1 Intersection of Trauma and Identity

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In the last four decades, lesbian, gay, bisexual, and transgender (LGBT) people have made significant progress in gaining social acceptance and securing legal rights in many parts of the world. Same-sex sexual and gender-nonconforming behavior used to be considered morally, pathologically, and legally aberrant throughout the world, but LGBT identities are now increasingly affirmed and celebrated in many countries. However, the trauma that LGBT people have experienced throughout history remains part of their shared identity. Moreover, even in relatively accepting parts of the world (e.g., North America, Western Europe), LGBT people continue to encounter verbal abuse, physical and sexual victimization, and structural oppression [1]. The increased risk of experiencing such events results in a "fundamental ecological threat," forcing sexual and gender minorities to choose between expressing their authentic selves or the identities validated by society [2, p246]. Constant exposure to marginalization and the frequent fear of victimization contribute to unrelenting vigilance that may ultimately become integrally linked to identity.

The primary aim of this chapter is to describe the intersection of trauma and identity among LGBT people. First, we will review diagnostic criteria for posttraumatic stress disorder (PTSD) and then discuss how current conceptualizations of trauma overlook associations between non-traumatic events and PTSD-like disorder. Next, we will discuss minority stress among sexual and gender minorities and draw upon microsociological theories to understand the impact of the social environment on the mental health of LGBT people. We will follow this discussion with the developmental impact of homophobia and transphobia and then focus on the connection between PTSD and traumatic and non-traumatic events. Finally, we will conclude with a clinical case to illustrate the concepts discussed in this chapter.

Any discussion about LGBT people must acknowledge their extraordinary diversity. Although LGBT people are often discussed as if they comprise a single population, we understand that the experiences and identities of lesbians may be quite different from those of gay men; those of bisexual and transgender people are likely to differ from lesbians and gay men even more [3]. Additionally, there are LGBT people in every part of the world [4], and they have a broad spectrum of life experiences influenced not only by their sexual orientation and gender identity but also by other intersecting identities, including race, ethnicity, social class, culture, religion, age, and ability status [5–10]. The intersection of these sociocultural characteristics results in highly diverse identities [11], life course trajectories [12], and experiences of privilege or marginalization and discrimination [4, 13]. Furthermore, all of these identities must be taken into consideration when attempting to understand how trauma impacts the mental health of LGBT individuals.

Traumatic Versus Non-traumatic Events

The term trauma is widely used in vernacular language and commonly refers to an experience "that is emotionally painful, distressful, or shocking" [14]. Traumatic experiences can precipitate a myriad of psychiatric disorders including depressive and anxiety disorders, and, of course, PTSD. PTSD is a commonly occurring disorder that can seriously impair an individual's psychosocial functioning, resulting in mood vacillations, disorganized thinking, dissociation, impaired judgment, hyperarousal, and the use of maladaptive coping

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strategies [14]. In the United States, the lifetime prevalence of PTSD ranges from about 6% to 9% [15–19]. Although initially categorized as an anxiety disorder, PTSD was removed from the chapter on anxiety disorders and included in a new chapter on Trauma- and Stressor-Related disorders in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; [20]). All of the disorders in the Trauma- and Stressor-Related disorders chapter account for the various clinical presentations that can emerge following exposure to a traumatic or stressful event [21]. See Table 1.1 for a list of Trauma- and Stressor-Related disorders in *DSM-5*.

According to *DSM-5*, traumatic events involve "exposure to actual or threatened death, serious injury, or sexual violence" [20, p271]. Exposure to traumatic events can occur in one or more of the following ways: (a) directly experiencing the event, (b) witnessing the event as it happened to others, (c) learning that the event occurred to a loved one, or (d) experiencing repeated or extreme exposure to aversive details of the event [20]. To be diagnosed with PTSD, individuals are required to have at least one intrusion symptom (spontaneous memories, nightmares, flashbacks), one avoidance symptom (avoidance of distressing memories or external reminders of the event), two symptoms of negative alteration in cognition and mood (estrangement from others, distorted sense of blame, diminished interest in activities), and two symptoms of marked alterations in arousal and activity (difficultly sleeping or concentrating, hypervigilance, self-destructive behavior). These symptoms must be present for a least 1 month following the traumatic event and cause significant impairment in social and/or occupational functioning (Fig. 1.1).

Studying the mental health consequences of life-threatening events and sexual violence has obvious value and importance; however, focusing solely on such events tends to ignore the psychological impact of so-called "non-traumatic" events [22]. The use of the term non-traumatic is not intended to minimize the psychological impact of these events, but to clearly demonstrate how they differ from events considered traumatic by the *DSM*. Non-traumatic events include major life events such as ending a marriage/relationship, psychological or emotional abuse, employment issues, homelessness, financial concerns, nonlife-threatening medical problems, and the expected death of a loved one. Ignoring the connection between non-traumatic events and symptoms that look very much like PTSD may overlook the suffering of many individuals and result in the use of inappropriate or ineffective treatment interventions [23].

The debate over whether events must involve threat to life or physical integrity to qualify as traumatic has existed since PTSD was first introduced as a psychiatric disorder in 1980 [24]. In our study of PTSD [23], we joined that debate by investigating the stressor criterion, which sets the threshold for the types of events qualifying as traumatic [25]. Referred to as Criterion A1 in *DSM-IV*, the stressor criterion defined traumatic events as those that involve "actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others" [25, p427]. Although the stressor criterion originated from the concept of PTSD as an expectable response following exposure to extraordinary events [26], it is still unclear why events that do not pose threat to life or physical integrity are excluded from the stressor criterion [27]. Excluding these events is contradictory to what is already well established in the trauma literