative press attention (Shepard, 2013) and lawsuits (Mallon & Woronoff, 2006) have sometimes been required.

One last thing that should be said about homeless LGBTQ+ youths' relationship to violence is that, if society fails to correct injustices toward them, the alternative is not that they will quietly suffer marginalization and victimization. Historically, homeless LGBTQ+ youth have risen up and fought back. Quentin has always carefully avoided being violent toward anyone, no matter what he had to sacrifice, but LGBTQ+ activists in the Stonewall riots (Carter, 2004), the White Night riots in San Francisco (Dowd, 2019), and at other times and places have used violence to defend themselves and their spaces. Those incidents are still part of the living memory of NYC homeless LGBTQ+ youth service providers, some of whom knew Sylvia Rivera personally. Those providers' clients remember moments in their personal and collective histories when violence was not only associated with risk and victimization but with survival and resistance. Martial artist Renzo Gracie said, "Fighting is the best thing a [person] can have in [their] soul," and fighting is definitely in the collective soul of homeless LGBTQ+ youth. Practitioners cannot expect to be able to erase violence from homeless LGBTQ+ youths' personal narratives, and it would be disempowering to try. Practitioners should rather take an empowering and nonjudgmental view of those narratives and work to help youth evolve their orientation toward violence to be better adapted to the specific setting in which they are presently trying to move toward stability.

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Religion and Violence Against Sexual and Gender Minorities: A Cyclical Minority Stress Model

22

Laura Price and Jeremy J. Gibbs

Abstract

Sexual and gender minorities (SGMs) are at a heightened vulnerability for a range of adverse outcomes as a function of the bias and discrimination they face in their social environment. Many of these adverse outcomes, in turn, become added stressors for these individuals. The stressor-mediator-outcome model creates a visual representation of how many SGM persons find themselves embedded in a cycle of adversity. Religious experiences interweave into this cycle, often mediating the relationships between stressors and negative outcomes. The violence of discrimination and internalized stigma is mediated by the influences of religion/spirituality, which alleviate or exacerbate negative outcomes for SGM persons. A secondary cycle, employing the perspective of a parent, addresses the identification of an SGM child as a stressor. Religiosity carries the potential to mediate the resulting parental responses from rejection to acceptance. In the extreme case of child ejection, a sub-cycle of homelessness develops. Homelessness, in turn, becomes a stressor that often results in street violence and victimization for sexual and/or gender minorities. Implications for treatment and recommendations for future research are reviewed in each section of the chapter.

Religion and Violence Against Sexual and Gender Minorities: A Cyclical Minority Stress Model

From the age of thirteen, David knew he was gay, and chose to disclose his identity years later to his family and friends. He had grown up in a deeply religious family; one that was expected to take the news of his sexuality poorly at best. The story of David, although a fictional case, is based on many SGM experiences when coming out or being outed in deeply religious environments (Lowrey, 2010). As a gay man, David is vulnerable to a series of stressors including prejudice/discrimination, internalized stigma along with a range of possible family reactions. Each of these stressors involves forms of violence. Discrimination, for example, is a form of violence. Family reactions can be a source of violence (e.g., rejection or sexual orientation/gender identity change efforts), a cause of violence (e.g., victimization while living on the streets after ejection), or a form of acceptance and support

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E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_22

which can lessen the effects of violence. Looking forward to David's future experiences, several questions become relevant. How might David cope with minority stressors such as prejudice or internalized stigma? And how might religion be protective or harmful for him? When addressing family reactions, the perspective is shifted to the parents. Why do David's parents react positively or negatively to their child's identification as a sexual and/or gender minority (SGM)? How does religion influence how his family chooses to respond? How might his family's opinions and beliefs about their child change over time? Finally, what are the risk factors and vulnerabilities for youth, such as David, who become homeless as a result of family rejection? Each of these questions and topics is addressed throughout the chapter.

Chapter Organization

The first section of the chapter focuses on the violence SGM individuals face through discrimination/prejudice and internalized stigma. While general interventions and coping strategies have been studied in this area, research on the effects of religion and/or spirituality is underdeveloped. Given that 76.5% of the United States identifies with a primary religion (Pew Research Center, 2015), understanding the relationship between religion and SGM stress is a critical area of study. Therefore, available research on spirituality and/or religion is discussed along with the resulting harmful and protective roles of religion for SGMs (e.g., Barnes & Meyer, 2012; Meanly, Pingel, & Bauenmeister, 2016). In the second section of the chapter, the focus will shift to the families of SGM individuals. The Riddle Scale presents a range of possible homophobic and positive attitudes regarding sexuality/gender identity, but the majority of research available addresses either family acceptance or family rejection (e.g., Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Finally, a subsection of the second half will consider homelessness among SGM individuals as a result of family rejection and ejection. Within each section, future research opportunities and clinical/practical implications are discussed. As an introduction to these two sections, a reconceptualization of Meyer's Minority Stress Theory into a cyclical model following an exploration of the patterns of SGM lives is presented.

It has been well documented that several types of minorities (racial, cultural, sexuality, etc.) are at a heightened vulnerability for risk factors. Meyer's (2003) Minority Stress Theory provides an explanation for the relationship between sexual and/or gender minority identity and negative outcomes. These include a heightened risk for mental and physical health issues. Most discussed in the literature are five specific associations with SGMs. This includes heightened disordered eating (Diemer, Grant, Munn-Chernoff, Patterson, & Duncan, 2015; Watson, Adjei, Saewyc, Homma, & Goodenow, 2017), mental health issues (e.g., depression, anxiety; Borgogna et al., 2019; Grant et al., 2014; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; Marshal et al., 2011), substance use (Marshal et al., 2008), homelessness (Choi, Wilson, Shelton, & Gates, 2015; Durso & Gates, 2012), and suicidality/self-harm (Connolly, Zervos, Barone II, Johnson, & Joseph, 2016; Marshal et al., 2011; Paul et al., 2002).

Identification as a sexual and/or gender minority has been associated with a multitude of risk factors in an array of areas, including both mental and physical well-being, along with adverse environmental encounters. In considering these relationships, a stressor-mediator-outcome model is formed. Stressors refer to experiences of adversity that an SGM individual encounters which are related to their identity as a sexual and/or gender minority person. Mediators are factors and other interventions that explain the relationships between stressors and divergent outcomes. Outcomes are the temporary and/or terminal result(s) of the stressor. A cyclical framework is an effective model to summarize research findings, as many of the negative outcomes become stressors. A basic cyclical model is presented below in Fig. 22.1.

Minority Stress Theory considers proximal stressors (e.g., internalized stigma, expectations of rejection) and distal stressors (e.g., events of

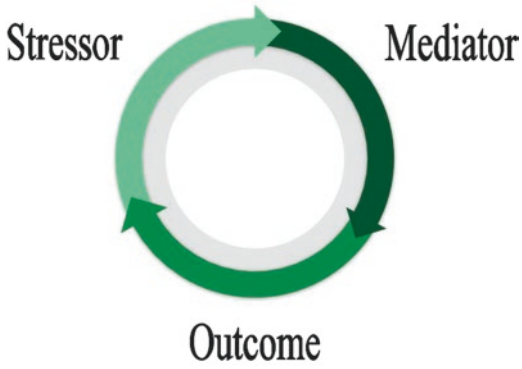

Fig. 22.1 Cyclical stressor-mediator-outcome model

prejudice/discrimination) to explain the heightened distress faced by the SGM community. The effects of stressors are mediated by additional factors (e.g., social support, positive role models). Religion will be the focal mediator discussed in this chapter. While social and family support and other interventions play a significant role in influencing health outcomes of these stressors, religion becomes noteworthy as it may influence these other mediating variables. For example, the stress of the identification as an SGM can lead to divergent responses from parents due to the influence of religiosity. Outcomes of stressors may influence the personal (e.g., mental or physical well-being) or environmental (e.g., home instability or street violence) well-being of an SGM.

Two specific cycles pertaining to prejudice/discrimination (Fig. 22.2) and family responses (Fig. 22.3) illustrate how SGMs are disproportionately confronted by such stressors. Violence operates as an antecedent cause and/or consequence in each of these stressor-mediator-outcome cycles. Microaggressions (subtle often unconscious discriminatory communications and behaviors; Nadal, Rivera, & Corpus, 2010) and hate crimes, for example, are two aspects of prejudice and discrimination. With family responses, violence may take the shape of ejection or being forced into sexual orientation/gender identity change efforts (SOCE or GICE). The first model uses the perspective of SGM individuals, whereas the second model takes the perspective of the parents/families.

A third sub-cycle (Fig. 22.4) within the second cycle is also considered. Discussed later in the chapter, homelessness is prevalent among SGM youth. Some studies estimate that up to 25% of SGM high school age youth experience homelessness (Corliss, Goodenow, Nichols, & Austin, 2011), often as a result of family rejection (Choi et al., 2015; Durso & Gates, 2012). It is critical to address how homelessness, an outcome in the family interaction stressor cycle can, in turn, become a stressor with its own mediators and outcomes as the cycle repeats. Violence against homeless SGM youth comes in many forms, ranging from exposure to life on the street, experiences within systems addressing homeless youth, and other factors (Ream & Barnhart, 2020). Sexual and physical victimization along with substance abuse vulnerabilities are widespread (Cochran, Stewart, Ginzler, & Cauce, 2002).

In considering a multitude of relationships (e.g., family interactions and outcomes, homelessness for SGM individuals and associated risk factors, religiosity, and outcomes), this review acts as a culmination of researched patterns among SGMs in relation to religion and violence. Much of the research related to SGM and religion appears convoluted because the relationships between constructs are not always clear. This chapter aids in using this current research to create an explanatory model that is complex, yet coherent. Regarding social justice, there is a dire need for awareness of the violence against SGM individuals (particularly youth). Lack of awareness stands as a barrier between the SGM community and the interventions needed to prevent negative outcomes. In reviewing the available research, various gaps become apparent. Social justice directions are situated in these gaps of research, more specifically, the lack of research on interventions for SGM youth facing family rejection (as a result of religious beliefs) as well as SGM's personal religion/spirituality.

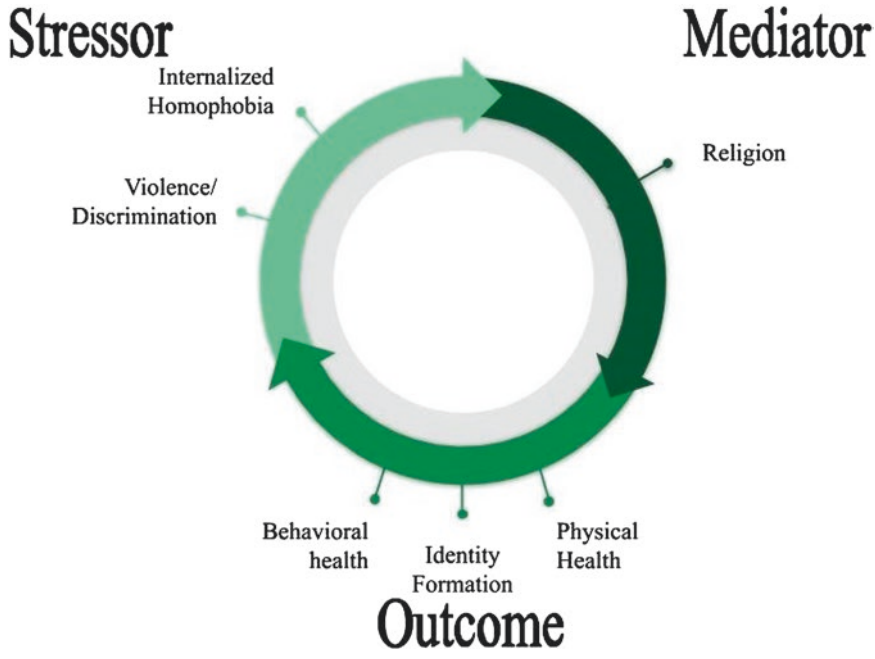

Fig. 22.2 Stressor-mediator-outcome model for SGM persons

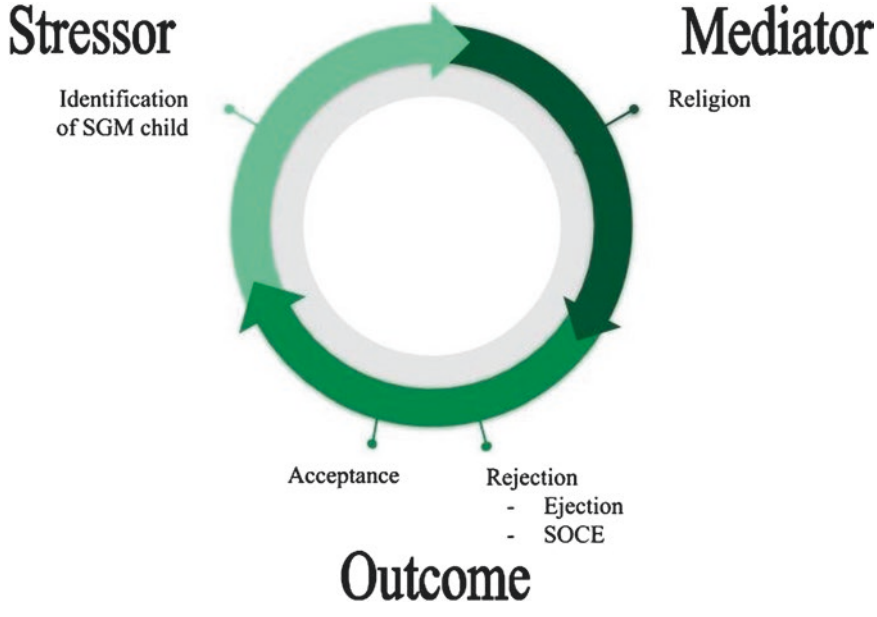

Fig. 22.3 Stressor-mediator-outcome model for parents/families of sexual and gender minority persons

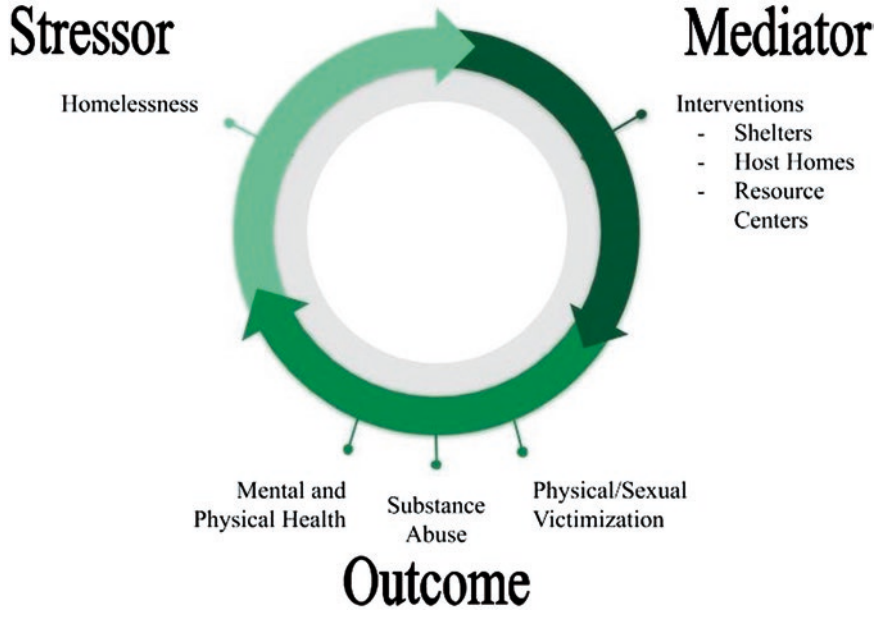

Fig. 22.4 Stressor-mediator-outcome sub-cycle: SGM person rejected from family

Section 1: Stressor-Mediator-Outcome Model for Sexual and Gender Minority Persons

According to Minority Stress Theory, adverse experiences of SGMs can be understood through an examination of the added stressors minority faced by individuals. Two stressors that have a particular connection to the stressor-mediator-outcome model are internalized stigma (i.e., internalized homophobia) and prejudice/discrimination. Internalized stigma related to SGM identity is the internalization of negative societal and community beliefs presented to SGMs (Meyer, 2003). This stressor is referred to as a proximal stressor, meaning it is a psychological process that occurs internally (Meyer, 2003). For many minorities, events of prejudice can be anticipated daily occurrences. Prejudice is considered a distal stressor, meaning it is an external process (Meyer, 2003).

The research literature addresses several modes of coping, including avoidance, community support, and religion for SGM individuals dealing with internalized stigma and discrimination. Avoidance, although theoretically helpful in the short-term, yields a strong positive relationship with psychological distress in the long term (Budge, Adelson, & Howard, 2013). Social and community support is shown to be protective against the negative outcomes that arise from minority stressors (Ajrouch, Reisine, Lim, Sohn, & Ismail, 2010; Pflum, Testa, Balsam, Goldblum, & Bongar, 2015; Trujillo, Perrin, Sutter, Tabaac, & Benotsch, 2017; Verrelli, White, Harvey, & Pulciani, 2019). In one study, however, social support was shown to bring about higher levels of psychological distress (Craney, Watson, Brownfield, & Flores, 2018). When social support acts in a harmful manner this could be explained by involvement in social justice as this may increase one's awareness of or exposure to discriminatory events (Craney et al., 2018). A similar protective and harmful interaction can be seen when addressing religion as a mediator.

Religion's ability to provide a protective factor against distress for the general population is well documented. Suicidality (Burshtein et al., 2016; Caribé et al., 2012), self-harm (Haney, 2019), depression (Cole-Lewis, Gipson, Opperman, Arango, & King, 2016; Ronneberg,

Miller, Dugan, & Porell, 2016), and substance use (Burke, van Olphen, Eliason, Howell, & Gonzalez, 2014; Van der Meer Sanchez, de Oliveira, & Nappo, 2008) are all influenced by religiosity in a protective manner. The protective ability of religion for the general population is evident, yet those same relationships are not consistently found with the SGM population. Research on SGM individuals finds that religion can have a harmful impact, a protective impact, sometimes neither, and sometimes both.

Sowe, Brown, and Taylor (2014) found a clear harmful effect as Christian SGM adults were at a higher risk of distress than their non-religious SGM counterparts. Meanly et al. (2016) showed a similar finding with religious attendance and commitment being associated with negative mental health outcomes for adults. Attending religious schools was also related to negative outcomes for sexual and/or gender minority youth with higher reported alcohol use behaviors (Stewart, Heck, & Cochran, 2015). To this end, religiosity for SGM individuals acts as a mediator perpetuating the stressors they face, such as internalized stigma, into negative outcomes (see Fig. 22.2).

However, just as research provides empirical evidence of a harmful relationship between religiosity and outcomes for SGMs, empirical evidence also shows potential protective effects alongside these negative effects. Longo, Walls, and Wisneski (2013) found that low to some religious guidance was protective for SGM youth against self-harming behaviors; however, quite a bit to a great deal of religious guidance became a risk factor for self-harming behaviors. Adding more confusion, Barnes and Meyer (2012) found attendance and affiliation with a religious organization are independently associated with internalized stigma, but not with adverse health outcomes for SGM adults. This intuitively seems contradictory, as internalized stigma is associated with adverse mental health outcomes unequivocally in the majority of literature on this subject (Newcomb & Mustanski, 2010). Similar findings showing religion as associated with increased internalized stigma yet having no effect on mental health outcomes were discovered throughout the literature with SGM participants (Kralovec, Fartacek, Fartacek, & Plöderl, 2014; Lease, Horne, & Noffsinger-Frazier, 2005; Shilo & Savaya, 2012).

In considering a differentiation between affirmative religiosity and non-affirmative religiosity, there was a strong association between non-affirmative environments and psychological distress for SGM adults (Lease et al., 2005). Affirmative religiosity displays attitudinal (e.g., celebration of SGM identity) and behavioral (e.g., performing SGM marriages) acceptance (Lease et al., 2005) of SGMs. High levels of this affirmative religiosity indirectly affect positive psychological outcomes through lower internalized stigma and higher spirituality (Lease et al., 2005). Affirming religiosity was associated with fewer depressive symptoms in research on youth (Gattis, Woodford, & Han, 2014). The role of affirmation in religious settings may help explain the pattern of inconsistent findings regarding the effects of religiosity within SGM populations.

In Lease et al. (2005), spirituality mediates the relationship between affirmative religiosity and positive outcomes. This becomes significant to note as newly emerging research addresses spirituality as an explanatory source of the inconsistent findings regarding religion and SGM mental health. Spirituality is a relatively new development in research on the topic. Oftentimes spirituality and religion are used interchangeably in the literature; however, current developments underline the need to properly define and differentiate these two terms. According to the Pew Research Center, 27% of U.S. adults would describe themselves as "spiritual, but not religious" (Lipka & Gecewicz, 2017). This group of individuals does not report an association with a religious institution (Barna Group, 2017). Within this group there are varying beliefs about God as over half are not monotheistic, only 20% see God in a traditional all-powerful, all-knowing creator light, and they are three times as likely to see God as a higher state of consciousness compared to the population as a whole (Barna Group, 2017). Spiritual practices also look different than religious prac-

tices. Spiritual individuals are more likely to reflect in nature whereas religious persons are more likely to pray and read scripture (Barna Group, 2017).

While religiosity is institutionalized, spirituality is individualized.

Research has found both religion and spirituality to correlate with well-being in general populations (Burke et al., 2014; Greenfield, Vaillant, & Marks, 2009; Olson & Metzger, 2019). Recent research with SGM persons found a similar positive association between spirituality and identity affirmation and self-esteem (Stern & Wright, 2018). Religiosity, however, was related to negative outcomes (Stern & Wright, 2018). Several other studies have shown significant results regarding spirituality's positive effect on health (Harris, Cook, & Kashubeck-West, 2008; Lease et al., 2005; Meanly et al., 2016). If spirituality is directly associated with positive outcomes, including it in explanatory models may aid in clarifying the convoluted relationships found in previous literature. Combining religiosity and spirituality into one construct could be the reason the literature is unclear. Based on recent literature, hypotheses can be proposed where spirituality acts to protect SGM from negative outcomes; however, more research needs to be done to further empirically test these theories.

One of the key pieces of development during adolescence is the process of identity formation. According to Erikson, "Identity versus Role Confusion" is one of the eight stages of psychosocial development and is theorized to take place during adolescence (Erikson, 1966).

Many adolescents develop within specific contexts, which may be a source of identity conflict. While it is expected that SGM adolescents progress through a time of identity formation, because sexual or gender identification may be at odds with social expectations, SGM identity formation may involve significant conflict. In the current literature, the studies below have described the internal conflict or dissonance experience by SGM who mature in rejecting religious contexts. In one study, identity conflict persisted even if an individual chose to deny either their sexuality/gender identity or religious identity (Ream & Savin-Williams, 2005). This was evidenced by heightened internalized stigma and in the case of leaving the church, poorer mental health outcomes for SGM youth (Ream & Savin-Williams, 2005). Due to youth being embedded in a social environment (Goldbach & Gibbs, 2017), a youth's ability to fully escape a religious environment may be impaired and therefore they are consistently confronted with their rejected religion. It is clear that identity formation is a key focus during adolescence; however, it is significant to address this conflict during adulthood. During adulthood, individuals have an increased level of autonomy as to the type of environment they reside in, along with a developmental advantage in terms of identity formation. Considering this advantage, a continuation of identity conflict into adulthood suggests that religious and SGM identity conflict may play a meaningful role in a cyclical model of minority stress.

A majority of research regarding the complex relationship between religion and SGM well-being in adulthood has used qualitative methods. Overwhelmingly, these studies find that SGM adults experience distress related to a perceived conflict between their SGM identity and religious identity. When attempting to reconcile seemingly conflicting identities, there are four responses. Whereas some outright deny or redefine their sexuality/gender identity to align with their religious beliefs, others leave their faith completely (Ganzevoort, van der Laan, & Olsman, 2011). If both identities are maintained, a third approach attempts to build two identities as mutually exclusive whereas the final approach works to seamlessly integrate the two identities (Ganzevoort et al., 2011). Identity conflict led to feelings of depression and anxiety for some individuals (Levy & Reeves, 2011; Wolkomir, 2001) and for others fostered suicidality (Gibbs & Goldbach, 2015). Gibbs and Goldbach (2015) focused specifically on young adult participants. This may affect the results as young adults are on the cusp of adolescence; however, the overarching continuation of identity conflict into adulthood was also apparent.

Given the identity conflict experienced by SGMs, both in adolescence and adulthood, several solutions have been proposed which strive to integrate their religious and sexuality/gender identity. Ideological revision, which alters one's religious ideology to be affirming of their sexuality/gender identity, is shown to ameliorate the depressive symptoms and suicidal impulses through the resolving of identity conflict (Wolkomir, 2001). Another method that integrates religious and sexuality/gender identity involves changing affiliation/denomination. In one study, becoming involved in a Metropolitan Community Church, which maintains an affirmation doctrine of SGM identity, was a method for healthy identity formation and liberation (Rodriguez & Ouellette, 2000). Forming a more individualized spirituality is another technique alongside ideological revision and affiliation change, which aided in the integrating of two identities (Anderton, Pender, & Asner-Self, 2011).

Applying identity conflict research to the inconsistent results seen in the literature can help explain how individuals in different stages of identity conflict (denial of sexuality/gender identity/religious identity, compartmentalization, or integration) might have significantly different levels of internalized stigma and negative mental health outcomes. Studies often include but do not identify or provide separate analyses for individuals who are avoiding conflict, individuals who are experiencing conflict, and individuals who have resolved the conflict. This could account for the inconsistent findings in the research literature on the relationship between SGM religiosity/spirituality and well-being.

Although spirituality, identity conflict, and affirmative/non-affirmative church models help to add clarity among the current research, much more needs to be done in order to better understand religion's harmful and protective aspects as it relates to the SGM community. Using what is known in the current literature, there are several clinical implications. When working with SGM clients, it is important to recognize the varied and complicated relationship many sexual and/or gender minority persons have with religion/spirituality. Based on preliminary research, spirituality might provide protective buffers against negative health effects as could resolving identity conflict and promoting engagement within affirmative church environments. Clinical providers should be mindful regarding the complexity of addressing religious and spiritual matters with SGM persons and follow the interests of clients when presented with religious identity and sexuality/gender identity conflict.

Section 2: Stressor-Mediator-Outcome Model for Parents/ Families of SGM Persons

In his book *Far from the Tree*, Andrew Solomon (2012) speaks of horizontal and vertical identities. Vertical identities develop from characteristics that align with our family background, attributes like race or socioeconomic status. Horizontal identities do not necessarily proceed down from our family history, for instance, genius or physical disabilities. In his understanding, parents often see these horizontal identities as flaws, thereby sparking conflict (Solomon, 2012).

Orienting around a framework such as Solomon's supports exploring the relationship between SGM adolescents and their parents. Sexual orientation and gender identity would be considered horizontal identities and may cause distress within a family unit. For SGM adolescents, family interaction becomes a stressor with several outcomes depending on if a family chooses to accept or to reject their child. Not surprisingly, there are several positive results as a family chooses to accept their child and several adverse effects of rejection. It is important to note that there are "levels" of acceptance and rejection, as more nuanced within the Riddle Scale (Riddle, 1994). In the Riddle Scale, there are eight levels of responses, four of which are positive, and four of which are homophobic. For example, tolerance might mean a parent chooses not to eject a child; however, homosexuality is seen as a "phase" and "less-mature" than heterosexuality (Riddle, 1994). Research fails to assess the discrete effects of different levels of accep-

tance or rejection. There is a need for further investigation to fully grasp the prevalence and outcomes of the full range of family rejection and acceptance. With the current research, however, there is much to be uncovered.

For this section, it is beneficial to begin by viewing the model from the perspective of the family. Identification of an SGM youth becomes the stressor, with religion mediating between positive acceptant and negative rejective outcomes. Rejective responses, in turn, become stressors for the SGM often leading to negative outcomes (e.g., conversion therapy, street violence) In this way, rejection is a form of violence, meaning for this section violence is both a stressor (e.g., family rejection) and an outcome. The cyclical model for this section is presented in Fig. 3.

Family rejection encompasses a specific form of violence faced by SGM adolescents that often results in further violence exposure. This type of rejection occurs often and puts SGM adolescents at further risk of negative outcomes. It is estimated up to one-third of SGM youth experience family rejection (Katz-Wise, Rosario, & Tsappis, 2016), and 8% are thrown out of their own homes (Sedlacek, VanderWaal, & Lane, 2017). This estimated 8% comes from research on religious populations, however, meaning it could be higher than the overall ejection rate. Further research is necessary to obtain more accurate prevalence statistics.

Research identifying social factors that contribute to rejection is limited; however, some research points to the mediating role of religion. Three main facets of research lead to this conclusion: surveys of rejected youth's understanding of their parent's rationale, attitudes towards homosexuality maintained by religious folk, and suicidality rates of SGM who had religious parents. Growing up in a religious household can be a risk factor for family rejection (Shilo & Savaya, 2012). Eighty-two percent of SGM youth report religious beliefs being the reason why their family struggled to accept them (Sedlacek et al., 2017) and 48% report difficulty discussing their sexuality because of religious beliefs (Gibbs & Goldbach, 2015). Intuitively, this makes sense as there are more negative attitudes toward SGM individuals among religious believers (Droogenbroeck, Spruyt, & Roggemans, 2015; Whitley Jr., 2009). Additional evidence for the mediating role of religion in relation to suicidal behaviors demonstrates that SGM youth with religious backgrounds report high levels of suicidal ideation and suicidal behaviors (Gibbs & Goldbach, 2015; Sedlacek et al., 2017). According to Gibbs and Goldbach (2015), the odds of suicidal ideation in the past month increased by 1.5 times and suicidal attempts over the past year doubled. The prevalence of suicidal attempts for these SGMs with religious backgrounds reaches almost 30% (Sedlacek et al., 2017). Findings such as these suggest SGM youth with religious parents/backgrounds are at a heightened risk for adverse outcomes, likely a result of some form of family rejection. Certainly, religion plays a role in the parent's response to the identification of an SGM youth although further research is necessary to discern the family dynamics that lead to a range of reactions from the rejection and ejection of these youth or to healthy acceptance.

Research in this area has identified several negative outcomes associated with rejection and acceptance. When a family chooses rejection, research evidence regarding negative outcomes is overwhelming. These include mental health issues (Feinstein, Wadsworth, Davila, & Goldfried, 2014; Pachankis, Sullivan, & Moore, 2018; Ryan et al., 2010; Ryan, Huebner, Diaz, & Sanchez, 2009), well-being (Shilo & Savaya, 2011), substance use (Padilla, Crisp, & Rew, 2010; Ryan et al., 2009, 2010), and suicidal behaviors (Needham & Austin, 2010; Ryan et al., 2009, 2010; Yadegarfard, Meinhold-Bergmann, & Ho, 2013). Youth also experience a disruption in their social environment due to rejection: including homelessness through parental ejection/rejection (Choi et al., 2015; Durso & Gates, 2012; Kipke, Weiss, & Wong, 2007; Rhoades et al., 2018; Schmitz & Tyler, 2015), low school belonging (Watson, Barnett, & Russell, 2016), and sexual orientation change efforts (Sedlacek et al., 2017). In many of these studies, family acceptance is shown to have the opposite effects. These would include positive health outcomes

(Feinstein et al., 2014; Ryan et al., 2010; Simons, Schrager, Clark, Belzer, & Olson, 2013), lower substance use (Padilla et al., 2010; Ryan et al., 2010), and higher levels of school belonging (Watson et al., 2016). Family rejection may play a role in placing youth at a heightened risk for negative outcomes due to the increased rate of homelessness as a result of family ejection/rejection and conversion/reparative therapy. Both of these outcomes follow the cyclical stress-mediator-outcome model as they, in turn, become stressors for SGM youth. While only making up 4.5% of the total population (Newport, 2018), SGM youth make up anywhere from 20% to 40% of the homeless youth population, meaning they are very overrepresented among the homeless (Choi et al., 2015; Durso & Gates, 2012; Morton, Samuels, Dworsky, & Patel, 2018). Several studies, including national surveys, have documented family rejection as the number one reason for SGM youth being homeless, with over 78% being forced out or reporting running away because of their sexuality and/or gender identity (Choi et al., 2015; Durso & Gates, 2012; Pearson, Thrane, & Wilkinson, 2017). Further, the lack of proper and safe intervention often makes SGM adolescents exceedingly vulnerable to violence on the streets. If SGM adolescents remain in a rejecting home environment, they may be pressured into sexual orientation change efforts (SOCE). More commonly referred to as conversion therapy or reparative therapy, SOCE is another form of violence that may have detrimental impacts on a young person. When youth are pressured into change efforts that are inherently homophobic and most often provided by nonclinical or laypersons, their risks for adverse outcomes are heightened. The Williams Institute estimates that 350,000 LGBT adults received SOCE during adolescence (Mallory, Brown, & Conron, 2019). Both homelessness and SOCE as a result of a family's religious prejudice are grim realities for SGM youth that warrant a response.

As briefly discussed previously, SOCE and its counterpart for gender diverse youth, gender identity change efforts (GICE), both come as a result of family rejection and hold the potential for serious negative outcomes. This type of therapy can be performed by licensed therapists, psychologists, clergy, and most commonly today, by non-licensed individuals or groups. In history, methods of SOCE include, but are not limited to, biological, behavioral, and religious (Morrow & Beckstead, 2004). Biological methods are surgical or hormonal, whereas behavioral interventions include electric shocks paired with homoerotic stimuli and social skills training (Morrow & Beckstead, 2004). Religious methods attempt to use God's power and prayer to strive after heterosexuality (Morrow & Beckstead, 2004).

Based on research using religious environments, 26% of SGM youth report being taken to some form of SOCE by their parents (Sedlacek et al., 2017). The literature surrounding this topic has results in highlighting the negative outcomes of SOCE. Qualitative research on adults has revealed those who have survived conversion therapy and the increased self-hatred, emotional distress, dehumanization, depression, and heightened suicidality that followed (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). In a study on the Mormon community, 37% reported moderately or severely harmful effects (Bradshaw, Dehlin, Crowell, Galliher, & Bradshaw, 2015). Where some studies report positive effects, such as feelings of relief when given an explanation for their same-sex attraction or feeling like they fit in among others who also had same-sex attraction (Beckstead & Morrow, 2004), it is important to note these effects are also possible through affirmative models of treatment (Beckstead & Morrow, 2004). In a more recent study, qualitative data on adolescents who were forced into conversion therapy by a parent were recorded. As a result, parent-initiated SOCE was associated with poor health outcomes in young adulthood and worse adjustment into young adulthood (Ryan, Toomey, Diaz, & Russell, 2018). Included in these health outcomes were elevated depressive symptoms, higher likelihood of suicidal behavior, and lower levels of life satisfaction, social support, and socioeconomic status (Ryan et al., 2018).

Studies which do show positive outcomes and changes to sexual orientation and/or gender identity have a range of validity issues. Of these include the lack of controlling for bisexual indi-

viduals and an inability to ensure the credibility of individuals reports of change (Shidlo & Schroeder, 2002; Spitzer, 2003, 2012). When considering those individuals who do claim positive change to sexual orientation and/or gender identity, almost half still report same-sex attraction and several remain celibate (Shidlo & Schroeder, 2002). Continuation of same-sex arousal is seen in many studies documenting the experiences of those who found conversion therapy to be "successful" (Beckstead & Morrow, 2004; Bradshaw et al., 2015). Definitions of sexuality and identity may have changed, but their sexual orientation did not which is the reason for reported success without ridding of same-sex arousal (Beckstead & Morrow, 2004). Of specific noting is Spitzer's 2003 study. Nine years after the researcher concluded on the potential for conversion therapy to be effective, a statement was released in which he invalidated such conclusions (Spitzer, 2012). The inconclusive and lack of valid data that supports the efficacy of conversion therapy is renowned in the field (Substance Abuse and Mental Health Service Administration, 2015; American Psychological Association, 2009), yet SOCE still persists.

In response to the data on lack of efficacy and potential harm, several policy changes have been made. The American Medical Association, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, the American Psychological Association, American Counseling Association, American Psychoanalytic Association, and the National Association of Social Workers have all made policy statements against the use of SOCE (Substance Abuse and Mental Health Service Administration, 2015). The Diagnostic Statistical Manual (DSM) removed homosexuality as a disorder decades ago (Drescher, 2015), and many of these policy statements are a decade old, yet proponents of SOCE persist, many based on religious prejudice. Where there is no disease, there is no need for intervention, especially an intervention shown to have no sound empirical effectiveness and have detrimental health outcomes. SOCE should be treated as acts of violence against SGM individuals, particularly youth, who are forced into SOCE by their parents. Sixteen states at the time of this writing have passed laws that protect individuals from being exposed to SOCE, however, it is imperative that the legislation, backed by research, safeguards the valuable lives of young SGM individuals through the national banning of SOCE for minors. These youth need to be nurtured, not neglected.

Sub-cycle Regarding SGM Homelessness

Homelessness among the SGM population is a significant example of the cyclical nature of the stressor-mediator-outcome model. As an outcome of family rejection, homelessness, in turn, becomes a stressor for these youth, developing its own sub-cycle with interventions and adverse outcomes. This cycle is presented in Fig. 22.4.

Homelessness among SGM populations is considerably understudied despite its high prevalence and the associated heightened risk for negative outcomes. Assessing the prevalence of SGM homelessness becomes complicated as it is estimated that a meaningful percentage of SGM may not be found in the local youth shelter (due to factors addressed later in this chapter). In spite of these estimation difficulties, it is clear that SGM youth are homeless at much greater rates that one would expect given their percentage in the overall population. The percentage of SGMs among the homeless youth population range between 20% and 40% (Choi et al., 2015; Durso & Gates, 2012; Morton, Samuels, et al., 2018). Studies in the United States have indicated homeless prevalence among all SGMs as anywhere from 15% to 25% (Corliss et al., 2011); while overall youth homeless in the United States is estimated to be 3% of the youth population (Morton et al., 2018). This overrepresentation may largely be due to family rejection. Considering the high numbers of SGM youth who are exposed to homelessness, one would expect that there would be meaningful efforts to design and implement effective population-specific interventions, however, this is not always the case. These interventions, or lack thereof, act as mediators between the stressor

of homelessness and outcome exposure to violent outcomes on the street for SGM youth.

Youth who are homeless need a breadth of interventive resources including housing programs (which include host home programs, transitional living programs, emergency shelters, etc.), street outreach programs, and drop-in centers. Insights on these services are taken both through surveys of these youth along with qualitative analyses. Experiences at such programs/centers vary, but through an examination of the current literature, a pattern emerges among the SGM community. Oftentimes there are a plethora of barriers between homeless SGM youth and adequate interventions. Documented barriers include the homophobic and discriminatory events that occur within the shelters along with the discrimination and hetero/cisnormativity seen in program policies. A Canadian study found three overall profiles for these youth: those who use homeless agencies to meet their basic needs despite the vulnerability to discrimination, those who avoid homeless agencies to steer clear of such discrimination and finally, those who have positive experiences with homelessness agencies (Côté & Blais, 2019). Although there are stories of positive experiences, 17.6% in the aforementioned study, a majority face some level of discrimination, 29.4%, or avoidance in fear of discrimination, 52.9%. In other reports, the prevalence of harassment or discrimination was 37.8%, which was double that of their heterosexual counterparts (McNair, Andrews, Parkinson, & Dempsey, 2017), or as high as 55% (Grant et al., 2011). Discrimination takes on many forms including non-affirmative shelters, religious prejudice, and violence which created significant barriers to safe and supportive services (Abramovich, 2017; Coolhart & Brown, 2017). Several youth in qualitative research recount experiences where shelter staff told SGMs to repent of their sin and other shelter residents making homophobic comments or acting in violence toward SGM individuals (Abramovich, 2017; Coolhart & Brown, 2017). Statistical evidence gives a perspective just as disheartening with 22% of transgender youth reporting sexual assault and 25% reporting a physical assault in the shelters (Grant et al., 2011). Often, SGM youth resort to spending nights on the street as it is safer than available services (Abramovich, 2017; Maccio & Ferguson, 2016).

Another considerable issue for intervention agencies is gender-segregation policies. This is most applicable to the transgender and gender-queer populations. Up to 29% of homeless transgender youth report being denied access due to their gender identity/expression (Grant et al., 2011; Hussey, 2015). 42% were allowed to stay if they assimilated and lived as the wrong gender (Hussey, 2015). The inability of services to create and implement policies to help provide safe and affirming environments for transgender youth is widespread (Abramovich, 2017; Grant et al., 2011). Most of the current research on homelessness interventions is qualitative with a couple of national surveys. Almost all of it focuses specifically on shelter services versus other possible interventions for homeless youth. Additional research is needed to more fully address the services, such as host homes or drop-in centers, available to SGM youth and their effectiveness for this vulnerable population.

When considering both the discriminatory events along with policy, it is not difficult to understand why many youth avoid shelters and services in fear of violence or other harm. Through the lack of appropriate and effective intervention, SGM youth become at risk for the violence that is prevalent on the streets. Empirical research indicated, survival sex, substance abuse, and victimization become common experiences as SGM youth have much higher odds of engaging in or being a victim of each of these outcomes, as discussed below. Survival sex involves selling sex in exchange for food, housing, money, or drugs. In comparison to their heterosexual counterparts, SGM youth are more likely to engage in survival sex (Pearson et al., 2017; Tyler & Schmitz, 2018; Whitbeck, Chen, Hoyt, Tyler, & Johnson, 2004). Survival sex is associated with HIV risk (Srivastava et al., 2019). SGMs also maintained higher odds for drug and alcohol abuse (Cochran et al., 2002; Rosario, Schrimshaw, & Hunter, 2012) which can persist into adulthood (Pearson et al., 2017). Spending nights on the

street is incredibly unsafe, as many SGM youth are victims of physical and sexual victimization. This prevalence is significantly higher than their heterosexual counterparts in the same environment (Cochran et al., 2002; Tyler & Schmitz, 2018; Whitbeck et al., 2004).

Thus far, social environment outcomes have been addressed as a result of homelessness and a lack of intervention. Aside from environmental outcomes, several psychosocial outcomes warrant discussion. Homelessness among SGM youth is associated with PTSD (Rhoades et al., 2018), suicidal ideation (Noell & Ochs, 2001; Pearson et al., 2017; Whitbeck et al., 2004), and depression (Cochran et al., 2002; Pearson et al., 2017; Rhoades et al., 2018; Whitbeck et al., 2004). With such a grave percentage of SGMs facing homelessness and the violence and psychological distress that follows, effective interventions and education are absolutely critical. Academia can help address this need through studying current effective interventions and applying research to bring forth policy changes.

Although the outcomes of SGM persons from families who choose rejection look rather grim, the outcomes for individuals from families who choose acceptance are overwhelmingly positive. As briefly mentioned earlier, in many studies regarding family responses to SGM identification, family acceptance is shown to have positive health effects (Feinstein et al., 2014; Ryan et al., 2010; Simons et al., 2013; Weinhardt et al., 2019), be associated with lower substance use (Padilla et al., 2010; Ryan et al., 2010), higher levels of school belonging (Watson et al., 2016), and lower suicidality (D'amico, Julien, Tremblay, & Chartrand, 2015). The reasoning behind such associations can theoretically be attributed to feelings of belongings and support from those around the SGM youth. Another factor is identity formation. Whereas rejection is predictive of adverse outcomes which slow or prevent healthy identity formation, acceptance has been shown to promote healthy SGM identity formation and act as a protective factor (Bregman, Malik, Page, Makynen, & Lindahl, 2013; D'amico et al., 2015).

Another important lens to address family acceptance is through the eyes of the parents themselves. Often, parents of SGM youth overtime show a positive change in their attitudes and beliefs toward their child's identity/orientation. Several studies have shown parent's opinions of the morality of homosexuality often move from less approving to more approving or accepting as time goes on (e.g., Freedman, 2008). After an initial shock, many parents cope with the disclosure and find peace (e.g., Freedman, 2008).

The stressor-mediator-outcome model helps to bring together several facets of research on the intertwining topics of SGM, religion, and violence. Of key importance is the cyclical nature of the model built on the patterns seen in the literature. A cyclical framework allows for outcomes to in turn become stressors creating a visualization of how many SGMs find themselves stuck in a cycle of adversity. Violence comes both as a stressor and an outcome for SGMs. When addressing the mediating role of religion, two significant models arise. One model delves into the violence which takes the form of internalized stigma and prejudice/discrimination that is faced as the result of minority status. In response to this stressor, religion, and distinctly spirituality, is seen to have harmful and/or protective mediating factors that predict personal and behavioral health outcomes. Second, a model that addresses family responses to SGM youth using SGM identification as a stressor for parents who, mediated by religion, choose to accept or reject their child. Within rejection, a sub-cycle of homelessness as an outcome turn stressor which, due to a lack of appropriate interventions, often results in further violence and victimization. SOCE (conversion/reparative therapy) was also considered as a form of violence against SGM that came as a result of family rejection.

Regarding the case of David, he is at risk for rejection and even ejection due to attitudes about his sexual orientation. Like many SGM youth from religious households, this includes experiences of homelessness and other forms of violence (Lowrey, 2010). Further research is needed

to examine the diverse long-term outcomes of SGM youth from religious households. Similarly, all of the areas that were explored throughout this chapter remain limited in the amount of research conducted despite the unequivocal significance of protecting SGMs. Within each section, there is an explicit call to researchers, clinicians, and policymakers to digest the current research and move forward, whether that be through additional empirical studies, changes in approaches with specific clients, or advocacy for change. With further awareness, additional research, and policy change, the overwhelming number of stories that are strikingly similar to David, a thirteen-year-old child who was accosted with violence due to parental attitudes toward his sexual orientation, will become a thing of the past.

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23

Violence and Harassment Against LGBTQ+ Elders: Continued Challenges in Health care, Housing, and Aging Services for Pioneers of the Movement

Lauren M. Bouchard, Courtney A. Potts, and Emily M. Lund

Abstract

LGBTQ+ people have faced violence, discrimination, and harassment throughout their lives as well as social isolation and stigma in their identities due to widespread heterosexism. This cohort of elders faced the AIDS crisis, institutional heterosexism, and homophobia in employment, housing, and personal affairs. Despite progress in policy and law, these pioneers still frequently face similar challenges in healthcare, housing, and supportive services as they progress into old age. These elders describe fear of going back into the closet due to harassment and discrimination in long-term care and housing facilities, healthcare services, and even public health and aging programs. This chapter will illustrate many of the challenges this cohort of LGBTQ+ elders may face as they age despite the progress of LGBTQ+ rights movements. Limitations in research as well as clinical and policy considerations will also be explored.

Historically, the lesbian, gay, bisexual, transgender/gender-nonconforming, and queer (LGBT+) community has experienced considerable stigma, discrimination, and violence due to their sexual orientation, gender identity/expression, or both. This history of violence, mistrust of the medical system, and general antagonism often prevents LGBT+ people from seeking social services, medical care, and support from professional providers (Orel, 2014). This cohort of LGBT+ older Americans are the first to age after the AIDS epidemic, Stonewall riots, and first thrust of the gay rights movement (Orel, 2014).

Due to this historical oppression, these elders often face unique stressors compounded over a lifetime of stigma, harassment, and violence. For example, these elders face more chronic health conditions (Fredriksen-Goldsen, Kim, Shui, & Bryan, 2017), increased loneliness (Hughes, 2015), and increased "invisibility" and erasure (Shankle, Maxwell Katzman, & Landers, 2003, p. 159) in the landscape of aging.

Sedgwick (2008) considered how the disparities of a population are further compounded by

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E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_23

emotional experiences of shame, stigma, and general neglect. Using the global response to HIV and AIDS in the 1980s as an example of societal neglect, Sedgwick (2008) noted an overwhelming lack of empathy and treatment for LGBT+ persons on all levels of the epidemic. In past versions of the DSM, the classification of "homosexuality" was a diagnosable condition until 1973 (Drescher, 2015). This impacted how individuals within the community learned to relate to the outside world and incorporated shame in their identity. The marginalization of sexual orientation and gender identity may lead to mental and physical illness (SMART, 2009). It is imperative that professionals working with LGBT+ older adults understand the cumulative effect of societal oppression, discrimination, and targeted harassment and violence. The cumulative effect of inequality across the life course, lack of current social support, and barriers in care may contribute to unsafe environments for older adults. It is estimated 48% of same sex couples have experienced discrimination in applying for senior housing (SAGE, 2018), and 34% of LGBT+ older adults and 54% of gender expansive older adults believed they may have to hide their identity in long-term care (AARP, 2018).

As Adams (2016) notes, the literature on LGBT+ elders is limited due to the intersectional nature of sexual orientation and gender identity with a host of other identity variables and life context. For example, he indicated it is imperative for researchers to consider factors such as race, socioeconomic status, and gender in addition to LGBT+ identity, as both aging and identity are neither homogeneous nor one-dimensional (Adams, 2016). Unfortunately, much of the literature presents a reductive and monolithic picture of LGBT+ elders with limited information into the multifaceted nature of identity. In this chapter, we attempt to present nuanced information regarding empirical research as it exists in the literature. Additionally, LGBT+ elders may have difficulty with the word "queer" due to generational difference and coming of age in a time when the term was used exclusively as a slur and had yet to be reclaimed by the community. Although the acronyms LGBTQ or LGBTQIA and their variants are appropriate as well, for the sake of consistency, "LGBT+" is used throughout this chapter.

Housing Challenges

This cohort of elders face continued challenges in accessing services that are both culturally competent and sensitive to their unique needs. Unfortunately, many elders report fear of "returning to the closet" when entering long-term care (Ranahan, 2017, p. 159). Residential care poses extreme challenges for elders outside of urban areas who may not be able to find culturally competent and welcoming care. In a review of the literature regarding residential care, Ranahan (2017, p.167) reported "interview data reinforce the notion that housing access is influenced by complex forms of stigmatization, including overt discrimination, expectations of mistreatment, and social isolation." LGBT+ elders consistently associate traditional housing communities, including residential and long-term care, as negative and reported "fear of discrimination" in these living environments (Orel, 2014, p. 63).

Further complicating the issue, LGBT+ elders are also less likely to have long-term partners, adult children, or other traditional family members who can provide care and are more likely to rely on "families of choice" (Ranahan, 2017, p. 160). This may also impact their ability to plan for long-term care, especially in the case of a disabling condition or cognitive impairment that makes it no longer safe to age in place (Ranahan, 2017). Although families of choice often provide excellent social support and companionship, these support networks also may have difficulty assuming informal caregiving responsibilities (Ranahan, 2017).

Although there has been progress in efforts to train residential care staff in LGBT+ cultural competency, there is always a chance for heterosexism, harassment, and violence from staff, visitors, or other residents. Westwood (2016, p. e155) conducted a study in the United Kingdom where LGBT+ elders reported "being heterosexualized" in the process of assimilating into a standard resi-

dential care placement. Participants in this study described "being heterosexualized," as the culture of residential care is primarily designed for heterosexual older adults, without regard for older adults who may be LGBT+. For example, these older adults described facilities as promoting "mundane heterosexism," which is promoting heterosexist family and relationship norms (Westwood, 2016, p e157). Other participants described a "lack of visibility" for their own families and relationships or "risky visibility," that is, inability to discuss certain topics due to heteronormativity in the facility (Westwood, 2016, p. e157). Many of these older adults stayed isolated in care due to fear of homophobia even if it had not explicitly occurred. Finally, they noted, even if there was no explicit prejudice displayed, they still often felt uncomfortable due to a general lack of inequality. Even if laws had changed, they often did not feel this changed their feelings of safety or inclusion in care.

This forced assimilation into a hetereosexist environment is a consistent fear among many LGBT+ elders in the United States who do not have access to specialized resources (Ranahan, 2017). Accordingly, many LGBT+ elders espouse a desire to live in LGBT+ residential housing facilities (Ranahan, 2017). Progress may be slow to create such facilities and programs, especially in rural areas, but, in one positive example, Chicago has created an intentionally designed LGBT+ senior housing development where elders can also access health services to enhance their well-being (Larson, 2016). For example, the Center on Halsted Town Hall Apartments include intentional common spaces for residents, LGBT+-specific case management services, and extracurricular programming specific to LGBT+ elders. In this facility, LGBT+ elders are not simply an afterthought; the entire community is designed with their specific needs in mind (Larson, 2016). SAGE (sageusa.org) is one organization promoting cultural competency for staff and facilities across the country as well as specialized housing services for LGBT+ elders in areas such as New York City, Chicago, Los Angeles, and Houston via a housing network for these seniors. They also specifically list LGBT+-friendly housing developers, resources (such as a hotline) for isolated seniors, and resources regarding legal and financial support.

Geographic Location

Geopolitically, elderly LGBTQ+ populations can experience their identity differently,

based on where they live, what they believe, and how the larger community accepts them in the culture. In this regard, the need for more LGBT+-competent counselors in rural America is critical (Willging, Salvador, & Kano, 2006). In rural America, the prevalence of services for LGBT+ individuals is significantly lower compared to other areas of the nation. This is coupled with antagonistic and prejudiced views from healthcare providers (Willging et al., 2006), which further reduce LGBT+ elders' ability to receive competent care. As a result, the health and well-being of LGBTQ+ elders who live in rural areas suffers as a result of lack of overall healthcare, a higher prevalence for mental health disorders, distress, suicidality, and other significant health disparities (Willging et al., 2006).

When factoring in the ripple effects of isolating an already vulnerable population, Grossman et al. (2014) found that the LGBT+ elders are at a greater risk for domestic harm and neglect than their cisgender, heterosexual counterparts due to their circumstances, treatment, and lack of access to services. The lack of LGBT+-competent education and support further marginalizes an entire generation of already disadvantaged individuals as they try to navigate through changing and complex roles such as caregiving as well as navigating the healthcare and older adult services systems.

Caregiving Challenges

Within the realm of caregiver needs, resources, and research, this population is consistently both disadvantaged and under-represented. Due to the historical context of LGBT+ communities, many gay and lesbian older adults care for families of

choice (Cohen & Murray, 2006). These caregiving responsibilities may strain the resources of the gay or lesbian elder. However, many elders report informal caregiving can often boost resiliency, sense of community, and psychological well-being (Cohen & Murray, 2006). A lack of formal family relationships can also impact planning for long-term care, especially in the case of disability or cognitive impairment that requires a greater level of care that a family of choice may be unwilling or unable to provide.

The current discourse on caregiver populations is not reflective of the LGBT+ population or their experiences of elderly caregiving. Further compounding this phenomenon is the reality that LGBT+ individuals are more likely to become caregivers to partners, biologically and non-biologically related family members and friends (Alzheimer's Association, n.d.; Croghan, Moone, & Olson, 2014). This may be untenable as caregiver stress can be debilitating and has the potential to impact the health of the individual receiving care as well as those providing care. Indeed, researchers (Grossman, Frank, Graziano, Narozniak, Mendelson, El Hassan, & Patouhas, 2014) have found a high prevalence of caregiver-perpetrated self-neglect, care neglect, and physical, mental, or emotional abuse among older LGBTQ+ adults. The rate of self-neglect was especially high, with over two-thirds of participants reporting experiencing it. Despite a tendency toward resilience, LGBT+ caregivers also need accessible resources and services and specialized training and interventions for caregivers who may themselves face harm, self-neglect, and chronic, caregiving-related stress.

Finally, many LGBT+ older adults may experience a compounded risk of violence due to the intersection of aging and LGBT+ identity. For example, like their heterosexual, cisgender peers, LGBT+ older adults may face financial exploitation, physical or emotional abuse by caregivers, neglect, or self-neglect (Grossman et al., 2014). Furthermore, Grossman et al. (2014, p.1651) reported "being open about that identity may not only lead to victimization, discrimination, and marginalization, but it also tends to create environments that underscore LGB people's vulnerability to threats, abuse, and oppression from adolescence to old age." The risk of victimization conferred by older age multiplied by the risk of victimization created by LGBTQ+ identity, thus potentially putting LGBT+ elders at even more elevated risk for victimization. Additionally, services, such as Adult Protective Services, may not have LGBT+-competent or LGBT+-inclusive programs or systems, further increasing the vulnerability of LGBT+ elders even when interacting with systems and services designed to protect them.

Chronic Conditions and Cognitive Impairment

LGBT elders are more likely to have both chronic health conditions (Fredriksen-Goldsen et al., 2017) and increased cognitive impairment and dementia risk (Flatt et al., 2018). LGBT+ elders who have chronic conditions often experience barriers in access to both overall medical care and culturally competent care specifically (Fredriksen-Goldsen et al., 2017; Fredriksen-Goldsen, 2011). Disparities in healthcare can be associated with loneliness, social isolation, and chronic stress (Fredriksen-Goldsen et al., 2017). These disparities often begin earlier in life and continue to progress during older adulthood. These disparities and the cumulative impact of a lifetime of health disparities and minority stress are an important consideration for informal caregivers (i.e., families of choice) who often have chronic conditions themselves, as well as elders who hope to plan for safe, meaningful, and fulfilling long-term care experience in the absence of informal caregivers (Ranahan, 2017).

Every 65 seconds, someone in the United States develops Alzheimer's disease (Alzheimer's Association, 2018). According to the Alzheimer's Association (2018), one in ten people aged 65 and above has Alzheimer's dementia in America. Alzheimer's disease and related dementias affect not only the person with the disease but those surrounding them, creating significant caregiver stress and burden. The caregivers and family members live with this complex and frightening

disease as well. LGBT+ elders may face barriers such as a general lack of trust for healthcare providers and geographical isolation from resources that create additional barriers to care and well-being for both the individuals with dementia and their caregivers.

Furthermore, when reflecting on the experience of Alzheimer's disease and other dementias for individuals who were pathologized for their gender or sexual identity in the past, there may be additional triggers or traumas to overcome, necessitating the need for nuanced and culturally competent training and care. LGBTQ+ elders who want or need to be placed in a nursing home, memory care facility, or assisted living home may face stigma or even blacklisting from certain facilities. It is also important to consider that elderly LGBTQ+ individuals may have come out later in life and do not have current spouses or close family members who can assist with care and life planning. This can complicate access to care, power of attorney, advanced directives, living arrangements, and quality-of-care decisions that may end up being determined by estranged blood relatives over chosen family due to state and federal laws that do not recognize more informal relationships (Brennan-Ing, Siedel, Larson, & Karpiak, 2014).

Finally, many LGBT+ older adults may have fears and concerns related to mental health symptoms and seeking mental healthcare (Drescher, 2015). Indeed, diagnosis was often weaponized against patients presenting with depression, anxiety, and personality disorders due to the inclusion of "homosexuality," and "gender identity disorder" in the DSM in the past, with "gender dysphoria" still being included in the DSM 5 (American Psychiatric Association, 2013). Having the ability to diagnose creates both the potential for othering and marginalization, as seen, as well as the potential to empower individuals, provide access to affirming treatment, and reduce suffering. However, the inclusion of "homosexuality" as a mental illness leads to a great deal of inappropriate and harmful pathologizing of LGBT+ individuals. In the past, various treatments were used for homosexuality and gender dysphoria with the aim of "converting" individuals to cisgender, heterosexual identities. These therapies ranged from shock therapy and other behavioral therapies to faith-based interventions (Flentje, Heck, & Cochran, 2013).

Conversion therapies have been consistently shown to be very iatrogenic—too often leading to suicidal ideation, attempts, and deaths—as well as ineffective at their stated, bigoted goal (Flentje, Heck, & Cochran, 2014). Conversion therapy is deemed to be unethical and harmful by the American Counseling Association (2017), the American Psychological Association (2009), the American Medical Association, the American Academy of Pediatrics, and the American Academy of Child and Adolescent Psychiatry, to name a few, and has also been banned for minors in 14 states including, but not limited to, Oregon, Illinois, and California (American Counseling Association, n. d.). Despite clinicians' best intentions, psychological care may be associated with further harm (Drescher, 2015; Gambrill 2014), and the strong history of mistreatment and pathologizing of LGBT+ individuals under the auspices of medical and psychological treatment has left many LGBT+ individuals, particularly older adults, understandably distrustful of medical and mental health systems and providers.

Implications for Counselors

When considering competencies, training, and practice, the lack of representation of LGBT+ individuals in research leads concerns and questions with regard to evidence-based assessment and treatment for this population (Heck, Mirabito, LeMaire, Livingston, & Flentje, 2017; Keo-Meier & Fitzgerald, 2017). Past stigma and DSM diagnosis of LGBT+ population has created an internal culture of distrust, victimization and trauma, and a general lack of care. Externally, prejudice and antagonistic views are still held for this population, even by healthcare practitioners, creating an external culture where individuals are made to feel wrong, discouraged, or even "dirty" (Mustanski et al., 2010). When working with LGBT+ individuals in counseling, both multicultural and systematic issues should be considered.

Although the LGBTQ+ community has developed their own inclusive and distinct culture to counter the strong current and historical social stigma, discrimination, and shame that are faced by LGBT+ individuals, the experiences of LGBT+ individuals are still very much subjective and cannot and should not be generalized across identities or individuals. Intersectionality of identities must be considered as well as the historical and social context in which a client came of age in order to inform culturally competent and affirmative treatment.

For current and future counselors, the need for social justice and reformation in curriculum and training is recognizable (Constantine, Hage, Kindaichi, & Bryant, 2007). Implications for healthcare providers and specifically counselors can be found in education, services, treatment, and ethical guidance (Croghan et al., 2014). For counselors and others who are not well-trained in working with LGBT+ individuals, there is an ethical responsibility to seek out the resources, supervision, and professional development necessary to be able to competently work with this population and to not force one's personal beliefs and values on clients (American Counseling Association, 2017).

Implications for Policy

LGBT+-inclusive aging policy can be used in health promotion (Mulé, Ross, Deeprose, Jackson, Daley, Travers, & Moore, 2009), intentional housing design (Larson, 2016), and healthcare (Fredrikson-Goldsen & Espinoza, 2014). The calls for action encourage a stronger knowledge base regarding LGBT elders (Fredrikson-Goldsen & Espinoza, 2014), the utilization of elder feedback in program design (Larson, 2016), and specific attention to the unique needs of this population in health, housing, and social services. Again, intersectionality should be strongly considered in decision-making and feedback processes, and both caregivers and care recipients should be included in conservations about caregiving and healthcare needs and programs. Additionally, it is vital for providers and policymakers to remember and respect the historical weight of injustice and violence carried by many LGBT+ elders and to recognize both the tremendous resilience of and the heavy burden carried by this particular population.

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24

Sexual and Gender Minority Marginalization in Military Contexts

Claire Burgess, C. B. Klemt Craig and Cary L. Klemmer

Abstract

This chapter details the current literature base on the victimization of active-duty service members and veterans who are sexual and gender minority individuals. Limited research exists examining the behavioral health experiences of sexual and gender minorities (i.e., lesbian, gay, bisexual, transgender, and queer people) as they relate to various social institutions. In particular, the experiences of these minority groups are not well understood in the context of active-duty military service. To begin the chapter, a historical description of policies and practices has been the backdrop to disparities faced by sexual and gender minorities serving in the US military. Then, empirical research is reviewed in order to elucidate the violent victimization experiences of these service members. Additionally, literature regarding other documented forms of social marginalization is reviewed. Specifically, the impact of social marginalization on individual and community functioning is detailed. Furthermore, sexual and gender minority service members' achievements are highlighted, which demonstrate this group's resilience in the face of exclusionary policies and systemic marginalization. To end, brief recommendations are offered for future research to improve understanding of these service members' experiences and needs. Recommendations for how organizational settings may promote safety and an affirmative environment for sexual and gender minority service members are given as well.

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Violence Against SGM in Military Contexts

Introduction: Historical Contexts of Violence

In order to understand the historical context of violence in military settings, one must first have a basic understanding of the groups involved. This process is complicated for sexual and gender minority ("SGM") service members. First, there

E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_24

is a dearth of official documentation of the mere presence of SGM military members throughout US history, even considering the repeal of Don't Ask, Don't Tell ("DADT") in 2010. Second, SGM military members have endured such a long history of oppression, suppression, and rejection within the armed forces that the repeal of DADT has only been the start of logistical trail-blazing necessary to conduct research on the presence and varied experiences of SGM service members. Moreover, this research may just scratch the surface of the diversity of experiences that SGM military members have experienced given specific eras of combat theater, racial/ethnic identity, and/or socioeconomic status. Given these complicated intricacies, exploration of historical context for SGM service members must be conducted with a careful hand, open posture, and eye toward welcoming and cultivating additions to the knowledge base.

A general timeline of the cultural attitudes toward LGBT individuals provides a frame for understanding the progression of attitudes toward SGM service members. During the early 1900s, acknowledgment of sexual orientation was quite limited. Gender identity was even less recognized and was generally conflated with sexual orientation. Typically, when same-sex relationships were acknowledged, it was within a punitive framework associated with religious stigma. This marginalization stemmed from the rise of the social purity movement in the United States, which "stigmatized certain forms of sexual expression well into the twentieth century" (Bronski, 2011, p. 85). For example, sexual behavior between cisgender (i.e., gender identity which is congruent with sex assigned at birth) men was considered to be morally wrong and an aberration to be avoided. Within this sociocultural context, laws were introduced in the United States to formalize the punishment of sexual behavior. This meant those who participated in same-sex relationships had a negative social perception from others.

Additionally, legal stigmatization emerged in military culture at this time. One of the first laws against consensual "sodomy" between two men was established in 1919 during World War I (Berube, 1990). The law impacted gay military members over several decades because it labeled gay military members as security risks due to perceived vulnerability to blackmail, particularly in the 1940s and 1950s (Ramirez & Sterzing, 2017). This culture of rejection was continued throughout the 1960s although witnessed a slightly positive shift toward gay service members in 1976 with the release of the Navy's "Crittenden Report." The report found that sexual minority service members were in fact not a security risk and had made positive contributions with their military service (Estes, 2007; Shilts, 1994). Just prior to the release of the Crittenden Report, the diagnosis of "homosexuality" was removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1973. This label had impacted gay, bisexual, and service members perceived as gay in receiving a medical discharge due to their sexual orientation (Berube, 1990). However, given the persistent nature of stigma toward SGM service members, medical discharge orders for diagnoses of "homosexuality" shifted into conduct-related discharges, which impacted the livelihood and benefits of service members.

The de-classification of homosexuality from the DSM (Bronski, 2011, p. 217) may have reduced stigma toward SGM individuals in the civilian population; however, military culture did not promulgate policies of acceptance at first. In fact, the shift toward conduct-related discharges for SGM service members resulted in a period of interrogation campaigns to identify gay, lesbian, and bisexual service members. These investigations by leadership cornered romantic partners, friends, and family as well as employed invasive tactics such as listening to phone conversations, reading mail, and raiding the address books of service members in search for evidence of homosexuality (Ramirez & Sterzing, 2017). Chilling accounts of persecution persisted through the 1990s despite rising civilian support of the SGM service member community.

As civilian support of sexual and gender minorities rose in the United States during the late 1980s and 1990s, equal rights activists began to gain political momentum in advocacy for the SGM community at large. Such efforts saw recognition of SGM individuals in previously

closed systems, such as the military. Advocates began to pressure elected officials to pay attention to the plight of SGM service members and to take measures to protect these individuals from the invasive homosexuality investigations. In an attempt to reach a compromise, President Bill Clinton introduced Don't Ask, Don't Tell (DADT) in 1993 as a policy in order to quell the conflict between SGM rights activists and those who objected to gay service members being in the military (Van Gilder, 2017). Prior to this point in time, military enlistment required confirmation of a heterosexual identity. The passing of DADT eliminated this prerequisite but kept elements of marginalization alive through prohibiting "homosexual conduct" and service members openly identifying as gay or bisexual. Essentially, DADT permitted enlistment for gay services members but required concealment of sexual orientation.

However well-intended this policy was, the negative consequences have been far-reaching. Not only did this policy limit service members' ability to serve in an authentic manner, but the lack of communication regarding the experiences of sexual minority service members perpetuated systems of discrimination and marginalization. Specifically, this policy's lack of acknowledgment of SGM individuals in the military led to a research gap within military settings regarding the experiences of SGM individuals. As a result of DADT, there was a dearth of documented literature on the subject of antigay aggression or victimization in military contexts or commendation of positive achievements by openly SGM service members prior to 2011 (Burks, 2011). Having a dearth of information not only posed harm to SGM service members' behavioral health but also meant that their positive contributions to US military achievements would have to wait many years to be publicly highlighted.

During the late 2000s, there was an increase in social support of the LGBTQ+ community in the United States accompanied by successful coordinated advocacy efforts. One such initiative aimed to dismantle LGBTQ+ discrimination in the military and, in particular, the DADT policy. With increased social support and political pressure, several key legislative elements came together, under the leadership of President Barack Obama, to repeal DADT in 2010 (Frank, 2013).

Since the repeal of DADT, gaps in research regarding the experiences of LGBTQ+ service members have begun to be addressed. First and foremost, estimates reveal that SGM service members make up a notable portion of US military service members and veterans; sexual minorities (lesbians, gays, bisexuals; LGB) make up between 0.9% and 6.1% of active-duty service members (Gates, 2010; Hoover, Tao, & Peters, 2017; Morral et al., 2015). Furthermore, transgender veterans with diagnoses of gender dysphoria have been shown to comprise nearly 23 of every 100,000 individuals in medical records research (Blosnich et al., 2013). The presence of SGM service members is notable, given the military's historic dearth of affirmative policies toward LGBTQ+ service members.

Victimization of Sexual and Gender Minorities

Research regarding SGM service members has not only established a rough estimate of enrollment numbers but has also confirmed the presence of overt aggression toward SGM service members, including physical violence and sexual trauma. In 2010 in the general military population, 2267 male identified and 2438 female identified service members were victims of rape perpetrated by other service members (Belkin, 2012). Sexual minority individuals, in particular, have an increased risk of sexual assault and harassment in military environments (Burks, 2011; the term *military sexual trauma* or "MST" refers to experiences of sexual trauma during military service).

General SGM Victimization Prevalence In 2000, The Office of Inspector General (OIG) found that 37% of perceived sexual minority service members surveyed had witnessed and/or experienced one or more harassment or violence event within the previous year. Physical assault was witnessed and reported by 5.3% of the sample. More recently, the Department of Defense (2010) found that 91% of those sampled said

DADT placed LGB-identified service members as at risk for blackmail. The impact of DADT extended to negatively impact both personal (86%) and work (76%) relationships as well. Additionally, SGM service members experienced emotional distress on duty: 72% of those surveyed indicated that they experienced daily anxiety and stress. Furthermore, 29% endorsed experiencing verbal aggression and 7% endorsed aggression in the form of verbal threats or injuries by other service members. Servicemembers Legal Defense Network (2003) documented 4600 reports of antigay harassment (verbal or physical) toward sexual minority service members from 1994 to 2002. The American Psychological Association Joint Divisional Task Force on Sexual Orientation and Military Service (2009) obtained data from 445 LGB and transgender veterans in 2004 (demographics: gay or lesbian-identified, 88.7%; bisexual-identified, 7.2%; heterosexual-identified, 1.2%; or "other," 2.9%). Experiences of victimization in the military related to sexual orientation were reported in almost half of respondents. Specifically, 8% reported sexual assault and 8% reported physical assault experiences. Female veterans demonstrated higher rates of sexual victimization compared to male veterans.

Victimization Among Heterosexual Male and Sexual Minority Male Service Members There is some literature that has documented the victimization experiences of cisgender sexual minority men. One cross-sectional study by Kwon, Lee, Kim, and Kim (2007) examined sexual violence experiences among cisgender male-identified South Korean soldiers. One quarter of respondents reported witnessing sexual violence and 15.4% had been victimized themselves. The authors found that acts of sexual violence were often under-reported, minimized, or normalized as a part of military culture. Military members who are gay or bisexual men may be specifically targeted because they are perceived as less able to protect themselves (Parrott & Peterson, 2008). Even among heterosexual men, sexual violence victimization has frequently gone unreported for fear of appearing "gay" within their service environment (Ramirez & Sterzing, 2017).

Victimization Among Heterosexual Female and Sexual Minority Female Service Members Similarly, literature has been published on the victimization experiences of sexual minority cisgender women within military settings (Burks, 2011; Mattocks et al., 2013). Multiple reports have documented a high prevalence of MST among military women (Himmelfarb et al., 2006; Kimerling et al., 2010). In Booth et al.'s study (2011), 11% of the sample of sexual minority women reported female partners at some point in their life and 62% reported sexual assault. Booth et al. found an increased likelihood of premilitary sexual assaults in a sample of women who have had sex with women. They found this concerning given that sexual minority women are then entering the military, a space with increased risk of further violence (Sadler et al., 2000). Many service members may have entered the service to seek shelter from trauma within their family or neighborhood contexts growing up, only to work and live in an environment that places them at risk for re-victimization.

Lucas, Goldbach, Mamey, Kintzle, and Castro (2018) found that sexual minority veterans had two times higher odds of having experienced a MST compared to heterosexual peers (Lucas et al., 2018). Furthermore, in their study, military sexual assault mediated the relationship between sexual minority status and negative mental health experiences including posttraumatic stress disorder (PTSD) symptoms and depression. As a result and given the prevalence, experiences of MST may be an important consideration in the psychological evaluation and treatment of all service members.

Mattocks et al. (2013) detailed different types of combat trauma and MST that sexual minority women reported being exposed to during their service. Researchers used a chi-square analysis to look at the incidence of these traumas, with a sample collected from 2008 to 2011 of 365 participants, and of those are 35 lesbian or bisexual-identifying women. There were no differences in terms of exposure to combat trauma or MST; however, the two groups did differ in terms of force or threat for sexual contact during service

(31% sexual minority women vs. 13% heterosexual women). Additionally, intimate partner violence was higher in lesbian-identified military women (24.7%) than heterosexual-identified military women (18%; Kimerling et al., 2016).

Transgender Service Members' Experiences of Violence The experiences of transgender service members, that is, those individuals whose sex-assigned at birth does not match with their internal sense of gender, are less well established. Given the high rates of violence experienced by transgender individuals in society at large (Institute of Medicine, 2011; Stotzer, 2009), rates of violence among transgender service members may likely be high. Little research has investigated this population, given the lack of documentation and permission for transgender individuals to serve. For instance, transgender service members were permitted to openly enlist in service starting in January 2018. However, even this achievement did not come without challenge, as a presidential memorandum prohibited the enlistment of transgender people and required currently enlisted transgender service members to be discharged by March 2018. Lawsuits from civil rights groups resulted in a temporary block on this change (Byne, 2018).

Factors Associated with SGM Victimization in Military Contexts

SGM service members may be perceived as "other" within the military, which leads to increased marginalization. It is possible that, within a group of people labeled and charged with fighting and defending a specific set of values, such "other" individuals are likely to be treated in pejorative ways.

The larger context of risk comes from policies that promote marginalization such as secrecy around sexual orientation and sexual behavior (i.e., DADT). For example, during the DADT era, SGM service members were at risk of being outed even in contexts where confidentiality is assumed, such as after discussing their sexual orientation with doctors, mental health providers, and/or chaplains (Ramirez & Sterzing, 2017). Burks (2011) argued that DADT increased sexual minority victimization, decreased reporting of violence, and prevented research from being conducted to elucidate such issues. Research is highly limited on this area, in that much information has been removed qualitatively through military personnel report, including non-peer-reviewed materials (Burks, 2011). According to Herek et al. (2009), power and status differential inherent to heterosexism in military contexts ultimately leads to discriminatory policy and practices. Tuomi (2015) found that heterosexism in the active-duty workplace was a mediating factor for negative social support outcomes with regard to LGB service member disclosures of sexual orientation. In other words, the more inflexibly heterosexist the work environment, the more likely a gay service member was to be socially marginalized during and after disclosure. Such outcomes could be reflected in single incidents (i.e., initial backlash after sexual orientation disclosure) or chronic impacts such as reduction in dating or off-base socialization opportunities. In Tuomi's 2015 study, service members commented that disclosing their SGM identity would impact their ability to succeed or advance in service rank.

Representations of Resilience Demonstrated by SGM Service Members

Many sexual and gender minorities have demonstrated great strength in expressing their identity despite receiving mixed messages about policies that support their minority status. Historically, there were several ways in which SGM service members utilized their status as minority individuals in order to support one another as well as positively contribute to their service branches. For instance, many service members engaged in subtle "queering" of military spaces in order to support themselves and thrive (Ramirez & Sterzing, 2017). This was done, for example, through referring to other SGM service members as "family" in order to develop a discrete social network. Additionally, the use of "camp" humor and gender performativity was utilized as a creative recreational outlet.

Furthermore, SGM service members made strategic use of remaining in the closet so as to protect other minority service members under their command. Such underground networks eventually developed into formal communities such as OutServe and SLDN, which provided SGM service members with critical legal counsel and workplace advice (Ramirez & Sterzing, 2017).

In addition to these general adaptive strategies, there are several notable SGM service members that made significant contributions to military culture and toward introducing symbols of inclusivity. For instance, Leonard Matlovich was noted for being on the cover of a 1975 *Time* magazine (Bateman, 2015). A Vietnam veteran, he had disclosed his sexual orientation to his commanding officer in the Air Force because he felt it was time for someone with an honorable service record to stand up against the policies against gay men in the military.

LGBT veterans have played a significant role in creating the SGM pride flags. Gilbert Baker, a US Army veteran, created the original rainbow gay and lesbian pride flag. The flag was hand-dyed and sewn at the request of Harvey Milk, influential San Francisco politician and gay-identified man, to increase LGBTQ+ community pride in the Bay Area and for use in future city pride events (Baker, 2007; Rapp, 2005). After creating the flag in 1978, he started working for a flag-making shop that would mass-produce the pride flag. He is known for not applying for a trademark for his pride flag so that it could be used freely by others (Riendeau, 2012). Another veteran, Monica Helms, a transgender woman who served in the Navy, created the Transgender Pride Flag in 1999. She is also credited with being the first woman to join the US Submarine Veterans group in Phoenix. Veteran Helms co-founded the Transgender American Veterans Association and served as the community grand marshal for the 2019 Phoenix Pride parade (Latzko, 2019). These are but a few narratives of influential SGM Veterans. Currently at the time of writing this book, a naval ship out of San Diego has been commissioned with the name "Harvey Milk," an unmistakable nod to Milk's commitment to civic duty. It may be that, with time, service members who do not identify as SGM increasingly promote policies and honor the service of SGM military members, who have long incurred trauma within a context of unsupportive policies and discrimination.

Current Knowledge of Sexual Assault in the Military

Though DADT was repealed nearly a decade ago, no large-scale military-wide assessments documenting the needs and experiences of LGBT service members currently exist (Alford & Lee, 2016; Castro, Kintzle, Schuyler, Lucas, & Warner, 2015). Rigorous and accurate prevalence estimates of military sexual assault among LGBT service members are difficult to come by. Nonetheless, existing data suggest that the rate of military sexual trauma is elevated –this impacts the mental health of minority service members both during their service and through their lifetime (Gurung et al., 2018). The literature would benefit from increased documentation of transgender service members' experiences with sexual assault in the military to fully and adequately guide policy makers in the development of health promotion policies (Alford & Lee, 2016).

Advances in Violence Prevention in Military Contexts

Structural changes are necessary to improve the lives of SGM service members. These changes signify acceptance and affirmation of diverse sexual identities, gender expressions, and gender identities. Well-conceived comprehensive policies that demonstrate affirmation of these groups within both the Military and Veterans Affairs demonstrate acceptance of SGM service members and stall violence perpetrated toward these minority service members at the door. Military and veteran institutions can both hire SGM staff and also create ombudsmen positions to promulgate inclusive, nondiscriminatory policies into place. Explicitly including groups of individuals on the basis of "birth sex, sexual orientation, gender identity, and gender expression" in nondiscrimination policies, harassment prevention,

and reporting protocols will ensure appropriate protection and oversight via violence prevention. All-staff trainings in bias prevention and policy declarations will need to be provided promptly as these developments occur, as it will be necessary to update staff knowledge in real time.

Some examples of important practice and policy shifts include the use of visual cues in the administrative or clinical environments within the military, which can have a powerful effect on patients receiving care who are sexual and gender minorities. Signs that indicate a "safe space" for patients within VA, including minority group members in picture brochures, or displaying nondiscrimination policy convey top-down support for SGM in military contexts. Additionally, promotion of affirmative practices via organizational certifications will also demonstrate to patients the presence of a safe space. The Veterans Health Administration (VHA) has done this by being the largest participant in the Human Rights Campaign's Healthcare Equality Index.

Further, to reduce the impact of MST, treatment options inclusive of minority experiences and identities will reduce stigma and improve health outcomes in trauma survivors. Survivors of intimate partner violence, discrimination, or crimes of bias as a part of patient care are examples of inclusive treatment options, as well as wrap-around care for trauma survivors. Kimerling et al. (2016) recommended awareness that individuals may have sexual and relational experiences with partners of all genders and to not make assumptions about this when screening for IPV in healthcare settings. The number of women and minorities in military and veteran settings will continue to grow (Assistant Secretary of Defense, 2003), and it is imperative to address the burden of violence encountered by minorities serving in the military.

Conclusion

SGM service members have contributed to US military achievements in the face of great personal strife and institutional discrimination, placing care for their country above their own well-being. Despite continued risk to their mental and physical health, SGM service members are to be commended for their perseverance in the face of violence. A strength-based understanding of SGM service members can aid providers and policy makers in delivering culturally responsive care and create safe environments in which SGM service members can continue their contributions to US military achievement.

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25

Navigating Potentially Traumatic Conservative Religious Environments as a Sexual/Gender Minority

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Abstract

Although many religions are becoming increasingly accepting of sexual and gender minority (SGM) identities and experiences, SGMs continue to report traumatic experiences with religion. SGMs describe traumatic experiences experienced in conservative religious environments on three levels: structural (e.g., discriminatory policies, institutionalized homophobia), interpersonal (e.g., stigma, closeting, rejection), and intraindividual (e.g., internalized homo-/transnegativity, internalized spirituonegativity). SGMs report a variety of responses to conservative religious environments including not experiencing trauma, compartmentalization of trauma from the positives of religion, rejecting religious teachings and practices, rejecting a sexual/gender minority identity, and integrating their sexual/gender and religious identities in a way that minimizes the impact of traumatic experiences. To assist mental health professionals in understanding and working with SGMs from conservative religious environments, we discuss barriers to reporting trauma, the types of traumatic experiences reported, the various strategies to dealing with these experiences and resultant identity conflict, and the mental health implications of these strategies.

For many, religious identity plays an integral role in their understanding of self, with over 75% of people in the United States identifying as religious (Pew Research Center, 2015). A religious identity typically connotes a sense of religiousness and some level of engagement or affiliation with religious communities, though the degree of engagement varies substantially between people (Wolff, Himes, Soares, & Kwon, 2016). In general, religiousness has been positively associated with well-being (Bonelli & Koenig, 2013), potentially due to the stable support network, belief structure, and community involvement provided by religion (Barnes & Meyer, 2012; Cranney, 2017).

Although religion and spirituality are often important for sexual and gender minorities (SGMs), SGMs are much less likely than heterosexual and cisgender individuals to affiliate religiously and to derive benefits from religiousness (Lefevor, Park, & Pederson, 2018b; Pew Research

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E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_25

Center, 2018). In particular, SGMs with experiences in conservative religious environments often report conflict between their SGM and religious identities (Cole & Harris, 2017; Rodriguez & Ouellette, 2000), and this conflict is associated with higher levels of depression, anxiety, and psychological distress (Lefevor, Sorrell, et al., in press). Typically, the difficult relationship between SGM identity, religiousness, and mental health has been understood as the result of discrimination and stigma associated with greater participation in conservative religious environments (Hatzenbuehler et al., 2014). However, not all SGMs in conservative religious environments report conflict between their sexual/gender and religious identities or negative experiences in conservative religion (Lefevor, Beckstead, et al., in press; Rodriguez & Ouellette, 2000).

Many SGMs in conservative religious environments present to therapy for help reconciling conflict between their SGM and religious identities, navigating religious environments, and improving their mental health (Jacobsen & Wright, 2014). Mental health professionals are thus tasked with providing culturally sensitive guidance for this heterogeneous group of clients but are often not attuned to the nuances and heterogeneity of their clients' experiences of both their SGM and religious identities, leading many to rely on overgeneralized formulations of how to work with SGM clients.

To help mental health professionals achieve greater nuance in their work with SGMs from conservative religious environments, we explore the varied experiences of these individuals. We begin by exploring the reactions of SGMs to conservative religious environments, focusing on the degree of trauma SGMs report in these spaces. In doing so, we follow the Substance Abuse and Mental Health Services Association (SAMHSA, 2018) in adopting a liberal definition of trauma as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (2018, paragraph 2). Thus, in the first section of the chapter, we catalogue the various ways SGMs from conservative religious environments may experience trauma from these environments, organizing our catalogue by the level on which the trauma is experienced: structural (e.g., institutional), interpersonal (e.g., between individuals), and intrapersonal (e.g., conflict within the self). Following this categorization, we explore the varied way that SGMs from conservative religious environments report experiencing (or not experiencing) and responding to these traumas, discussing barriers to reporting traumatic experiences. We conclude with recommendations to help mental health providers facilitate healing, empowerment, healthy relationships, and resilience among SGM individuals who have experienced or been exposed to trauma in religious environments.

Sources of Trauma Experienced by SGMs in Conservative Religious Environments

In conservative religious environments, SGMs may experience trauma on at least three levels: structural, interpersonal, and intrapersonal. Structural trauma occurs as the result of society, institutions, and formal discriminatory policies. Interpersonal trauma occurs as the result of negative interactions with other individuals. Intrapersonal trauma occurs in the absence of identifiable institutions or others – though it may be inculcated by exposure to negative structural or interpersonal experiences – and is experienced as intrapsychic conflict.

Structural Contributors to Traumatic Experiences

Many SGMs report negative interactions with religious institutions vis-à-vis policies, doctrines, and practices. These interactions may contribute to an overarching sense of minority stress (Meyer,

2003) and trauma (Foster, Bowland, & Vosler, 2015), which are both negatively related to well-being (Crowell, Galliher, Dehlin, & Bradshaw, 2014). We consider three common structural inequities that may contribute to experiences of trauma among SGMs in conservative religious environments: formal discriminatory policies, the propagation of hetero-/cisnormative discourse, and encouragement of harmful ways of dealing with same-sex attraction or gender diversity.

Discriminatory Policies Minority stress and trauma may result from formal discriminatory policies. Although religious institutions are more accepting of same-sex sexuality and gender diversity than they have ever been (Murphy, 2015), many prohibit clergy from officiating same-sex marriages or refuse to honor officially the names and pronouns of gender diverse individuals. Others discourage individuals from coming out and, in some cases, explicitly prohibit sharing of SGM identities (Dulin, n.d.). Some organizations do not allow SGM individuals to be full members of their congregations or participate in sanctioned religious events in official capacities. These practices may lead SGMs to experience feelings of rejection and trauma from the religious institution and community.

Propagation of Hetero-/Cisnormative Doctrines and Discourse Religious organizations also have the power to determine the discourse around same-sex sexuality and gender diversity in their communities and may cause trauma among SGMs via more subtly discriminatory practices. These practices vary and may include sermons decrying same-sex sexuality or gender diversity and propagating hetero-/cisnormative standards. The language that religious communities use in discussing SGM identities can contribute to a sense of a lack of acceptance because pervasive non-accepting language can engender and perpetuate a sense of othering. Some conservative religious communities use religious texts as a basis for denouncing same-sex sexuality and gender diversity and may threaten SGMs with divine retribution if they do not comply with hetero-/cisnormative standards (Rodriguez, 2010). Participating in conservative religions, specifically, attending non-SGM affirming services, can adversely impact SGM well-being (Hamblin & Gross, 2011) through feelings of isolation, insecurity, hypervigilance, and helplessness. Thus, on a structural level, formal policies and doctrine can perpetuate discrimination and, in turn, trauma.

Support of Harmful Ways of Managing Same-Sex Attraction and Gender Diversity Religious institutions might also support sexual orientation change efforts (SOCE) as a viable option for members seeking to manage same-sex attractions, and because of the trust afforded to religious leaders, many religiously affiliated SGM individuals may attempt SOCE, which can be traumatic (Beckstead & Morrow, 2004). Although SOCE may lead some to an increased understanding of the immutability of their same-sex attractions, engagement with prolonged SOCE is related to lowered psychosocial functioning and an increase in internal conflict (Dehlin, Galliher, Bradshaw, & Crowell, 2015). Religiously affiliated SGM individuals are often motivated to attempt SOCE because of the internal conflict arising from the incongruence between their religion and SGM identity, the negative psychological effects resulting from internalized homo-/transnegativity, pressure from family and religious community, and feelings of disbelonging and isolation (Foster et al., 2015; Barnes & Meyer, 2012; Dahl & Galliher, 2012a; Dehlin et al., 2015). Because sexual orientation infrequently appears to change (Beckstead & Morrow, 2004) and because SOCE may delay identity integration, many SGM individuals recall their experience with SOCE as traumatic (Dehlin et al., 2015). Indeed, many major health organizations such as the American Medical Association, the American Psychological Association, and the

National Association of Social Workers have condemned the practice of SOCE as ineffective and harmful (SAMHSA, 2015). These trends likely extend to individuals' experiences with feeling pressured to conform cisnormative conceptions of gender.

Interpersonal Contributors to Traumatic Experiences

Where structural inequities experienced in conservative religious environments result from formal policies, doctrines, and practices within religious institutions, interpersonal trauma results from interactions between SGM individuals and members of the religious community including interactions with clergy, friends, and family members. Such trauma can take many forms and can depend on the extent to which an individual is open about their sexual orientation. We discuss several forms of interpersonal trauma that may be particularly salient in conservative religious environments including rejection, stigma, closeting, invisibility, and violence.

Rejection Perhaps the most easily identifiable source of interpersonal trauma for SGMs is rejection from their religious community. In some communities, SGM individuals are encouraged to abstain from same-sex or gender-nonconforming identification and behavior, but not condemned for their identity, while in other communities, any indication of same-sex attraction or gender nonconformity is grounds for ostracism (Lefevor, Sorrell, et al., in press). Negative reactions from family members' and non-accepting attitudes can negatively influence mental health and contribute to a sense of isolation (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). SGMs can also experience interpersonal rejection through interactions wherein others focus attention on enforcement of doctrines, policies, and practices that are discriminatory, which may lead to increased depression, feelings of inadequacy, and religious-related guilt (Dahl & Galliher, 2012a). This lack of acceptance from one's religious community – as a function of non-accepting practices – can exacerbate feelings of conflict between religious and sexual identities and thus has the potential to be highly damaging to SGMs' mental health and general well-being (Lefevor, Sorrell, et al., in press).

Stigma Many SGMs in conservative religious environments experience interpersonal stress through stigma, which is marked by expected rejection, disapproval, condemnation, and discrimination from one's environment and community. Stigma may be experienced as a result of both explicit and implicit language and behaviors and may make SGMs feel singled out within religious spaces whether or not they are open about their experiences as an SGM. Because of this stigma, many SGMs may feel pressure to modify their dress, comportment, or affective expression to pass as heterosexual or cisgender so as to not lose approval from the religious community (Crowell et al., 2014). Stigma may also hinder SGM individuals from reporting or discussing traumatic experiences that occur in the context of same-sex relationships or encounters because SGM individuals may fear invalidation of their experiences due to being an SGM.

Stigma stress, like minority stress, has severe adverse effects on mental health and well-being (Crowell et al., 2014). Just as many religiously affiliated SGM individuals are exposed to minority stress in conservative religious environments, many are likewise exposed to high rates of stigma stress in their religious community (Barnes & Meyer, 2012). High exposure to these kinds of stress is associated with higher levels of internalized homophobia, identity confusion, the need for concealment, and the need for others' acceptance, all of which are linked to poor mental health (Crowell et al., 2014). Unfortunately, experiences of stigma stress can also prevent individuals from seeking mental health treat-

ment, which may keep individuals from addressing the effects of these stresses.

Closeting The minority and stigma stress that SGM individuals experience in conservative religious environments may lead SGMs to conceal their sexual orientation (i.e., closeting), which may itself be traumatic for SGM individuals. Although identity concealment can be protective in settings where SGM identities are not affirmed (Crowell et al., 2014), long-term identity concealment may be stressful and isolating (Sowe, Brown, & Taylor, 2014). In some religious communities, SGM individuals may be officially discouraged from coming out, which can inhibit SGM individuals from accessing resources that might be beneficial in supporting their navigation of their SGM and religious identities (Dulin, n.d.). Coming out can be associated with positive outcomes for SGMs, though this depends on context: for those who come out and are embraced, there are more positive outcomes, while others might experience more negative stressors as a result (Riggle, Rostosky, Black, & Rosenkrantz, 2017). Because coming out can be associated with positive outcomes such as alleviation of stress, we consider the increased pressure to conceal their sexual/gender identities experienced by SGM individuals in religious spaces to contribute to the trauma they experience (Whitman & Nadal, 2015).

Invisibility In many conservative religions, SGM identities and experiences are not recognized institutionally or interpersonally, which may lead to feelings of invisibility. Invisibility is largely a function of the hetero-/cisnormative assumptions made in many religious traditions, which suggest that all individuals desire other-sex relationships and are cisgender. This invisibility may be evident in a variety of ways, ranging from family and community members continuing to refer to a life partner as a "friend" to individuals continuing to misgender someone after they have come out (Saari, 2001). The sense of invisibility that SGMs may experience is not always a function of their personal outness: for SGMs who acknowledge their identity openly, the process of repeatedly having to disclose their identity to those who already know but fail to incorporate this identity into their understanding of the SGM individual may be both traumatic and invalidating (Saari, 2001). SGMs may also feel the effects of invisibility when otherwise supportive individuals stand by while witnessing discrimination or violence toward the SGM individual (Mann, 2013), which, if experienced repeatedly in a religious community, can lead SGM individuals to feel that their religious community does not understand, value, or support them.

Violence Where invisibility can contribute to isolation and a more covert sense of disbelonging, many SGM individuals also experience overt violence as a result of their SGM identities in their religious communities (Nielson, 2016). In its extreme, violence can take the form of sexual abuse by religious leaders, physical assault done by members of a congregation, or aggression toward SGMs in religious contexts such as being banned from their church and/or home (Sherry, Adelman, Whilde, & Quick, 2010). More frequently, however, violence takes the form of emotional manipulation and verbal abuse, such as using derogatory language to scare and shame SGM individuals. These experiences can engender feelings of worthlessness, othering, and helplessness (Yoakam, 2006), which may be compounded by others' passivity regarding injustices toward SGMs (Russell & Richards, 2003). Members of religious communities may also exploit SGMs' fears of harassment and violence as a means of control including using social threats – such as ostracism and dehumanization – to manipulate SGMs to act in accordance with hetero-/cisnormative expectations (Mann, 2013) or at its extreme to comply with extortion. Most SGMs have experienced some form of violence (Page, Lindahl, & Malik, 2013), and many find themselves hypervigilant, particularly in the settings in which this violence has occurred, which in itself may be traumatic (Meyer, 2003; Sowe et al., 2014).

Intrapersonal Contributors to Tramatic Experiences

Frequent exposure to homo-/transnegative contexts and interpersonal discrimination – conceptualized as structural and interpersonal contributors to traumatic experiences – can lead to internalized negative beliefs about self and conflict or intrapersonal trauma. These intrapersonal traumas can take a number of forms and include a sense of conflict within self that results from the internalization of societal messaging. We explore four intrapersonal sources of trauma commonly experienced by SGMs in conservative religious environments: crises of sexuality/gender, crises of faith, internalized homo-/transnegativity, and internalized spirituonegativity (i.e., internalized negative affects and beliefs about what it means to be a religious or spiritual person).

Crisis of Sexuality/Gender Because many conservative religions as well as broader societal institutions condemn same-sex attractions and gender nonconformity, many SGMs in conservative religious environments initially repress or deny feelings of same-sex attraction or gender dysphoria. The emergence of the awareness of these experiences may be experienced as traumatic by SGMs and may lead to a reappraisal of previous experiences and life goals. This conflict can produce powerful adverse effects on mental health and well-being by increasing one's confusion about their identity, decreasing one's sense of self-worth, and by putting one at odds with their community (Dehlin, Galliher, Bradshaw, Hyde, & Crowell, 2014).

Crisis of Faith Experiencing same-sex attraction or gender dysphoria and recognizing that those experiences do not conform to hetero-/cisnormative religious teachings may trigger a crisis of faith for SGMs (Dahl & Galliher, 2012a). This crisis is conceptualized as an intrapersonal source of trauma since many individuals experience it as threatening and destabilizing to their sense of self, meaning-making, and place in the world. Crises of faith may be experienced by SGMs in conservative religious environments as conflicts on three levels: with God, with religious institutions, or with one's religious worldview (Ellison & Lee, 2010). Most SGMs engaged with conservative religions appear to resolve the conflict by separating themselves from religion (Dahl & Galliher, 2012b; Lefevor, Park, & Pedersen, 2018b); however, others stay engaged with conservative religion, find a more affirming religion, or do not experience conflict (Rodriguez, 2010). Those who remain engaged with religion often do so through a reconceptualization of their faith through affirming interpretations of scripture (c.f., Hartke, 2018; Helminiak, 1994; Robertson, Meléndez, & Tolton, 2018). Studies have found SGMs to report well-being in a variety of religious identities (Dehlin, Galliher, Bradshaw, & Crowell, 2014; Lefevor, Beckstead et al., in press) but seems to be clear that resolving crises of faith are critical to positive mental health (Lefevor, Sorrell, et al., in press).

Internalized Homo-/Transnegativity SGM individuals are often the subjects of violence and discrimination, which can lead to hypervigilance about future instances of violence and may also lead to the internalization of negative beliefs about same-sex sexuality or gender nonconformity (Hendricks & Testa, 2012; Meyer, 2003), which functions as an intrapersonal source of trauma. Because many religious communities ascribe to hetero-/cisnormative values, internalized homo-/transnegativity is often instilled within the individual early on and is perpetuated by repeated exposure through teachings, social norms, and communal attitudes (Lapinski & McKirnan, 2013). Internalized homo-/transnegativity is an intrapersonal trauma because an individual may continue to feel the effects of discrimination and minority stress in the absence of specific external stressors (Schuck & Liddle, 2001). Internalized homo-/transnegativity can be experienced as a rejection of self, which can be associated with feelings of unworthiness or like an imposter within the religious community. Internalized homo-/transnegativity is linked to poor mental health, as it is associated with an increased sense of shame and decreased feelings

of social support (Foster et al., 2015; Szymanski, Kashubeck-West, & Meyer, 2008).

Internalized Spirituonegativity Just as SGM individuals may internalize negative beliefs about same-sex sexuality or gender identity, religiously affiliated SGM individuals may also internalize negative beliefs about religion and spirituality. We term these beliefs, *internalized spirituonegativity*, and define internalized spirituonegativity to include internalized negative affects and beliefs about what it means to be a religious or spiritual person. These beliefs may stem from perceived rejection for religious identity from lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities and may lead SGMs from conservative religious backgrounds to distance themselves from religion or spirituality in a way that is not authentic to them. Internalized spirituonegativity may manifest as questioning whether or not one's religious identity is valid, feeling stuck in an "us vs. them" dynamic with religiously non-affiliated SGMs, feeling delegitimized, and feeling othered or unwelcome in LGBTQ communities. These negative beliefs may be perpetuated in SGM communities because of the residual negative psychological effects of experiences of religious discrimination had by many SGM individuals (Haldeman, 2002). Religiously affiliated SGM individuals can feel alienated for their association with non-affirming religious institutions, even when they would not otherwise experience conflict with their religious identity. Internalized spirituonegativity may be problematic because it may keep SGMs from conservative religious environments from engaging with LGBTQ communities and may lead them to inauthentically reject a religious identity, both of which may be detrimental to well-being.

For a religiously affiliated SGM individual, perceiving rejection from both one's religious community and their SGM community can result in significant experiences of trauma, as such conditions of being caught between two extreme worlds and not being fully accepted by either instill deep feelings of disbelonging and isolation. Many SGMs with religious backgrounds may seek sexuality/gender-specific support from the LGBTQ community as the LGBTQ community is "supposed" to be a place where individuals can find validation for their sexual or gender minority identities, especially since many religious communities at large are non-affirming. Within the LGBTQ community, SGMs from conservative religious environments might feel judged and unwelcome because of the lack of understanding and acceptance of their religious identity. This rejection can also exacerbate the feeling of isolation resulting from the loss of a support system (which is perpetuated by both their religious and LGBTQ communities) because those who are caught between their two communities can lose the sense of ability to relate to either completely (Dehlin et al., 2015). As a result of approaching the LGBTQ community from a conservative religious background, SGMs might also feel that they have no safe places – meaning nowhere that they can escape the stresses of their religious community and also nowhere that they can be truly and fully themselves (honoring both SGM and religious identities).

Furthermore, religious SGMs may feel as though they cannot find acceptance of their sexual or gender identity within their religious communities (Jacobsen & Wright, 2014). Many religious communities consider themselves "open but not affirming" meaning that no formal disciplinary measures are taken against SGM individuals for being an SGM but also that SGM individuals are not eligible to hold leadership positions. Some work suggests that these positions may have negative consequences for SGM and heterosexual/cisgender congregants alike (Lefevor et al., in press).

As a function of perceiving rejection from the LGBTQ community, individuals might feel the need to choose between their "selves," which is similar to some of the traumas they might face in religious contexts. Such pressure can feel like an attack on beliefs that are central to individuals' worldviews and conceptions of themselves, leading them to feel the need to conceal their religious identity (Pitt, 2010).

Ways Sexual/Gender Minorities Navigate Trauma in Conservative Religious Environments

Although many SGMs report experiencing trauma from conservative religious environments, not all do (Lefevor, Beckstead, et al., in press). We now turn to discuss the varied reactions of SGM individuals to these potentially traumatic environments. We follow Pitt (2010), Dehlin et al. (2015), and Rodriguez and Ouellette (2000) in describing five different ways that SGMs from conservative religious backgrounds may navigate these potentially traumatic experiences: not experiencing trauma, compartmentalizing identities, rejecting a sexual/gender minority identity, rejecting a religious identity, and integrating identities.

Not Experiencing Trauma

Some SGM individuals struggle to navigate trauma experienced in religious spaces, where others report not experiencing conflict in these spaces (Rodriguez & Ouellette, 2000). SGM individuals might report not experiencing trauma or conflict for a number of reasons. For example, an SGM's family might be religious but not actively practicing, so the SGM individual does not frequently come in contact with conservative religious ideologies. Alternately, an SGM individual's family might be involved in the religion, but the SGM individual might not be invested in the religion and just goes through the motions of participating. Similarly, an SGM individual who has grown up in a diverse environment, or in an affirming congregation, might have been exposed to more varied perspectives around gender and sexuality and thus experience less intrapersonal trauma. Individuals who are involved in conservative communities and participate can also report not experiencing trauma, for example, by finding ways to understand and re-interpret religious texts and traditions such that they can become affirming of their sexuality or gender (Foster et al., 2015). SGM individuals may adjust their meaning-making strategies to normalize SGM identity, for example, by continuing to engage in traditional heterosexual and cisgender customs but as an SGM individual, like waiting until marriage to have sex, placing value on monogamy, or prizing binary gender expression (McQueeney, 2009; Lapinski & McKirnan, 2013). Others might differentiate between God as a perfect being and their non-affirming congregation as imperfect beings and thus do not experience as much trauma in this context (Foster et al., 2015).

Although many SGMs who do not report experiencing trauma likely have not experienced trauma, others may fail to report experiencing trauma despite having had traumatic experiences. This failure to report may occur for many reasons including invalidation of the traumatic experiences by others such that the individual does not label an experience as traumatic though it is clearly distressing. Others may not report traumatic experiences because they are not open about their SGM experiences, and identifying an event as traumatic would involve a disclosure of their SGM identity or experience. Yet others may not report traumatic experiences because they do not feel safe to do so in conservative religious environments.

Compartmentalizing Identities

For SGM individuals who experience conflict or trauma in conservative religious environments, one method of navigating it is to compartmentalize their identities, prioritizing one identity at a time based on situational demands. For instance, in religious settings, individuals may minimize their SGM identity and experiences to convey a sense of similarity to heterosexual and cisgender religious peers. Alternatively, in LGBTQ spaces, individuals may minimize their religious identity and emphasize their SGM identity. Compartmentalizing occurs most often in settings where individuals feel unable to authentically express all aspects of their identity, whether it be in the context of religion or sexuality/gender (Riggle et al., 2017). Although this strategy is commonly employed and may be an optimal way to react in some circumstances, it does not appear to be linked to the best long-term health (Dehlin et al., 2015).

Research on SGMs who compartmentalize their SGM and religious identities indicates that they are more likely to be religiously active, less likely to identify as an SGM, less likely to be in a committed relationship, and more likely to engage in sexual orientation change efforts relative to those who do not compartmentalize (Dehlin et al., 2015). Many SGMs who compartmentalize report feeling isolated, being stuck between two worlds, and struggling with their separate lives leaking into each other (Pitt, 2010). However, others indicate that compartmentalization and concealment are important to maintain a sense of balance and mental health (Riggle et al., 2017). Overall, compartmentalizing can be mentally taxing for SGM individuals (Dehlin et al., 2015), but for some, this may be the most effective way of navigating conflict given situational demands. Compartmentalizing may help reduce trauma in some areas in the short term (e.g., temporary distancing from disclosing information that would incite more direct discrimination, harassment, homo-/transnegativity), but it may also lead to increased trauma in the long run by cultivating conditions that could exacerbate trauma (e.g., perpetuating feelings of isolation, invisibility, rejection).

Rejecting Sexual/Gender Minority Identity

Other SGMs navigate potentially traumatic experiences in conservative religious environments by rejecting SGM experiences and identity. Although rejecting an SGM identity is uncommon, there is evidence that doing so may buffer distress among SGMs from conservative religious environments, particularly those who are more religiously oriented (Lefevor, Sorrell, et al., in press). Those who reject an SGM identity appear to be more likely to have a heterosexual marriage, have children, be more religiously devout, engage with SOCE, ignore same-sex attractions or gender nonconformity, and identify as heterosexual or cisgender than individuals who do not reject an SGM identity (Dehlin et al., 2015). This strategy may have long-term negative mental health implications (Dehlin et al., 2015), but it may effectively help some SGMs maintain balance in their lives and avoid the confusion and difficulty of reconciling sexual/gender minority and religiously conservative identities (Lefevor, Beckstead, et al., in press), effectively avoiding many sources of trauma.

Rejecting Religious Identity

Most commonly, SGMs from conservative religious backgrounds navigate trauma experienced in religious spaces by rejecting a religious identity and separating themselves from religious spaces (Lefevor, Blaber, & Huffman, 2018b). SGMs who reject a religious identity tend to be older, have fewer children, adopt an LGBTQ identity label, be more open about their sexual/gender identity, have greater social support, and report more sexual activity than those who do not reject a religious identity (Dehlin et al., 2015). Many SGMs reject a religious identity due to experiences of trauma in religious environments. Overall, rejecting a religious identity appears to be helpful in reducing the negative effects of religious trauma (Dehlin et al., 2015). Some who reject a religious identity maintain a sense of spirituality by separating themselves from organized religion but maintaining a connection with God, nature, or the Divine, which may further mitigate some of the potential negative experiences from religious involvement, such as exposure to discrimination, minority stress, and ostracism (Foster et al., 2015). Many SGMs who have rejected a religious identity report having found a strong sense of belonging and acceptance within the LGBTQ community, which can also positively influence their well-being (Lefevor, Beckstead et al., in press). Rejecting a religious identity may help in navigating trauma as it allows for distancing from continued exposure to structural, interpersonal, and intrapersonal sources of trauma.

Integrating Sexual/Gender Minority and Religious Identities

A small portion of SGMs from conservative religious backgrounds report navigating trauma experienced in religious environments by inte-

grating their SGM and religious identity in a way that enables continued engagement with both SGM and conservative religious communities (Dehlin et al., 2015). The infrequency with which individuals integrate identities may be reflective of the difficulty of reconciling SGM and conservative religious identities in a way that validates both. SGM individuals who report integration of their religious and sexual identities may be able to navigate conservative religious environments due to support from an otherwise affirming environment including partners, social connections, and an LGBTQ community (Dehlin et al., 2015). These individuals are often still involved with their religion insofar as it is personally meaningful and have worked to cope with any distress experienced around their SGM identity in the context of their religious values and vice versa.

Although SGM individuals who report integrating SGM and conservative religious identities evidence improved quality of life relative to those who do not, they still report internalized homo-/transnegativity, identity confusion, depression, sexual identity distress, and self-esteem deficits (Dehlin et al., 2015). Likely, SGM individuals who have integrated their identities have recognized and determined how to balance the most important aspects of each identity, as well as developed resilience strategies for coping with conflict and trauma (Lefevor, Beckstead, et al., in press; Foster et al., 2015). For some, integration may include finding a new religious community that expressly validates SGM identities (Rodriguez, 2010; Rodriguez & Ouellette, 2000) where for others it may involve finding support within their existing religious communities.

Integrating one's SGM and religious identities may help reduce the impact of trauma on structural, interpersonal, and institutional levels. By mediating the conflict between identities and finding a space that has the capacity to support a healthy integration of sexual and religious identities, the threat of trauma inflicted by an institution may be reduced. One may then also gain a stronger sense of social support from their community, which could help reduce trauma on an interpersonal level, as increased perceived social support is strongly associated with increased mental health outcomes (Higa et al., 2012). Further, trauma may be reduced on the intrapersonal level as a result of the alleviation of dissonance, the mediation of conflict between identities, and the benefits arising from reductions in trauma on the institutional and interpersonal levels.

Recommendations for Mental Health Professionals and Conclusions

As many SGMs who have been in conservative religious environments seek therapy, mental health professionals may benefit from understanding the heterogeneity of their experiences, as discussed in this chapter. It is imperative that mental health providers understand the differences between the traumas experienced by SGMs as a function of their SGM identity and those that are specific to their SGM identity in a religious context, in order to provide the best possible care. As the types of traumas that SGM individuals may experience in religious contexts vary across a variety of domains including source, intent, and impact, we emphasize the importance of navigating identity conflict and trauma in a way that is natural to each SGM individual. This could entail prioritizing one's SGM or religious identity over the other – depending on the relative salience of each – or attempting to balance the identity conflict and trauma. Mental health providers should strive to address each client's needs in a way that emphasizes authenticity for the individual.

We discussed several different sources of trauma experienced by SGMs in religious environments: structural, interpersonal, and intrapersonal. As each individual likely has different experiences with each source of trauma, we recommend that therapists assess clients' experiences with trauma and intervene at each level as appropriate. For example, it may be helpful for therapists to understand to what degree clients are aware of and impacted by hetero-/cisnormative messaging that has occurred within their religious contexts. Further, as some SGM individuals experience religious institutions as oppressive but others do not, it may be important for therapists to assess clients' feelings toward religious institutions and structural sources of trauma.

SGM individuals may be most drawn to be forthcoming with interpersonal sources of trauma, and appropriate trauma-informed care should be given to those who do (Simmons, 2017). SGM individuals may be less likely to recognize or articulate intrapersonal sources of trauma, and therapists should be attentive to understand to what degree clients experience internalized homo-/transnegativity and internalized spirituonegativity.

Due to the heterogeneity among SGMs from conservative religious backgrounds, we cannot recommend a "one-size-fits-all" approach to address the trauma experienced by SGMs. Rather, we recommend that therapists be aware of and understand these five methods of navigating trauma for SGMs with experience in conservative religion and that individuals may engage with each of these methods at different times and places in their lives (Dehlin et al., 2015). We recommend that therapists understand the unique needs, strengths, and limitations accompanying each method, so that they may present this information to their clients to enhance their autonomy and self-determination.

In this chapter, we have given an overview of trauma as uniquely experienced by SGMs in religious contexts, with the purpose of providing insights to therapists that will aid in developing more effective, personally tailored treatment plans for clients. We have provided a brief explanation of different types of trauma, organizing them in three levels (structural, interpersonal, and intraindividual), to show how trauma can manifest in different forms and arise from a variety of sources, with each eliciting unique responses. We have also briefly discussed five methods of navigating traumas commonly experienced by SGMs of conservative religious backgrounds, identifying distinguishable trends in characteristics of those who typically choose each path, as well as the outcomes and implications accompanying them. We hope that in so doing, we have elucidated a range of experiences that will better prepare therapists to work with SGM clients with a variety of experiences with religion.

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26

Affirming Resources for LGBTQ+ Individuals Exploring Faith and Religious Identities: An Annotated Bibliography

Austen Hartke

Abstract

When care providers begin working with an LGBTQ+ client, they can often feel unprepared to help the client explore the role faith and religion play in that individual's life. Even though cultural narratives tend to pit people of different orientations and genders against people of faith, the reality is that many LGBTQ+ people are trying to find ways to integrate their religious identity into a more complete sense of self. This chapter seeks to provide recommendations for affirming, faith-based resources that can help care receivers move from confusion and conflict to pride and synthesis in all areas of their identity. Recommendations for online and in-print resources, as well as for community organizations, are broken up into larger categories for those from Christian, Jewish, and Muslim backgrounds, with a shorter list provided for those from other religious traditions.

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Introduction

Author's Note: Throughout this chapter I will use the acronym "LGBTQ+" when referring to people of all gender and sexual minorities. When describing only people of diverse sexual and affectional orientations, I have chosen to use the label "same-gender-loving," and when describing only people of diverse gender identities and expressions, I have chosen to use the label "gender-expansive." Neither of these terms are ideal, as the label "same-gender-loving" can obscure the experiences of bisexual, pansexual, and even asexual people, and the label "gender-expansive" may not reflect the experiences of transgender people whose identities adhere closely to binary male or female presentations. Given the limits of our current descriptive language, I look forward to a day when a more accurate vocabulary is made mainstream.

When LGBTQ+ clients or care receivers first begin sharing their experiences with faith and religion, the most important thing an advocate or care provider can do is suspend assumptions. Because of overarching cultural narratives that tend to pit religious communities and LGBTQ+ communities against each other, it would be easy to assume that all LGBTQ+ people have had neg-

E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_26

ative experiences with religion, but this is not always the case. Many LGBTQ+ people today, especially those under age 18, have not been directly confronted with a point of conflict between their orientation or gender and their religious tradition and may see no problem with embracing multiple identities. At the same time, with faith-based sexual orientation and gender change efforts still practiced in many countries including the USA, it is also not safe to assume that a care receiver has never had a negative or even traumatizing religious experience. The goal of the care provider, then, should be to listen closely to the real lived experiences of each client, not assuming past experiences or future desires for religious connection. If the care receiver articulates at any point that they have no desire to further explore faith or to connect with religious communities, that wish should be normalized, and must be respected.

If a care receiver does wish to continue exploring personal faith and religious identity, the care provider should then assess whether the client has had negative religious experiences in the past and might benefit from informed care related to spiritual violence. Although a comprehensive study of spiritual violence is beyond the scope of this chapter, clients and care providers may find the following publications helpful.

- Brownell, P. (2015). *Spiritual competency in psychotherapy*. New York, NY: Springer Publishing Company.
- Fitchett, G. (2002). *Assessing spiritual needs: A guide for caregivers*. Lima, OH: Academic Renewal Press.
- Merritt, C. H. (2018). *Healing spiritual wounds: Reconnecting with a loving God after experiencing a hurtful church*. New York, NY: HarperOne.
- Pasquale, T. B. (2015). *Sacred wounds: A path to healing from spiritual trauma*. St. Louis, MO: Chalice Press.
- Walsh, F. (2010). *Spiritual resources in family therapy*. New York, NY: Guilford.

The remainder of this chapter seeks to provide a guide for care providers who want to connect their clients to affirming resources related to LGBTQ+ identities and faith. When choosing a resource from the list below, it is important to take the following into consideration:

(1) **What is the care receiver's primary language and reading level?** While most of the resources included here are in English, there are a handful published in other languages, and not every source is written in an accessible style. When relevant, I have noted if a resource uses more academic language that may only be helpful to readers familiar with that style.

(2) **Is the care receiver in need of a resource primarily related to sexual orientation or to gender?** It goes without saying that a book directed toward transgender readers may not be as helpful to someone who identifies as a gay, cisgender woman as would a book geared toward same-gender-loving readers, and vice versa. Though there is often overlap in LGBTQ+ identities, it is important to match the client with a resource that includes perspectives from those who share their orientation or gender identity. If a resource is focused on either orientation or gender, but the title does not specify this, I have included the primary focuses in the annotations.

(3) **Is there a resource on the list that shares more than one of the care receiver's identities?** Even better than a resource that merely matches the client's sexual or gender identity is a resource that also speaks to their other identities related to race, ethnicity, ability, immigration status, age, etc.

(4) **Does the care receiver have a history with or currently belong to a specific religious denomination?** It can be tempting to assume that all adherents of a religion hold to the same beliefs and practices, but in reality almost all religious traditions are divided into multiple denominations or sects. A resource that relates the experiences of Reform Jews may not be helpful to someone raised Orthodox; stories from LGBTQ+ Catholics may not be relevant to someone from a Black Pentecostal church background, and groups for Zen Buddhists may feel alien-

ating for someone from the Theravada tradition. It is most helpful to match clients with resources from their own denomination when possible.

The framework for the annotated bibliography below comes from the Cass Identity Development Scale,[11] beginning each section with the resources that may prove most helpful for those in the early stages of identity development and ending with the resources that may help the client move toward identity integration. Resources for those experiencing Identity Confusion and Comparison focus on each particular tradition's sacred texts and most prevalent practices, as these are often the first points of conflict for the individual. Resources for those experiencing Identity Tolerance and Acceptance attempt to help the client connect with others through shared narratives, since this is the point at which LGBTQ+ people often begin to seek out those who share their orientation or gender identity. Resources for those experiencing Identity Pride and Synthesis highlight experiences and ideas related to diversity and complex interactions between multiple social identities, in the hope of providing role models for integration. Finally, the list of organizations at the end of each section can help the care provider connect the LGBTQ+ individual with supportive community.

Christian Resources

Resources for those experiencing Identity Confusion and Comparison:

- Bellis, A. O., Hufford, T. L. (2010). *Science, scripture, and homosexuality*. Eugene, OR: Wipf and Stock Pub.
  - Co-written by a biblical scholar and a biologist, this book seeks to understand biblical examples of same-gender attractions and relationships through a scientific lens. It also considers other times in church history when science has changed theological interpretations. A good resource for those who would benefit from seeing the natural basis for diversity in sexual orientation.
- Boswell, J. (2015). *Christianity, social tolerance, and homosexuality: Gay people in western Europe from the beginning of the Christian era to the fourteenth century*. Chicago, IL: The University of Chicago Press.
  - An in-depth investigation into historical references made to same-gender-loving individuals and couples from ancient Rome through to the times of Abelard and Aquinas. Written in a more academic style, this resource might be especially helpful to those who hold church tradition in high regard, and who want to see what early Christians thought about identity and inclusion.
- Brownson, J. V. (2013). *Bible, gender, sexuality: Reframing the church's debate on same-sex relationships.* Grand Rapids, MI: W.B. Eerdmans Pub. Co.
  - A deconstruction of the larger themes in non-affirming arguments from scripture, such as the argument for celibacy for gay, lesbian, and bisexual people and the argument for gender complementarity that requires all people to align with specific gender expectations. The author does not mention transgender people, and so this book is more specifically geared toward a discussion of sexual orientation; however, some of the writing about gender can be incidentally helpful for gender-expansive people.
- Center for LGBTQ and Gender Studies in Religion (2014, June 15). *Ni juicio, ni condena: Leyendo de nuevo los textos bíblicos sobre la homosexualidad.* Retrieved from https://clgs.org/multimedia-archive/ni-juicio-ni-condena-leyendo-de-nuevo-los-textos-biblicos-sobre-la-homosexualidad/
  - A straightforward look at eight biblical texts used against same-gender relationships, with an introduction on things to keep in mind when reading scripture. This primer is organized in talking points and is a good beginning resource for those con-

[11] Cass, V. C. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality*, 4(3), 219–235.

cerned about verses used against them but who may feel put off by larger sources. Written in Spanish.

- DeFranza, M. K. (2015). *Sex difference in Christian theology: Male, female, and intersex in the image of God.* Grand Rapids, MI: William B. Eerdmans Publishing Company.
  - A comprehensive look at intersex people and people with differences in sex development in scripture and Christian tradition. Chapter 2 covers scripture and interpretation regarding assigned sex, chapter 3 covers the treatment of people with assigned sexes outside the binary in Christian history, and chapter 4 looks at current Christian understandings of intersex people/people with DSD. It is important to note that this text uses academic language and can be hard to read for those unfamiliar with the style but can be helpful for those who want a deeper understanding.
- De La Torre, M. A., Castuera, I., & Rivera, L. M. (2016). *A la familia: Una conversación sobre nuestras familias, la Biblia, la orientación sexual y la identidad de género.* Retrieved from http://welcomingresources.org/a_la_familia.pdf
  - A resource with both English and Spanish translations side by side in the same document, this PDF is especially helpful for bilingual individuals and families. Filled with testimonies from Spanish-speaking LGBTQ+ Christians and their families, as well as discussion questions and exercises. Attention is paid to stories from both same-gender-loving people and gender-expansive people. A middle-of-the-road resource that deconstructs non-affirming interpretations of scripture but is short and accessible to those without much background in religion or LGBTQ+ identities.
- Gomes, P. J. (2002). *The good book: Reading the Bible with mind and heart*. New York: HarperOne.
  - Written by American Baptist preacher and revered Harvard lecturer Peter Gomes, this book is about understanding scripture broadly, but Gomes' own experience as a gay Black man prompted the book's second section on the abuse of biblical texts used to discriminate. Chapter 8 looks at the texts used against same-gender-loving people, and the author suggests alternate readings. This easy-to-read resource might be especially helpful for those who have had negative experiences in Christian community but want to re-engage with their faith in a more positive way.
- Hartke, A. (2018). *Transforming: The Bible and the lives of transgender Christians*. Louisville, KY: Westminster John Knox Press.
  - Combining biblical stories with interviews from transgender Christians today, this book seeks to deconstruct the passages used against gender-expansive people, as well as to provide examples of biblical stories that trans people may find healing and affirming. After part 1, which introduces language related to gender and the current Christian climate regarding trans inclusion, the book moves on to stories written in an easy-to-read narrative format.
- Human Rights Campaign (2015). *Coming home to Catholicism and to self*. Retrieved from https://www.hrc.org/resources/coming-home-to-catholicism-and-to-self
  - A short pamphlet that highlights the experiences of LGBTQ+ Catholics in Church communities, chronicles the changes in Church behavior under Pope Francis, encourages LGBTQ+ Catholics to listen to the inner voice of God, and provides further community resources.
- Human Rights Campaign (2018). *Coming home to Evangelicalism and to self.* Retrieved from https://www.hrc.org/resources/coming-home-to-evangelicalism-and-to-self
  - A short pamphlet that highlights the experiences of LGBTQ+ people in Evangelical communities, as well as the experiences of affirming parents. Filled with words of encouragement and using the language of personal relationship with Jesus that is familiar to many from Evangelical contexts.

- Lee, J. (2013). *Torn: Rescuing the gospel from the gays*-vs.-*Christians debate*. Nashville, TN: Jericho Books.
  - This book is the author's story of growing up gay and Evangelical, his experiences in ex-gay programs, and how he came to see that his faith and his sexual orientation weren't actually in conflict. A thoughtful introduction to the lived experiences of many same-gender-loving Christians, and may be helpful for those feeling alone or misunderstood.
- Martin, J. (2018). *Building a bridge: How the Catholic Church and the LGBT community can enter into a relationship of respect, compassion, and sensitivity*. New York, NY: HarperOne.
  - This affirming book written by a Catholic priest explores the roadblocks that hamper the Catholic Church's relationship with LGBTQ+ people and uses stories from the Gospels to encourage a new commitment to inclusion. This is an easy introduction to the subject for LGBTQ+ Catholics, but note that the author is speaking primarily about same-gender relationships and does not speak extensively about gender-expansive people.
- Robinson, G. (2016, January 19). *Transgender welcome: A bishop makes the case for affirmation*. Retrieved from https://www.americanprogress.org/issues/religion/reports/2016/01/19/129101/transgender-welcome/
  - A short deconstruction of some of the verses used against transgender people, this resource written by the first gay bishop in the Episcopal Church helps readers to rethink scripture. A great option for those who are not seeking a book-length source but would like a basic knowledge of inclusive interpretations related to gender diversity.
- Vines, M. (2015). *God and the gay Christian: The biblical case in support of same-sex relationships.* New York, NY: Convergent Books.
  - One part memoir, two parts biblical text study, this resource follows the author as he digs deep into each of the biblical passages used against same-gender-loving people. Solid scholarship is paired with accessible language to make this a good starting point for those curious about inclusive interpretations.

Resources for those experiencing Identity Tolerance and Acceptance:

- Alison, J. (2001). *Faith beyond resentment: Fragments Catholic and gay*. Chestnut Ridge, NY: Crossroad Publishing Co.
  - A journey of reclamation as the author imaginatively interprets classic Bible stories that help him come to a place of healing. This resource may be helpful to those who are open to a less literal interpretation of scripture, and who are looking for ways to reconnect with Catholic life and faith while not ignoring prior trauma.
- Beardsley, C., & O'Brien, M. (2017). *This is my body: Hearing the theology of transgender Christians.* London, UK: Darton, Longman & Todd Ltd.
  - This compilation of essays, scholarship, and storytelling was put together by a group called The Sibyls, a Christian spirituality group for gender-expansive people based in the United Kingdom. Part 1 is academic in nature, with essays on trans identities and theology, science, and the arts. Part 2 is a collection of stories from those who identify as transgender, as cross-dressers, or as allies. Especially helpful for those familiar with church cultures in the UK, or those involved in Anglican communities.
- Cane, C. (2017). *Live through this: Surviving the intersections of sexuality, God and race.* Jersey City, NJ: Cleis Press.
  - Personal essays from the author on his experiences coming to understand his sexuality, his racial identity as the son of a white mother and Black father, and his faith in and outside of historically African-American churches. A helpful resource for those who feel like most writing on faith, orientation, and gender leaves out a critical piece of who they are, and for those who

are unsure about whether they want faith to be a part of their lives moving forward.

- Cantorna, A. (2019). *Unashamed: A coming-out guide for LGBTQ Christians*. Louisville, KY: Westminster John Knox Press.
  - An easy-to-read guide for those who are considering inviting in or coming out to friends and loved ones. Topics include breaking down internalized homo/transphobia, finding and building support networks, and setting boundaries. Helpful for those who are looking to deepen their faith, and who need encouragement and practical suggestions.
- Chellew-Hodge, C. (2008). *Bulletproof faith: A spiritual survival guide for gay and lesbian Christians.* San Francisco, CA: Jossey-Bass.
  - Written specifically for same-gender-loving Christians who are familiar with the "culture wars," this guide attempts to help deepen the individual's faith and turn attacks from others into opportunities for growth, curiosity, and compassion. Helpful for those who experience theologically driven verbal confrontations, and who want to learn how to ground themselves in knowledge of self and relationship with God.
- Cherniak, M., Gerassimenko, O., & Brinkschröder, M. (2017). *"For I am wonderfully made": Texts on Eastern Orthodoxy and LGBT inclusion.* Amsterdam: European Forum of Lesbian, Gay, Bisexual and Transgender Christian Groups.
  - This collection of essays from LGBTQ+ Christians and allies in the Eastern Orthodox Church includes a variety of experiences. Parts 1 and 2 include reflections on theology, part 3 looks at Eastern Orthodox Church history, and part 4 focuses on pastoral care and concerns for LGBTQ+ Christians in the Church—all of which may be helpful for those trying to see diversity and affirmation within this tradition.
- Chu, J. (2014). *Does Jesus really love me?: A gay Christian's pilgrimage in search of God in America.* New York, NY: Harper Perennial.
  - The author uses his background in journalism to explore more than a dozen Christian communities' interactions with same-gender-loving Christians, from the most antagonistic to the most affirming. Narrative and engrossing, this resource my help same-gender-loving people see the possibility of finding an affirming faith community.
- Lewin, E. (2018). *Filled with the spirit: Sexuality, gender, and radical inclusivity in a Black Pentecostal church coalition*. Chicago, IL: University of Chicago Press.
  - Both a history and a collection of stories from Black same-gender-loving Christians, this book chronicles the creation of The Fellowship of Affirming Ministries. Helpful for those who are coming from a Black or African-American church tradition, or who are looking for role models who have found ways to bring their sexual, racial, and religious identities together.
- Murr, R. (2014). *Unnatural: Spiritual resiliency in queer Christian women*. Eugene, OR: Resource Publications.
  - One of the few books to look specifically at the experiences of female same-gender-loving Christians, this resource includes both the author's own story and the stories of ten other women and one transgender man. The book moves from experiences of negative messaging and homo/transphobia to the reclamation and reinterpretation of identity and faith. May be helpful for those trying to understand the effect of specifically gendered expectations of women in Christian traditions.
- Robertson, B. (2017). *Our witness: The unheard stories of LGBT Christians*. London, UK: Darton, Longman & Todd Ltd.
  - A collection of stories from LGBTQ+ Christians, categorized into three sections that focus on experiences of rejection, reconciliation, and revival. Can help provide a sense of community and recognition for those who feel isolated.

- Sabia-Tanis, J. (2018). *Trans-gender: Theology, ministry, and communities of faith (2nd ed.).* Eugene, OR: Wipf and Stock Pub.
  - This reprint of a foundational text covers scriptural interpretation, a survey of the experiences of gender-expansive Christians in various denominations, and examples of theology through a gender-expansive lens. Though some of the descriptions and language have changed since the original printing, this resource is still one of the most accessible dives into gender-expansive theology.
- Tigert, L. M., & Brown, T. (2001). *Coming out young and faithful*. Cleveland, OH: Pilgrim Press.
  - A collection of stories from 21 LGBTQ+ youth about their experiences with faith and in Christian churches. A helpful resource for LGBTQ+ youth themselves, as well as for those who want to better understand the experiences of same-gender-loving and gender-expansive teenagers in faith communities.

Resources for those experiencing Identity Pride and Synthesis:

- Cheng, P. S. (2011). *Radical love: An introduction to queer theology*. New York: Seabury Books.
  - An accessible introduction to the world of queer theology, the author begins by defining the field as more than just theology done by queer people. Rather, he argues, queer theology is focused on a love that breaks down binaries such as male and female, gay and straight, and divine and human. May be especially helpful for those who are healing from previous experiences of binary labeling.
- Edman, E. M. (2017). *Queer virtue: What LGBTQ people know about life and love and how it can revitalize Christianity*. Boston, MA: Beacon.
  - The author argues that rather than being inherently homo/transphobic, the foundation of Christianity is inherently queer and that LGBTQ+ people are particularly positioned to help the church rediscover forgotten wisdom. Topics include identity formation, love for our bodies, the experience of adoption and creation of found families, authenticity, and hospitality. Helps readers to build pride and self-esteem by seeing the best parts of LGBTQ+ identities.
- Goss, R. E., & West, M. (2001). *Take back the word: A queer reading of the Bible.* Cleveland, OH: Pilgrim Press.
  - Unlike previous scripture-based resources listed for those experiencing identity confusion and comparison, this resource does not focus on apologetics or defense. Rather, LGBTQ+ theologians and scholars look at the experiences of biblical characters and tease out the similarities between those characters and gender-expansive and same-gender-loving people today. A good recommendation for those who are already familiar with responses to passages used against LGBTQ+ people, but who are curious about how scripture could relate to their lives in a positive way.
- Khalaf, D., & Khalaf, C. (2019). *Modern kinship: A queer guide to Christian marriage*. Louisville, KY: Westminster John Knox Press.
  - Traditional Christian guides to love and marriage may be alienating to same-gender-loving people, but this resource written by a queer, Christian married couple seeks to bring forward stories and advice that better serves LGBTQ+ communities. The authors' own stories pair with interviews from other LGBTQ+ Christians, and topics include dating, sex and shame, gender roles, engagement, transitioning within a marriage, and parenthood.
- Kim-Kort, M. (2018). *Outside the lines: How embracing queerness will transform your faith.* Minneapolis, MN: Fortress Press.
  - Both personal journey and biblical exploration, this resource follows the author as she begins to understand how her queer identity relates to her other identities as a Christian, wife, mother, and Asian-American woman. Helpful for those moving toward integration and synthesis of multiple identities.

- Lightsey, P. R. (2015). *Our lives matter: A womanist queer theology*. Eugene, OR: Wipf and Stock Publishers.
  - An exploration of queer theology specifically through the lens of the movement for Black lives, and focusing specifically on the experiences of Black LGBTQ+ Christian women. This resource is written in an academic style that may be difficult for some readers but that others may find empowering.
- Phillips, K. J. (2009). *Quench!: Refreshing devotionals by gay, trans, and affirming Christians*. Indianapolis, IN: Found Pearl Press.
  - A classic devotional collection with scripture readings, reflections, and prayers for each day. A companion for those who are looking for an affirming guide for daily use.
- Shore-Goss, R. (2013). *Queering Christianity: Finding a place at the table for LGBTQI Christians*. Santa Barbara, CA: Praeger.
  - This collection of essays attempts to show what a radically open and affirming church could look like. Topics include expanded metaphors and understandings of God, baptism and communion, pastoral care, marriage, and music, among others. Much like "Radical Love," listed above, this resource may be helpful for those wishing to push theological boundaries and complicate binaries.

Organizations and Groups:

- Believe Out Loud – https://www.believeoutloud.com/
  - Blog posts, affirming church guide. Based in the USA.
- Generous Space Ministries – https://www.generousspace.ca/
  - Hardcopy and downloadable resources, trainings, online community. Based in Canada.
- Kinship – https://www.sdakinship.org/
  - In-person gatherings, online community, hardcopy and downloadable resources. Seventh-Day Adventist. Based in the USA.
- Many Voices: A Black Church Movement for Gay and Transgender Justice – https://www.manyvoices.org/
  - Hardcopy and downloadable resources, help finding an affirming church. Based in the USA.
- Our Bible App – https://www.ourbibleapp.com/
  - App for Apple and Android, Bible translations, devotionals, podcasts. Based in the USA.
- Q Christian Fellowship – https://www.qchristian.org/
  - Yearly conference, hardcopy and downloadable resources, online community. Based in the USA.
- Queer Grace – http://queergrace.com/
  - Encyclopedia of articles, hardcopy and downloadable resources. Based in the USA.
- Queer Theology – https://www.queertheology.com/
  - Daily affirmation emails, podcast, online seminars, blog posts. Based in the USA.
- New Ways Ministry – https://www.newwaysministry.org/
  - Blog posts, informational articles, affirming church guide, affirming school guide, trainings. Roman Catholic. Based in the USA.
- The European Forum of LGBT Christian Groups – https://www.euroforumlgbtchristians.eu/
  - Yearly conference, hardcopy and downloadable resources, online community, research. Based in the Netherlands.
- The Fellowship of Affirming Ministries – https://www.radicallyinclusive.org/
  - Blog posts, online community, affirming church guide. Focus on African and African-American churches. Based in the USA.
- The Metropolitan Community Church – https://www.mccchurch.org/
  - Affirming church guide, in-person gatherings, hardcopy and downloadable resources. Based in the USA.

- The Naming Project – https://www.thenamingproject.org
  - Affirming Christian summer camp for LGBTQ+ youth. Based in the USA.
- The Reformation Project – https://www.reformationproject.org/
  - Yearly conference, hardcopy and downloadable resources, online community, in-person gatherings. Based in the USA.
- The Sibyls – http://sibyls.gndr.org.uk/
  - In-person gatherings, hardcopy and downloadable resources, online community. Focus on transgender and gender-expansive individuals. Based in the UK.
- Transmission Ministry Collective – https://www.transmissionministry.com/
  - Peer support groups, workshops, Bible studies, spiritual care, online community. Based in the USA.

Jewish Resources

Resources for those experiencing Identity Confusion and Comparison:

- Drinkwater, G., Lesser, J., & Shneer, D. (2012). *Torah queeries: Weekly commentaries on the Hebrew Bible*. New York, NY: New York University Press.
  - Organized to pair with each week's Torah portion, this compilation of reflections and scholarship on Torah texts opens up interpretations that can be healing to those who have only heard non-affirming readings. While many of the essays are written in an academic style, they may still be helpful as a reference source for those who are looking for information on particular passages.
- Dzmura, N. (2010). *Balancing on the mechitza: Transgender in Jewish community*. Berkeley, CA: North Atlantic Books.
  - A collection of essays from gender-expansive Jews, this resource is divided into three sections, first focusing on stories of struggle and love, then experiences of service and crossing over, and finally a section on experiences with Torah and teachings. While sexuality and orientation are mentioned, the focus is on diverse experiences of gender.
- Greenberg, S. (2004). *Wrestling with God and men: Homosexuality and the Jewish tradition*. Madison, WI: University of Wisconsin Press.
  - The author provides context for the two Torah verses used most often to condemn same-gender relationships between men, then goes on to highlight stories of same-gender-loving people and same-gender couples through Jewish history, before finally tackling four of the most common rationals behind non-affirming attitudes. An easy-to-read text for those who want an introduction to affirming theology related to sexuality and orientation.
- Human Rights Campaign (2016). *Coming home to Judaism and to self*. Retrieved from https://www.hrc.org/resources/coming-home-to-judaism-and-to-self
  - A short pamphlet that highlights the experiences of LGBTQ+ Jews in the four largest movements within Judaism, provides some commentary on Torah texts, and suggests action steps and further resources.
- Michaelson, J. (2011). *God* vs. *gay?: The religious case for equality*. Boston, MA: Beacon Press.
  - This resource looks at biblical texts from both Christianity and Judaism, but because the author is a Jewish scholar, many Jews have found the Torah-related chapters to be helpful. Parts 1 and 3 present a scripture-based case for inclusion, while part 2 looks at the passages used against same-gender-loving people. This resource focuses specifically on sexuality and orientation.
- Rapoport, C. (2004). *Judaism and homosexuality: An authentic Orthodox view.* London, UK: Vallentine Mitchell.
  - As the Chief Medical Adviser to the Chief Rabbi of the United Hebrew Congregations of the Commonwealth, the author relates the scholarship and experiences that have brought him to an understanding and acceptance of same-gender-loving people. This resource may be most helpful for same-gender-loving

Orthodox individuals who are experiencing distress because of a lack of support within their tradition.

Resources for those experiencing Identity Tolerance and Acceptance:

- Alpert, R. (1998). *Like bread on the seder plate: Jewish lesbians and the transformation of tradition.* New York, NY: Columbia University Press.
  - A look at the Torah through a Jewish lesbian lens, as well as an exploration of how modern Jewish lesbians can connect to scripture and tradition through commitments to justice and love. May be helpful for those who are looking for a resource that centers the experience of same-gender-loving women.
- Balka, C., & Rose, A. (1991). *Twice blessed: On being lesbian, gay, and Jewish.* Boston, MA: Beacon Press.
  - A collection of reflections by same-gender-loving Jews, covering topics such as reclaiming history and sacred texts, honoring relationships, building community, and leadership. A helpful banquet of different perspectives and experiences that gives the same-gender-loving reader many different possible points of connection.
- Kabakov, M. (2010). *Keep your wives away from them: Orthodox women, unorthodox desires*. Berkeley, CA: North Atlantic Books.
  - Essays from same-gender-loving women who either grew up or are currently a part of Orthodox communities. May be helpful for same-gender-loving women looking for history and connection, even if they do not currently have any desire to be in an Orthodox community.
- Ladin, J. (2019). *The soul of the stranger: Reading God and Torah from a transgender perspective.* Waltham, MA: Brandeis University Press.
  - A biblical study of the treatment of difference, as seen through a transgender lens. May provide courage and comfort for any LGBTQ+ Jews who feel like outsiders, but specifically centers the experiences of gender-expansive people.
- Ladin, J. (2013). *Through the door of life: A Jewish journey between genders*. Madison, WI: The University of Wisconsin Press.
  - The author's memoir of coming to understand her gender, which chronicles her coming out process, her family relationships, her career changes, and her relationship with God. Does not shy away from some of the most difficult experiences in transition, and may be overwhelming for some readers, but may be cathartic and encouraging for others.
- Shneer, D., & Aviv, C. (2002). *Queer Jews*. New York, NY: Routledge.
  - An updated version of "Twice Blessed," listed above, this time including voices from both same-gender-loving and gender-expansive Jews. Focuses on telling stories about the creation of identity, interactions with institutions, and creating queer Jewish culture.
- Sienna, N. (2019). *A rainbow thread: An anthology of queer Jewish texts from the first century to 1969*. Philadelphia, PA: Print-O-Craft.
  - A collection of excerpts from primary sources of history, poetry, midrash, law, letters, and literature related to gender-expansive and same-gender-loving people throughout Jewish history. Each primary source excerpt is followed by further reading suggestions. May be encouraging for those who are curious about the diversity of opinions and experiences within Jewish traditions.
- Zeveloff, N. (2014). *Transgender and Jewish*. New York, NY: Forward Association.
  - Essays from transgender Jews about their experiences at Jewish camps, in the ordination process, through conversion, and more. A more modern version of "Balancing on the Mechitza" above, this resource looks toward the future of trans Jewish culture.

Resources for those experiencing Identity Pride and Synthesis:

- Bergman, S. B. (2013). *Blood, marriage, wine & glitter*. Vancouver, CAN: Arsenal Pulp Press.
  - Autobiographical essays from the author on family, parenthood, and friendship as a queer transgender Jew. May be especially helpful for LGBTQ+ Jews exploring family dynamics, building up a chosen family, the difficulty of conception, and the choice to parent.
- Brown, A. (2004). *Mentsh: On being Jewish and queer*. Los Angeles, CA: Alyson Books.
  - A compilation of essays from LGBTQ+ Jews from around the world, focusing on experiences of identity formation and integration. Representation of narratives from outside the USA may make this more accessible to those who grew up or currently live outside the US. More focus put on orientation, with few chapters exploring gender-expansive identities.
- Ramer, A. (2010). *Queering the text: Biblical, medieval, and modern Jewish stories*. Maple Shade, NJ: Lethe Press.
  - The author leans into the tradition of midrash to produce a collection of stories about same-gender-loving people inspired by sacred texts and Jewish history. May help readers think about their connections to Jewish tradition, even if they have no desire to currently be part of a worshiping community.

Organizations and Groups:

- Bat Kol – http://www.bat-kol.org/
  - Blog posts, articles, in-person gatherings. Specifically for same-gender-loving Jewish women. Orthodox. Based in Israel. Website in Hebrew.
- Eshel – http://www.eshelonline.org/
  - In-person gatherings, call-in support groups, affirming shuls guide, hotline. Orthodox. Based in the USA.
- Havruta – https://havruta.org.il/
  - Blog posts, articles, downloadable resources, advocacy, in-person gatherings. Specifically for same-gender-loving Jewish men. Orthodox. Based in Israel. Website in Hebrew.
- Jewish Queer Youth – https://www.jqyouth.org/our-mission/
  - In-person gatherings, online community, hardcopy and downloadable resources, college and university support, affirming yeshiva guide. Orthodox, Chasidic, and Sephardic. Based in the USA.
- Keshet – https://www.keshetonline.org/
  - In-person gatherings, advocacy, hardcopy and downloadable resources, affirming organization guide. Based in the USA.
- Ma'avarim – https://www.maavarim.org/
  - In-person groups, online community, articles, advocacy, trainings. Specifically for transgender and gender-expansive Jews. Based in Israel. Website in Hebrew.
- Ritualwell – https://ritualwell.org/gender-sexual-identity
  - Prayers, blessings, rituals, poems related to gender and orientation. Based in the USA.
- SVARA: A Traditionally Radical Yeshiva – https://svara.org/
  - Talmud study, in-person gatherings, summer camp, downloadable resources. Based in the USA.
- The Institute for Judaism, Sexual Orientation & Gender Identity – http://ijso.huc.edu/
  - Hardcopy and downloadable resources, affirming synagogues guide, list of statements of affirmation from major Jewish organizations. Based in the USA.
- The World Congress: Keshet Ga'avah – http://glbtjews.org
  - Yearly conference, newsletter, list of affiliated organizations worldwide. Based in the USA.
- TransTorah – http://transtorah.org/
  - Articles, videos, rituals, prayers. Specifically for transgender and gender-expansive Jews. Based in the USA.

Muslim Resources

Resources for those experiencing Identity Confusion and Comparison:

- Habib, S. (2009). *Islam and homosexuality*. Santa Barbara, CA: Praeger.

  - A two volume set of essays on same-gender relationships and same-gender-loving individuals in historical and modern Islam. Academic language may present a barrier to some readers, though individual chapters may be helpful to those whose cultural background includes Muslim traditions from Malaysia, Iraq, Australia, Germany, and Turkey, since contributing authors highlight those experiences.
- Human Rights Campaign (2015). *Coming home to Islam and to self*. Retrieved from https://www.hrc.org/resources/coming-home-to-islam-and-to-self
  - A short pamphlet that highlights the experiences of same-gender-loving and gender-expansive Muslims. Touches on experiences of coming out to self and others, finding community, studying sacred texts and traditions, and dealing with Islamophobia.
- Kugle, S. A. (2010). *Homosexuality in Islam: Critical reflection on gay, lesbian and transgender Muslims*. Oxford, UK: Oneworld Publications.
  - Through the first five chapters of this book, the author investigates the treatment of same-gender relationships and same-gender-loving people in scripture, in hadith, and in the law. In the sixth chapter, the author pivots to talk about gender and the treatment of gender-expansive people through Muslim history. Although very densely packed, the language used in this resource is still accessible to most readers.
- Muslim Youth Leadership Council. (2018, November 8). *I'm Muslim and I might not be straight: A resource for LGBTQ+ Muslim youth*. Retrieved from https://advocatesforyouth.org/resources/health-information/im-muslim-and-i-might-not-be-straight/
  - A short pamphlet for youth who are questioning their gender or sexual orientation, with assurances that they can hold on to their identity and their faith. Filled with quotes from other LGBTQ+ Muslim youth, this resource may provide comfort to those feeling alone.

Resources for those experiencing Identity Tolerance and Acceptance:

- Habib, S. (2019). *We have always been here: A queer Muslim memoir*. Toronto, ON: Viking.
  - Growing up as an Ahmadi Muslim in Pakistan, the author chronicles her experiences with family, marriage, discovering her queer identity, and coming out, all while emigrating and settling in Canada. An easy-to-read resource that may be helpful for those attempting to understand their own story and place in family and community. May be more helpful for those who wish to hold on to some of the cultural pieces of Islam but are unsure about connection to the spiritual practices.
- Jama, A. (2008). *Illegal citizens: Queer lives in the Muslim world*. United States: Salaam Press.
  - An easy-to-read collection of stories about LGBTQ+ Muslims from 22 different countries. The author interviewed individuals and recorded their stories, occasionally including some of his own story as a queer Somali-American. May provide readers with a sense of community and an appreciation for the diversity of Muslim experiences.
- Shah, S. (2018). *The making of a gay Muslim: Religion, sexuality and identity in Malaysia and Britain.* Cham, Switzerland: Palgrave Macmillan.
  - The product of the author's research comparing the experiences of same-gender-loving Muslims in Malaysia and the United Kingdom, this readable exploration covers both struggles and blessings. May be helpful for those who need examples of individuals overcoming the assumption that their orientation and faith are at odds.

Resources for those experiencing Identity Pride and Synthesis:

- Jama, A. (2013). *Queer jihad: LGBT Muslims on coming out, activism, and the faith.* Los Angeles, CA: Oracle Releasing LLC.
  - Another easy-to-read collection from Jama, this resource is made of up of one-on-one

interviews with LGBTQ+ Muslims. The interviews examine themes related to the integration of multiple identities, spiritual and physical immigrations, and personal choice and practice and may provide examples of the many different ways Islam can be lived out.

- Kugle, S. A. (2014). *Living out Islam: Voices of gay, lesbian, and transgender Muslims*. New York, NY: New York Univ. Press.
  - The author shares narratives he has collected from his work with gender-expansive and same-gender-loving Muslims worldwide, with several stories per themed chapter. Topics include coming to understand and form community and family, engaging with politics, integrating multiple identities, and forming a grounded sense of self.

Organizations and Groups:

- Al-Fitrah Foundation – http://al-fitrah.org.za/
  - In-person gatherings, spiritual counseling, training. Based in South Africa.
- Bedayaa Organization – https://www.facebook.com/bedayaa1
  - Advocacy, legal help, online community, downloadable resources. Based in Egypt. Website in Arabic.
- Hidayah – https://www.hidayahlgbt.co.uk/
  - In-person gatherings, blog posts, advocacy. Based in the UK.
- Imaan UK – https://imaanlondon.wordpress.com/
  - Newsletter, online community, in-person gatherings, articles. Based in the UK.
- Inclusive Mosque Initiative – http://inclusivemosque.org/
  - In-person gatherings, blog posts, trainings. Based in the UK.
- Just Me and Allah: A Queer Muslim Photo Project – https://queermuslimproject.tumblr.com/
  - Photography and stories from LGBTQ+ Muslims. Based in Canada.
- Masjid al-Rabia – https://masjidalrabia.org/
  - In-person gatherings, prison ministry, hardcopy and downloadable resources, advocacy. Based in the USA.
- Muslim Alliance for Sexual and Gender Diversity – http://muslimalliance.org/
  - In-person gatherings, hardcopy and downloadable resources, advocacy. Based in the USA.
- Muslims for Progressive Values – http://www.mpvusa.org/
  - Affirming community guide, trainings, spiritual counseling, advocacy, blog posts. Based in the USA.
- National Queer Asian Pacific Islander Alliance – https://www.nqapia.org
  - Yearly conference, advocacy, downloadable resources in multiple languages. Based in the USA.
- Salaam Canada – https://www.salaamcanada.info/
  - In-person gatherings, resource lists. Based in Canada.
- The Queer Muslim Project – https://www.facebook.com/thequeermuslimproject
  - In-person gatherings, online community. Based in India.

Other Traditions and Multi-faith Perspectives

Resources for those experiencing Identity Confusion and Comparison:

- Copeland, M., & Rose, D. (2016). *Struggling in good faith: LGBTQI inclusion from 13 American religious perspectives*. Woodstock, VT: SkyLight Paths Publishing.
  - Chapters devoted to different traditions including Buddhism, Hinduism, and Unitarian Universalism, among others. More attention paid to issues related to same-gender relationships than to gender-expansive identities.
- Human Rights Campaign (2017). *Coming home to Mormonism and to self.* Retrieved from https://www.hrc.org/resources/coming-home-to-mormonism-and-to-self
  - A short pamphlet that highlights the experiences of LGBTQ+ Mormons, gives brief

explanations of doctrinal positions, and provides recommendations for support.

- Jacobs, S.-E., Thomas, W., & Lang, S. (1997). *Two-spirit people: Native American gender identity, sexuality, and spirituality.* Urbana, IL: University of Illinois Press.
  - This resource includes chapters written by Native LGBTQ+ people as well as western anthropologists, and seeks to untangle and correct some of the historical misunderstandings and mischaracterizations of gender-expansive and same-gender-loving Native groups.
- Prower, Tomás. (2018). *Queer magic: LGBT+ spirituality and culture from around the world.* Woodbury, MN: Llewellyn Publications.
  - The author attempts to survey references to gender-expansive and same-gender-loving people through multiple spiritual traditions. Major religious traditions are explored, but readers may find helpful the descriptions of lesser-acknowledged traditions from Western and Central Africa, the Caribbean, Central and South America, and more.

Resources for those experiencing Identity Tolerance and Acceptance:

- Conner, R. P., & Sparks, D. H. (2013). *Queering Creole spiritual traditions: Lesbian, gay, bisexual, and transgender participation in African-inspired traditions in the Americas*. New York, NY: Routledge.
  - A look at gender and orientation diversity within Vodou, Santeria, and other African-diaspora religious traditions, especially in the Caribbean, Brazil, and the USA. Attention is paid to reconstructing sources and listening to the stories of LGBTQ+ people participating in these traditions today.
- Manders, K., & Marston, E. (2019). *Transcending: Trans Buddhist voices*. Berkeley, CA: North Atlantic Books.
  - An anthology of essays from gender-expansive Buddhists from Mahayana and Theravada traditions, this easy-to-read volume explores community, Buddhist teachings, and identity.
- Pattanaik, D. (2001). *The man who was a woman and other queer tales from Hindu lore*. Abingdon, UK: Routledge.
  - A collection of ancient stories related to gender-expansive and same-gender-loving people in Hindu folklore, this resource provides excerpts from each story followed by commentary and context from the author.
- Pattanaik, D., & Johnson, J. (Eds.) (2017). *I am divine, so are you: How Buddhism, Jainism, Sikhism and Hinduism affirm the dignity of queer identities and sexualities*. Noida, Uttar Pradesh, India: HarperCollins Publishers India.
  - This introduction to perspectives on gender and orientation from the Karmic faiths does not attempt to deconstruct dogma, but rather to show how each tradition can see a way toward becoming LGBTQ+ affirming. Special attention is paid to the use of rituals in the lives of LGBTQ+ people.

Resources for those experiencing Identity Pride and Synthesis:

- Harrington, L., & Kulystin, T. F. (2018). *Queer magic: Power beyond boundaries.* Anchorage, AK: Mystic Productions.
  - Narratives, essays, rituals, and art from LGBTQ+ people in Pagan, Wiccan, and other Occult traditions. Topics include integration of multiple identities, imagining complex and diverse deities, and claiming one's agency and sense of self.
- Manuel, Z. E. (2015). *The way of tenderness: Awakening through race, sexuality, and gender.* Boston, MA: Wisdom Publications.
  - A Zen Buddhist examination of the meaning of cultural and embodied identities as seen through the narrative of the author's experience as a Black gay woman.
- Mollenkott, V. R. (2001). *Omnigender: A trans-religious approach*. Cleveland, OH: Pilgrim Press.
  - The author describes some of the problems caused by cultural pressure to claim one single identity, whether it be a gender identity or orientation or a religious identity. Instead, she presents examples of religious traditions that include gender diversity and

argues for the creation of communities that break down harmful binaries.

Organizations and Groups:

- Affirmation: LGBTQ Mormons, Families, and Friends – https://affirmation.org/
  - Yearly conference, in-person gatherings, online community, blog posts. Based in the USA.
- Hindu American Foundation – https://www.hafsite.org/
  - Articles, advocacy, research. Based in the USA.
- National Queer Asian Pacific Islander Alliance – https://www.nqapia.org/
  - Yearly conference, advocacy, downloadable resources in multiple languages. Based in the USA.
- Queer Asian Spirit – http://www.queerasianspirit.org/
  - Affirming organization list by country, hardcopy and downloadable resources. Based in the USA.
- TransBuddhists – https://transbuddhists.org/
  - Blog posts, downloadable resources. Based in the USA.
- Transfaith – http://www.transfaithonline.org/
  - In-person gatherings, online community, hardcopy and downloadable resources. Based in the USA.
- Unitarian Universalist Association – https://www.uua.org/lgbtq
  - Affirming church guide, in-person gatherings, affinity groups, hardcopy and downloadable resources. Based in the USA.
- Two Spirit Journal – https://twospiritjournal.com/
  - In-person gatherings, articles, newsletter. Based in Canada.

An Interpersonally Based, Process-Oriented Framework for Group Therapy with LGBTQ Clients

27

G. Tyler Lefevor and Jennifer S. Williams

Abstract

Group psychotherapy may be particularly effective in meeting the needs of lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) clients; however, few frameworks exist that encompass work with both sexual and gender minorities. We synthesize the literatures on LGBTQ experiences—including transgender and gender non-conforming experiences—and provide an interpersonally based process-oriented (IBPO) framework to group therapy. We discuss practical considerations for such a group including facilitator characteristics, logistics, format of the group, advertisement and recruitment, group composition, and rules. We then discuss process considerations including cohesiveness, universality, interpersonal learning and self-understanding, imitative behaviors, instillation of hope, altruism, socializing techniques, catharsis, and existential factors.

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Lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) individuals experience consistently high rates of psychological distress (Bouman et al., 2017; Cochran, Sullivan, & Mays, 2003), which may lead them to disproportionately seek therapy (McAleavey, Castonguay, & Locke, 2011), including group psychotherapy. In doing so, however, LGBTQ individuals encounter numerous barriers (Johnson, 2012; Owens, Riggle, & Rostosky, 2007; Scherrer, 2013) such as a lack of therapists trained to work with LGBTQ individuals and a scarcity of sexual/gender minority specific process groups (O'Hara, Dispenza, Brack, & Blood, 2013; Phillips & Fitts, in press). The current literature on group therapy with gender and sexual minorities focuses almost exclusively on group therapy with sexual minorities (e.g., Chojnacki & Gelberb, 1995; Reading & Rubin, 2011), leaving room for growth in examining how group therapy may proceed for gender minorities. Given this gap in the literature and the need for therapists to work competently with LGBTQ individuals, we review relevant literature on LGBTQ mental health and LGBTQ group counseling approaches. Drawing from these literatures and Yalom and Leszcz's (2005) framework for an interpersonally based, process-oriented therapy group, we then discuss several practical and process considerations for therapists when running such a group, illustrating these through a case example.

E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_27

Throughout the manuscript, we discuss "LGBTQ" individuals or "sexual and gender minorities," implying a degree of shared experiences across sexual and gender minority experiences. We do so because we recognize that sexual and gender minority individuals may experience minority stress in similar ways (Lefevor, Boyd-Rogers, Sprague, & Janis, 2019; Meyer, 2003) and because sexual and gender minorities are often served in the same spaces (i.e., LGBTQ centers and groups). Nonetheless, we are conscious of the separate and distinct nature of sexual and gender identities (APA, 2015) and group the two together only insofar as relevant to treatment considerations. As much of research on LGBTQ individuals is actually research on LGBQ individuals with the "T" attached without any meaningful treatment (Moradi et al., 2016), we emphasize where possible relevant research on transgender and genderqueer (TGQ) individuals.

LGBTQ Mental Health

LGBTQ individuals experience higher rates of psychological difficulties than their heterosexual and cisgender counterparts, including depression, anxiety, panic attacks, PTSD, psychological distress, and suicidal ideation (Bouman et al., 2017; Cochran et al., 2003; Kuyper & Fokkema, 2011; Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010). LGBTQ individuals also have an increased likelihood of suffering interpersonal victimization both in childhood and adulthood as compared to their heterosexual and cisgender counterparts (Balsam, Rothblum, & Beauchaine, 2005; National Coalition of Anti-Violence Programs, 2011; Roberts et al., 2010).

Within the LGBTQ population, bisexual, queer, and TGQ individuals are at higher risk of having such mental health problems than either lesbians or gay men (Author, In Press; Bouman et al., 2017; Dodge & Sandfort, 2007). These differences may be due to the effects of minority stress, which is experienced through discrimination, resultant hypervigilance, and internalized homo/transnegativity (Meyer, 2003; Hendricks & Testa, 2012).

Sexual and gender minorities' experience of minority stress is rooted in historical systems of oppression. Prior to the removal of homosexuality from the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (Knudson-Martin & Laughlin, 2005), sexual minorities were subject to incarceration and psychiatric commitment (Morris, 2013). Even after the American Psychiatric Association disavowed minority sexual orientation as a mental illness, it continued to classify gender identity disorder as a mental illness until 2013, when the diagnosis was replaced with "gender dysphoria" (APA, 2013). Efforts to "treat" minority sexual and gender identities have persisted in the form of conversion therapies. Although sexual orientation and gender identity conversion therapies have largely ceased due to questionable efficacy (e.g., Beckstead & Morrow, 2004, Haldeman, 2002) and the advent of laws against such treatments for minors (currently in nine states and the District of Colombia; Movement Advancement Project, 2017), the pursuit of change is slow toward the development of affirming therapies for sexual and gender minorities.

As a result of this disciplinary ambivalence, many practitioners are not trained to provide competent services to sexual and gender minority clients (Phillips & Fitts, in press). LGBTQ individuals experience many practical and instrumental barriers to mental health treatment including lower likelihood than the general population of having health insurance, inability to afford counseling services, and prior negative experiences with mental healthcare providers (Benson, 2013; Owens et al., 2007). In particular, TGQ individuals, who are currently *required* to obtain support from a medical professional for gender-affirming hormones or surgery (Coleman et al., 2012), report additional difficulties accessing trans-affirming providers and treatments (Rachlin, 2002). Little research compares treatment outcomes for sexual and gender minorities relative to heterosexual and cisgender individuals (e.g., Lefevor, Janis, & Park, 2017), and relatively few approaches have been adapted specifically for working with sexual and gender minorities (e.g., Austin & Craig, 2015). Although

most therapists will work with at least one LGBTQ individual at some point in their career, there remains a distinct lack of specialized training and coursework across graduate school curricula regarding LGBTQ issues (Owens et al., 2007; Phillips & Fitts, in press). Therefore, there is a need for the development and proper delivery of resources for therapists that speak to the needs of LGBTQ individuals.

LGBTQ Group Therapy

Literature describing LGBTQ group therapy is limited and primarily oriented toward support rather than process groups (Chojnacki & Gelberb, 1995; Muller & Hartman, 1998). LGBTQ support groups may be peer- or leader-led and may effectively help clients normalize and explore their sexual or gender identities, working through some conflict to develop positive views of self and provide positive interpersonal feedback (Chojnacki & Gelberb, 1995). Support groups may also provide a space for LGBTQ individuals to identify and discuss of feelings related to being a sexual/gender minority, develop skills to cope with minority stress, and explore local LGBTQ community resources (Muller & Hartman, 1998). Nonetheless, without a trained therapist to lead the group, support groups may not fully explore interpersonal processes that are complicated by internalized stigma or address mental health concerns. Further, a trained therapist may also be important in order to preserve group safety, provide confidentiality, and keep the group from becoming a place to meet romantic partners.

Many LGBTQ individuals seek group therapy instead of support groups to address family and social rejection, self-esteem, family-of-origin issues, and interpersonal skills related to emotional intimacy (Holahan & Gibson, 1994). Group therapy has been consistently shown to be an efficacious method of treatment, comparable and in some cases more favorable than individual therapy (Burlingame, Seebeck, Janis, Whitcomb, & Bardowski, 2016).

Interpersonally based, process-oriented (IBPO) therapy groups focus on difficulties in social roles and relationships by attending to here-and-now processes and may be particularly helpful for LGBTQ clients for several reasons. First, since LGBTQ individuals may seek group therapy for difficulties related to minority stressors, a sexuality- or gender-themed IBPO group may provide a sense of community for LGBTQ clients. This support in turn may be particularly helpful in buffering against the negative effects of minority stress (Kwon, 2013). Next, the group can be an opportunity for individuals to engage in sexual or gender identity exploration in an affirming environment, which can be an integral condition for healthy sexual or gender identity development (Chojnacki & Gelberb, 1995). Similarly, the group can be an effective format for working through shame and internalized homo/transnegativity as these beliefs could be identified, processed, and dispelled as they are enacted within the group. Fourthly, an IBPO therapy group may empower participants through its emphasis on client autonomy, which contrasts with the powerlessness and lack of privilege many LGBTQ individuals experience within the larger societal context. Finally, a process approach allows group members to focus on sexual or gender identity issues when *they* believe they are relevant to what is being discussed. This self-direction may be an improvement over LGBTQ support groups and even individual therapy where facilitators and therapists often overfocus (e.g., relate client issues to sexuality or gender that a client does not see as related) or underfocus (e.g., be resistant to discussing experiences of discrimination as a sexual or gender minority) on sexual or gender identity (Muller & Hartman, 1998; Mizock & Lundquist, 2016).

In addition, group therapy may be particularly helpful to gender and sexual minorities with intersecting identities. The literature demonstrates that process groups may be an especially effective format to help LGBTQ individuals who are navigating conflict between their religious and sexual identities (Yarhouse & Beckstead, 2011), LGBTQ asylum seekers who address trauma and acculturation issues in an affirmative context (Reading & Rubin, 2011), and LGBTQ survivors of child abuse who are living with HIV/

AIDS (Masten, Kochman, Hansen, & Sikkema, 2007). LGBTQ process groups show promise in helping individuals with a variety of presenting concerns to increase their self-acceptance, navigate identity disclosure/concealment authentically, and improve social relationships (Nel, Rich, & Joubert, 2007).

Despite this promise, the majority of the small literature on LGBTQ group therapy has focused on group therapy for gay men (Conlin & Smith, 1982; Lenihan, 1985; Masten et al., 2007; Neal, 2000; Nel et al., 2007). We were only able to locate two articles that focused on group therapy with other sexual and gender minorities: one article describing a group therapy format with gay men and lesbian women (Getzel, 1998) and another chapter discussing group therapy with lesbian, gay, and bisexual individuals (DeBord & Perez, 2000). A more comprehensive framework is needed that meaningfully integrates the experiences of women, bisexual men and women, and TGQ individuals. Further, as many LGBTQ individuals may benefit from group therapy and as therapists report feeling undertrained to work with this population, additional guidelines are needed. We will now illustrate important practical considerations for the structure of such a group. We then apply Yalom and Leszcz's (2005) IBPO group therapy framework to LGBTQ clients, discussing considerations for the process elements of the group.

Structural Characteristics

Facilitators interested in establishing an IBPO group for LGBTQ clients must first attend to several structural and practical considerations in establishing such a group. These include facilitator characteristics, time and place, the group format, advertisement and recruitment, the group composition, and rules. As the literature on IBPO therapy groups with LGBTQ clients is scant, we draw on literature on group therapy and LGBTQ clients' experiences in individual therapy, extending these findings where appropriate.

Facilitator Characteristics

In group therapy, LGBTQ clients have been found to respond best to facilitators who have knowledge of LGBTQ developmental models, are aware of unique challenges faced by LGBTQ individuals of color, are familiar with local LGBTQ resources, understand the harmful effects of internalized homo/transnegativity on an individual and institutional level, and are comfortable with LGBTQ choices and relationships (Perez, DeBord, & Brock, 1999). Similarly, in individual therapy, LGBTQ clients find it essential that therapists be skilled in establishing a working alliance, be LGBTQ-affirming, and have specialized knowledge in LGBTQ issues (Burckell & Goldfried, 2006). Many LGBTQ clients identified warmth, respect, trustworthiness, and a caring nature as critical therapist characteristics (Israel, Gorcheva, Burnes, & Walther, 2008). Specific therapist behaviors cited by LGBTQ clients as most helpful include teaching new coping skills; teaching new communication skills; teaching anger management skills; providing a safe environment and using self-disclosure; demonstrating acceptance, validation, and normalization of sexual or gender identity; focusing on LGBTQ issues only when they are relevant to the problems presented; and being actively involved in the LGBTQ community (Israel et al., 2008). Further, many therapists are trained in working with lesbian women and gay men but may be less familiar with bisexual or TGQ individuals (APA Task Force on Gender Identity and Gender Variance, 2009; Scherrer, 2013). Bisexual and transgender individuals particularly identified the importance of having therapists who are affirming of their identities and who have specific knowledge of relevant issues (Mizock & Lundquist, 2016; Scherrer, 2013).

Although LGBTQ clients may express a desire for an LGBTQ therapist, the quality of the therapeutic alliance may be more closely tied to gains in therapy than sexual or gender identity match (Liddle, 1997). Regardless of identity, therapist self-disclosure around sexual or gender

identity early in the group therapy process may help model self-disclosure, demonstrate transparency, and build trust (Chojnacki & Gelberb, 1995; Holahan & Gibson, 1994). This disclosure can then be processed to ensure safety for individuals of all identities.

Time and Place

Considerations regarding the time and place for group meetings may vary according to geographic location. In some areas, privacy and safety are salient concerns for LGBTQ individuals as hate crimes and victimization are not uncommon (FBI, 2013; National Coalition of Anti-Violence Programs, 2011). Some members of the group may be "closeted" and may not wish to be recognized entering or leaving the group. If the group takes place in an area where hate crimes are common, facilitators may choose areas and times that are safest. Similarly, if group members tend to be closeted, group facilitators may consider selecting a location where participants are unlikely to encounter others in their social sphere. Group facilitators should ensure that safety and security measures are given appropriate attention, especially if the group is held in the evening.

Group Format

Group facilitators must also consider whether to have an open (maintains consistent size by replacing members as they leave) or closed (once begun accepts no new members and meets for predetermined number of sessions) format. A closed group offers the advantage of privacy and stability, which may work best for LGBTQ group members who are particularly concerned about confidentiality and building trust. On the other hand, an open format may provide long-term services to LGBTQ individuals and serve as a standing resource for the local LGBTQ community. If adopting an open format, group facilitators should carefully screen and orient potential new group members to determine fit and timing of entry for the group. These determinations should be made in consultation with local LGBTQ community members and leaders to ensure the appropriateness of the format to the needs of the community.

Advertisement and Recruitment

Advertising an LGBTQ group is essential for recruitment, but may be particularly challenging, as some potential members may not publicly disclose or still be questioning their sexual or gender identity. Group facilitators may decide to advertise more widely to reach these individuals or may select more targeted approaches that may bring in people more strongly tied to the LGBTQ community. Advertising broadly may include putting up flyers and ads in places like local health clinics, churches, and universities. In contrast, an LGBTQ-targeted approach may involve placing flyers and ads in locations specific to the LGBTQ population such as LGBTQ organizations and local LGBTQ clubs or bars (Yarhouse & Beckstead, 2011). Targeted advertising may also include placing advertisements in places where those questioning their sexual or gender identity may spend time such as local high schools or colleges. These materials may be tailored to focus on the experiences of those who experience same-sex attractions but do not identify as LGBTQ (Lefevor et al., 2019) by using words such as "questioning" or "discussing sexuality or gender" rather than "LGBTQ." Regardless of approach, establishing relations within the local LGBTQ community may be helpful in generating word-of-mouth referrals (Yarhouse & Beckstead, 2011).

In addition to the typical interview process that may screen for serious risk or severe pathology, additional measures should be taken when screening for an LGBTQ group. First, facilitators need to clarify the motives of individuals attempting to enter group to ensure the safety and confidentiality of group members. Second, group facilitators need to ensure that prospective members understand the nature of the therapy and are not looking for conversion therapy approaches (Yarhouse &

Beckstead, 2011). Third, facilitators may need to redirect potential group members who may be more appropriate for individual counseling or another group. These may include people who are excessively prone to shame regarding their sexual or gender identity (DeBord & Perez, 2000) or who are struggling intensely in the earliest stage of identity development (Chojnacki & Gelberb, 1995). Fourth, it is important to orient potential members to the understanding that group is not a place to meet romantic partners as beginning romantic relationships with other group members may prevent participants from deriving a therapeutic benefit from the group. Further, if romantic relationships between group members ended, it may render the group unsafe for one or both partners.

Group Composition

During the interview process, facilitators should be attuned to the heterogeneity and homogeneity of the group. A combination of homogeneity for presenting concerns and heterogeneity of experiences may be particularly beneficial. Groups homogenous for presenting concerns have been found to have more cohesion and support, better attendance, less conflict, and faster reduction of symptoms (Burlingame, Fuhriman, & Mosier, 2003; Yalom & Leszcz, 2005). Further, having experienced group members who advocate for group norms in addition to less experienced group members may also be important (Yalom & Leszcz, 2005). For an LGBTQ group, this advocacy may include having members in various stages of sexual or gender identity development and various experiences with coming out or transitioning. Additionally, effectiveness may be enhanced when individuals of all genders are included as inclusion may approximate actual social environments outside of group (Burlingame et al., 2003).

It is unclear whether an IBPO group for LGBTQ individuals would be most effective as a single group or as two groups with one focusing on sexual identity and the other on gender identity. On one hand, having separate groups may increase the homogeneity of presenting concerns and lead to faster symptom reduction (Burlingame et al., 2003) as sexual and gender identity developments occur separately. On the other hand, practical considerations such as available facilitators to lead groups or the presence of strong TGQ community willing to participate in therapy may necessitate a single group. In either case, facilitators should ensure that they have the necessary competence to work with *both* sexual and gender minorities as sexual and gender identity are distinct yet interrelated (APA, 2015).

Rules

Yalom and Leszcz (2005) delineated a set of basic group therapy rules, such as discouraging tardiness, absences, and maintaining confidentiality. Confidentiality may be particularly important for LGBTQ process groups as group members will likely vary on the degree to which others know about their sexual or gender identity. It may also be important to discuss parameters around having contact outside of the group as members may have preexisting relationships with other members due to the insularity of some LGBTQ communities. The facilitator of an LGBTQ process group may want to recommend that members share encounters they may have had with each other outside of group but also encourage the members to work together to set their own guidelines regarding outside contact (Haldeman, 2002 , Yarhouse & Beckstead, 2011).

Process Elements of an IBPO Group for LGBTQ Clients

Yalom and Leszcz (2005) identified several process factors essential to change in an IBPO therapy group. They are cohesiveness, universality, interpersonal learning and self-understanding, imitative behaviors, instillation of hope, altruism, corrective recapitulation of primary family experiences, socializing techniques, catharsis, and existential factors. We discuss these factors and, drawing particularly on the work of DeBord and Perez (2000), illustrate how they may be applied in an IBPO therapy group with LGBTQ clients.

Cohesiveness

Cohesiveness is the analogue to the therapeutic relationship in individual therapy. Cohesiveness is the crucial therapeutic factor upon which all others hinge, as feelings of connectedness and belonging to the group help members to establish trust and engage in self-disclosure. Cohesiveness is consistently linked with positive outcomes, including symptom reduction (Burlingame & Jensen, 2017). As many sexual and gender minorities experience heightened hypervigilance due to experiences of discrimination (Hendricks & Testa, 2012; Meyer, 2003), establishing trust within the group is of paramount importance. As the group progresses, the process of moving beyond the superficial sharing to developing cohesiveness through more deep and vulnerable disclosures within an IBPO group may provide LGBTQ clients with particularly helpful experiences of acceptance, affirmation, and belonging.

Universality

Universality is the sense among group members that they have shared experiences, which can reduce isolation and provide validation for members. Unlike many other minority statuses, sexual and gender identity may be hidden. Additionally, although racial and ethnic minorities often share their minority status with their families, this shared minority status is not present for sexual and gender minorities. Years of being "in the closet" may lead to a tendency to hide important aspects of one's experience or self from others in an effort to protect themselves from others' judgments (Sedgwick, 2008). As a result, the protective effect of having community membership with similar others may be less present for LGBTQ clients because they are so closeted and may not have family awareness or support. Increased social support may buffer the experience of minority stress (Kwon, 2013) meaning that an LGBTQ group may provide a forum for sexual and gender minorities to discuss experiences that are common but stressful, such as difficulties finding competent healthcare providers who are informed and affirming (Benson, 2013), difficulties with experiences of victimization or discrimination (Balsam et al., 2005), obtaining letters of support for hormones or surgeries (Mizock & Lundquist, 2016), and making decisions about potential gender transitioning (Rachlin, 2002). Having a therapeutic space where they can explore these minority stressors and other commonalities with other group members may be validating, normalizing, and transformative.

Interpersonal Learning and Self-Understanding

With an established sense of trust in a group, members may begin to provide each other with feedback, promoting interpersonal learning and self-understanding. Group members may begin to understand how their emotional and cognitive distortions affect their relationships and interpersonal interactions, which may empower them to change their relationships in desired directions (DeBord & Perez, 2000). This process may be particularly helpful for LGBTQ clients who may have internalized negative views of themselves or others due to discrimination based on their minority identity or behavior (Meyer, 2003). By engaging with this type of feedback, LGBTQ clients may be better able to separate the effects of discrimination from their heightened alertness that may have resulted from discrimination. Moreover, the interpersonal setting of the therapy group may be a safe and productive place for individuals to continue the process of sexual or gender identity development, since this process is inherently interpersonal (Ponticelli, 1999). For example, if group members are exploring their gender identity, they may use group to experiment with various modes of gender expression, pronouns, or names. Ideally, the group may be a place where members can work through which parts of themselves they want to share with others and how they want to identify.

Imitative Behaviors

Imitative behaviors, or modeling, can be helpful when members learn new skills by adopting the approaches taken by others within the group. LGBTQ individuals face many identity-related stressors, such as addressing discrimination and coming out to friends, family, or coworkers. Seeing and hearing how others in the group have handled these situations may provide them with new coping strategies and skills. For example, a group member who desires to come out to family may benefit from hearing how other group members have shared a movie or discussing a pop culture reference to an LGBTQ person may help them understand the attitudes of their family toward LGBTQ people. Given the isolation that many sexual and gender minorities may feel in their families of origin and communities, LGBTQ clients may also not have had mentors available to provide modeling and guidance for how to think, feel, and respond in the challenging situations they may face in life. This process may be particularly important for TGQ individuals, as there remain very few positive portrayals of TGQ individuals in media. The availability of similar others in the group may provide a space where LGBTQ individuals are able to learn through imitation. In particular, having group members who have successfully navigated various aspects of discrimination and oppression (e.g., talking about a same-sex significant other to family, socially transitioning) may help those group members who have yet to face these challenges to navigate them more successfully.

Instillation of Hope

Instillation of hope, defined as the generation of optimism and positive expectation for progress, can encourage members to continue to make personal progress and invest in healthy interpersonal connections. Especially given the high rates of victimization and mental disorders among LGBTQ individuals (Bouman et al., 2017; FBI, 2013; National Coalition of Antiviolence Programs, 2011), having a sense of hope may be particularly important when handling the stress of self-identifying as a sexual or gender minority or coming out. DeBord and Perez (2000) have noted that, for sexual minority clients, merely knowing that an LGBTQ community exists (whether they participate in it or not) can create hope for them, even *prior to entering group therapy*. Thus, having LGBTQ group therapy as an additional resource advertised in the community could instill hope in LGBTQ individuals, whether they attend group or not. This finding may be particularly true for TGQ individuals if the group is focused specifically for gender minorities, as transgender perspectives are often elided in the LGBTQ acronym (Moradi et al., 2016).

Altruism

Altruism is the ability of members to be helpful to one another, which may increase the self-esteem and self-efficacy of members while encouraging the use of adaptive coping strategies. For LGBTQ group members, helping other sexual and gender minorities feel a sense of affirmation, validation, and pride in their identity and supporting them through their struggles could nurture in themselves an increased sense of purpose, positive view of self, and enhanced sense of self-efficacy (DeBord & Perez, 2000). For example, both a more and less experienced group membership may benefit from the mentorship bond that may develop in an LGBTQ process group. Additionally, as each group member has unique experiences, all may benefit from sharing their unique experiences, which may make it clearer that LGBTQ individuals face systemic discrimination (Lefevor et al., 2019; Meyer, 2003).

Corrective Recapitulation of Primary Family Experiences

The corrective recapitulation of primary family experiences involves group members' transference reactions that lead them to reenact important interpersonal themes learned within their

early relationships. This reenactment can be useful because problematic interpersonal themes can be identified and processed within the safe context of the group, and it may also symbolize incorrect assumptions learned from previous interpersonal interactions that can be rectified. This factor may be particularly salient as many LGBTQ clients' families react negatively and even violently to a family member's sexual orientation or gender-nonconforming behaviors (D'Augelli, Grossman, & Starks 2005). Other themes such as mistrust, rejection, criticism, and discrimination by family members may also be particularly relevant to LGBTQ clients. Processing these interpersonal themes may thus be a significant benefit of group therapy. Given evidence that patterns of behavior involving boundaries, control, cohesiveness, and parental availability can be unconsciously reenacted in the families individuals form in adulthood (Alexander & Warner, 2003), working through early family issues within the context of group therapy may foster the healthy construction and engagement in future relationships.

Socializing Techniques

Group may also provide a powerful setting for conveying social norms and expected behaviors. In addition to expanding one's social skills and learning about norms within queer culture, LGBTQ clients who are newly self-identifying may benefit from learning about LGBTQ community norms from more experienced members. Such learning may include receiving feedback on ways to engage a same-sex romantic interest, the use of an individual's "dead name," and the appropriate terminology to describe a variety of LGBTQ-specific topics (e.g., binding, packing, passing). Moreover, this learning may be a particularly helpful aspect of the group process for individuals experiencing identity intersectionality, who are required to learn socializing techniques of multiple, sometimes mutually exclusive, cultural groups (e.g., religiously conservative LGBTQ individuals).

Catharsis

Catharsis can give members the opportunity to express thoughts and emotions in a less inhibited way, which can result in a sense of relief. For example, simply sharing an experience of rejection in a safe environment may provide a sense of relief to a group member. LGBTQ individuals may experience oppression and discrimination and may simultaneously feel the need to engage in distress tolerance or emotion regulation until they are in a space where they feel safe expressing these negative feelings. Having a place to express fear, anxiety, anger, hurt, and sadness, which come about as a result of discrimination, may be liberating. Furthermore, for individuals who have been "in the closet" or discouraged from expressing their sexual or gender identity, there may be considerable relief experienced through expressing the emotions related to their attempt to remain hidden or experiencing discrimination (Sedgwick, 2008).

Existential Factors

Confronting existential factors, which concern issues such as the meaning of life, death, isolation, and total responsibility for life, can lead group members to take accountability for their life and make positive changes. Existential issues such as aging, independence, isolation, death, and loss may be particularly salient to LGBTQ individuals since minority stressors often create challenges in these areas that heterosexual, cisgender people do not experience (e.g., Elder, 2016). For instance, many LGBTQ individuals are confronted with questions about dating, relationships, and family as they navigate their sexual or gender identities. LGBTQ individuals from conservative political and religious backgrounds may experience crises of faith, fears of being denied access to heaven after death, restriction of religiously/spiritually affirmed marriages, and rejection by faith communities, family, and friends (Schuck & Liddle, 2001). These situations can lead the individual to grapple with life choices that have here-and-now as well as existential implications. Since these issues may be more

likely to emerge in a process group, rather than with more directive and structured group approaches, a process group may be an optimal context in which LGBTQ clients might address them.

An LGBTQ Process Group Vignette

To illustrate these elements, we present a case vignette comprising experiences of two IBPO therapy groups at college counseling centers: one for gender minorities and one for sexual minorities. As both groups were facilitated by the same queer, cis-male group facilitator, the structure and many of the process elements of the two groups were largely similar and are discussed together. The gender minority group consisted of eight group members identifying across the gender identity spectrum including transgender FTM, transfeminine, transmasculine, gender nonbinary, and gender fluid. Additionally, one participant identified as intersex. Group members were mixed race, Latinx, Asian-American, and Non-Hispanic White and were undergraduate and graduate students. Similarly, the sexual minority group consisted of eight group members identifying as questioning, bisexual, or gay. All identified as cis-male. Group members were Black, Latinx, and Non-Hispanic White and were undergraduate and graduate students. The composition of the groups both in terms of ethnic and gender diversity and in terms of similarity of presenting concern allowed for a natural cohesiveness to emerge among group members. Because the group facilitator identified as part of the LGBTQ community, even though not sharing minority gender identification, the facilitator served as a positive role model for group members, which provided hope for a positive life as an LGBTQ individual.

The groups were advertised as IBPO groups; thus the group facilitator did not have an agenda for each meeting but focused on interpersonal processes and allowed themes to emerge from discussion. Throughout the course of the semester, several relevant themes emerged from group discussions such as coming out to family and friends, how to meet other LGBTQ individuals, dating, sex, and internalized homo/transnegativity. Because members had a variety of experiences with and differing levels of comfort around their sexual and gender identities, these discussions often served several purposes including helping group members recognize the universality of their experiences, facilitating imitation as members gained insights into new ways to approach situations, and providing opportunities for altruism as group members who had a more well-defined sense of identity shared with group members with more questions around their identity.

Group members' relational patterns with parental figures often played out in the here-and-now process of the group. Becoming aware of how members diverted attention away from a group member who felt uncomfortable in an effort to help the uncomfortable group member avoid a difficult topic was an example of both interpersonal learning as individuals recognized their patterns and a corrective recapitulation of earlier experiences as they were able to engage differently with the group members. Further, these experiences helped group members engage differently with others outside of the group around coming out and internalized homo/transnegativity.

Group sessions frequently began with naturally emerging discussions about LGBTQ political issues and LGBTQ-affirming media. These discussions, along with discussions throughout groups about various LGBTQ resources and venues, provided an important socialization for group members to the LGBTQ community. As discussions deepened, group members recognized commonalities in their experiences such as feeling isolated, ashamed, or socially awkward in dating circumstances. These themes allowed for discussion of existential factors, the ways in which LGBTQ individuals may experience them uniquely, and ways to address these concerns and the stress associated with them.

At the end of groups, members expressed gratitude to each other for the ways that group had

helped them grow. Group members referenced feeling accepted and loved (cohesion, altruism), relief in being able to discuss things they were not able to discuss in other contexts (catharsis), and learning from each other as their primary gains (interpersonal learning, imitation, socializing techniques).

Conclusion

Group therapy may play a critical role in the identity development of sexual and gender minorities. Though important, scant attention has been given to the development or implementation of LGBTQ interpersonally based, process-oriented therapy groups. It is our hope that this article may serve as a guiding document for therapists interested in developing and implementing LGBTQ therapy groups and as the beginning of a larger discussion about the impact of IBPO therapy groups for LGBTQ clients.

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28

Research, Practice, and Advocacy in the Movement to End Gender and Sexual Minority Violence: No Room for Complacency

Emily M. Lund, Claire Burgess, and Andy J. Johnson

As the preceding chapters detail, violence against LGBTQ+ individuals is a serious and critical issue that must be addressed at all levels—individual, community, and policy. The pervasive marginalization and victimization of LGBTQ+ persons span nations, cultures, race, ages, genders, gender identities, sexual orientations, and a myriad of other communities and demographic variables. It is a deep and far-reaching issue with complex cultural, religious, medical, and social and historical roots, and yet its consequences are often profoundly personal, harmful, and even deadly. This final chapter details several considerations in the theory, study, and practice of understanding, treating, and ultimately ending violence against LGBTQ+ people as well as some strategies for continuing to advance this difficult but critical mission.

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Coercive Control: Violence Against LGBTQ+ People as a Human Rights Issue

On a broad level, violence against LGBTQ+ people can be understood as a human rights issue. To this end, Stark (2009) explains how interpersonal violence consists of coercive control, a form of captivity where one partner entraps another. Writing primarily in the framework of heterosexual intimate partner violence where males abuse females, Stark explains that rather than using a literal cage or prison in which to detain their targets, men who use coercive control employ behaviors and tactics that manipulate, constrict, and limit their partners through emotional, relational, financial, and violent means which serve to restrict the freedom, choices, life movement, and human rights of the targeted person.

The analogy of a cage is helpful in illuminating the combined effects of violence against LGBTQ+ persons at the interpersonal and systemic levels. The bars of the cage restricting the human rights of LGBTQ+ persons have serious consequences, even when those bars are "only" psychological or defended in terms that sound compassionate to the perpetrators, such as religiously grounded discussions of "curing" and "saving" LGBTQ+ people that ultimately only

E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2_28

serve to inflict harm and suffering (Flentje, Heck, & Cochran, 2014). In the coercive control model, one must identify the metaphorical bars to the cage that restrict the lives and human rights of LGBTQ+ individuals.

To this end, the chapters in this edited volume have described diverse means of coercive control such as manipulation, isolation, and other tactics at the interpersonal and systemic levels that inhibit autonomy, compromise liberty, and hinder the full development, self-confidence, and self-esteem of LGBTQ+ persons. Traditional models of gender-based violence often stress the importance of establishing safety for survivors first (Stark, 2009). Safety is indeed a critical need; however, a sole focus on safety is a limited and limiting paradigm—in order to make progress in understanding and ameliorating the true reach and scope of violence against LGBTQ+ individuals, a human rights paradigm is necessary. Community-level activism and professional advocacy are essential to encourage protections from human rights violations and preserve the autonomy and liberty of LGBTQ+ persons. That is, protection of the self-determination, the right to engage in self-determination, and the safeguarding of the freedom of LGBTQ+ people are essential aspects of a human rights paradigm of LGBTQ+ violence and marginalization. Links between characteristics or forms of coercive control and the human rights that are violated as a result are described by Stark as follows:

> Within a broad justice discourse, it is nonetheless useful as a practical matter to link each component offense to the right it offends most immediately—violence to the right to security, intimidation to the right to dignity and to live without fear, isolation to the right to autonomy, and control to liberty rights. (Stark, 2009, p. 221)

The structural dimensions of violence against LGBTQ+ persons are often hidden from view and may be seen via their effects on victims who are then blamed by bystanders. Unhealthy, oppressive ambiguity is created if one does not keep a human rights perspective in the foreground. Similar paradigms such as racialized violence (e.g., Cone, 2011; Nicolas & Thompson, 2019), colonization (e.g., Skewes & Blume, 2019), and other forms of exploitation and oppression that restrict access to resources required for personhood or for full community membership demonstrate the corrosive effects of dominant-subordinate relationships (Eisler, 1987; Eisler & Fry, 2019). Research is needed to more thoroughly investigate how to dismantle the dynamics of common coercive control practices that restrict the freedom of LGBTQ+ people through systematic enactment of prejudice and discrimination via restrictive and even bigoted social norms. Micromanagement of gender issues, including the normative regulation of gendered behavior such as dress, manner of expression, and so forth, degrades people into stereotypes that trap and restrict them rather than releasing their creativity and ultimately increase the oppression and silencing of LGBTQ+ people.Fortunately, there have been recent improvements in the United States as a result of the United Nations Free and Equal Campaign (https://www.unfe.org/). Conservative religious communities are increasingly becoming the primary social places where oppressive anti-LGBT worldviews find support. As Ream (2020) discusses in, Chap. 21, this volume, there has been a tendency for violent persons to switch to more subtle forms of intimidation and control over time in order to make their behavior appear more benign and socially acceptable. It can thus be challenging to identify a social justice violation in acts that target behavior or identities already devalued by social convention and assumed to be willfully deviant or disordered according to community norms. However, we must remain clear and consistent in the message that there are no appropriate religious exemptions to human rights issues and that marginalization and violence against LGBTQ+ people in any form, even in the name of religion, are highly unethical and immoral and may even be deadly.

Mind the Gap: Limitations and Considerations in Interpreting Violence Prevalence Data

Violence against LGBTQ+ people must be examined on theoretical, empirical, and clinical levels. Models such as the coercive control model provide theoretical and conceptual data, while empirical data help us to understand the scope and nature of an issue and clinical knowledge helps guide effective treatment. All three ways of thinking are necessary in order to truly understand and effectively address violence against LGBTQ+ individuals.

When discussing research and empirical data, it is important to consider the limitations of our knowledge of violence against LGBTQ+ people and the ramifications of those gaps in knowledge. The range of types of victimization experienced by LGBTQ+ individuals is broad, and the definitions of each of these types of violence (e.g., child abuse, sexual abuse, intimate partner violence, bullying) may differ substantially across studies (Corliss, Cochran, & Mays, 2002; Brown & Herman, 2015; Lund & Ross, 2017). Differing prevalence rates for victimization across studies may be, in part, a product of both what questions are asked and how they are asked, and the results of any one study should be viewed in context of its definitions and measures of violence (Brown & Herman, 2015). Likewise, studies may include different subpopulations from under the broad LGBTQ+ umbrella, such as gay men, lesbian women, or bisexual men, and may not always explicitly identify whether or not participants are cisgender or transgender (Brown & Herman, 2015). These distinctions again add a layer of complexity and nuance to study interpretation.

Relatedly, specific datasets may only focus on violence victimization that occurs during a certain time of life (e.g., childhood, adulthood) and by a particular type of perpetrator (e.g., parent, intimate partner, peer) (Brown & Herman, 2015; Corliss et al., 2002; Freedner, Freed, Yang, & Austin, 2002). Similarly, systematic forms of violence—such as medically unnecessary surgery forced upon intersex individuals (see, Khanna, 2020, Chap. 14, this volume) and medicalization and pathologizing of asexuality (see Lund, 2020, Chap. 13, this volume)—as well as covert microaggressions may not be included in many studies and surveys that focus on more traditional intimate partner or interpersonal violence and thus may not be captured alongside those data. Accordingly, any one study is unlikely to capture the scope and totality of victimization against LGBTQ+ individual (or any particular LGBTQ+ individual) and must be examined within its particular context, participant population, and research questions with an eye toward understanding both overarching population trends and validating individual lived experiences. Clinicians should account for these gaps and variety of experiences as part of their intake and client history process, and researchers should seek to fill these gaps by studying the spectrum of violence and marginalization and its cumulative effects in individual LGBTQ+ subpopulations.

Evidence-Based Assessment and Treatment with LGBTQ+ Clients: Considering Gaps

Studies of violence victimization among LGBTQ+ individuals often rely on nonrepresentative convenience samples due to the exclusion of questions regarding gender identity and sexual orientation from many large national datasets. This makes direct comparisons to heterosexual and cisgender samples often difficult (Brown & Herman, 2015). In addition, even datasets that do include information on sexual orientation or gender identity may include too small of subsamples for meaningful statistical analysis (Coston, 2019), and less commonly discussed sexual and gender minority groups, such as nonbinary and asexual individuals, may not be represented in large-scale datasets at all (Hinderliter, 2009). This point may be especially true when individuals hold multiple marginalized gender and sexual minority identities, other marginalized identities in addition to gender and sexual minority status, or both (Coston, 2019; Hinderliter, 2009). Thus, researchers and clinicians may have little choice but to extrapolate findings from other broader

samples that may or may not accurately reflect the demographics and experiences of their actual client population. Further, these assumptions may unintentionally marginalize or even erase the unique lived experiences of certain subsets of the LGBTQ+ community from the scientific record, making it harder for the experiences of multiply marginalized individuals to be considered in policy and treatment discussions (Cuthbert, 2017; Dawson, Scott, & McDonnell, 2018; O'Toole, 2000; O'Toole & Brown, 2002).

Similarly, data on participant sexual orientation and gender identity are rarely included in studies of treatment for anxiety, depression, and substance use (Flentje, Bacca, & Cochran, 2015; Heck, Mirabito, LeMaire, Livingston, & Flentje, 2017) despite these issues being common clinical concerns among LGBTQ+ individuals and potential consequences of victimization and minority stress (Michaels, Parent, & Torrey, 2016; Meyer, 2003; McCabe, West, Hughes, & Boyd, 2013; Plöderl et al., 2013). As a result, there is a critical lack of data on the reliability and validity of common psychological assessment measures with LGBTQ+ clients, particularly those who are transgender or nonbinary, and clinicians are often unsure of how to best interpret these measures when working with transgender and nonbinary clients (Keo-Meier & Fitzgerald, 2017).

Since truly evidence-based practice must account for contextual factors in the selection of treatment (Spencer, Detrich, & Slocum, 2012), clinicians who work with LGBTQ+ individuals are left in an ethical and clinical quandary: because there is limited evidence of the effectiveness of many common psychological interventions in LGBTQ+ clients specifically, to what degree can clinicians who are working with LGBTQ+ clients truly trust that the assessments and treatments they are providing are evidence-based, appropriate, and effective for the population at hand? Although decisions about evidence-based practice must be made in the context of the best available evidence, in conjunction with clinical judgment and client preference and context (Spencer et al., 2012), the onus is also on researchers to improve the quality of the available evidence through more thorough and consistent collection and reporting of data on participant sexual orientation and gender identity and by examining outcome data for potential differential effectiveness in sexual and gender minority clients (Flentje et al., 2015; Heck et al., 2017). Additionally, researchers and clinicians should communicate about observations of treatment effectiveness or lack thereof in clinical work and discuss clinical needs and quandaries that researchers may be able to help investigate and address.

Nothing About Us Without Us: The Critical Role of Affirmation in Research, Policy, and Practice

LGBTQ+ individuals have a long and difficult history of having their identities pathologized and discriminated against (Brown, 2017; Drescher, 2015; Flentje et al., 2014; Gupta, 2017). They have historically been told—and are often still told to this day—that their identities are wrong, "sick," "confused," in need of curing, or sinful (Drescher, 2015; Dawson et al., 2018; Flentje et al., 2014; Gupta, 2017). At turns, they are confronted with both inappropriate pressure to prove the legitimacy of their identity (Dawson et al., 2018; Gupta, 2017) and inappropriate pressure to deny or change it (Flentje et al., 2014; Gupta, 2017). As Boucher, Potts, and Lund (2020) discuss in Chap. 23, this volume, the historic roots of trauma run deep in the LGBTQ+ community, and progress toward social acceptance and affirmation, while notable, continues to coexist with disparate health outcomes, covert and overt victimization, and minority stress (Friedman et al., 2011; Heck, Flentje, & Cochran, 2013; Katz-Wise & Hyde, 2012; Meyer, 2003; Nadal, Rivera, Corpus, & Sue, 2010; Plöderl et al., 2013).

Despite the long-standing and continued marginalization, medicalization, and victimization of LGBTQ+ people, they have frequently been denied the right to tell their own story and to have their voices and experiences centered in the discussion of their identities and experiences (Brown, 2017; Gupta, 2017), a centering which is

critical to understanding and addressing matters of importance to individual subsections of the broader LGBTQ+ community (Dawson et al., 2018; Labuski & Keo-Meier, 2015). Marginalization can be even more pronounced in individuals who are also members of other marginalized communities (Brown, 2017; Cuthbert, 2017), who may face further false delegitimization of their stories as a result of the intersection of their identities (Lund & Johnson, 2015). True progress cannot be made until LBGTQ+ and other marginalized individuals are truly centered in both the identification of issues of critical concern and the process of conducting rigorous and responsive research to address them, a process known as community-based participatory research (CBPR; see Nicolaidis et al., 2011; Raymaker, 2020). Allies can only assist in the liberation of LGBTQ+ people, helping them to shoulder the burden and lift of systematic and individual discrimination while understanding that they themselves cannot truly understand its weight nor the relief that comes with feeling that weight lift.

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Index

E. M. Lund et al. (eds.), *Violence Against LGBTQ+ Persons*,
https://doi.org/10.1007/978-3-030-52612-2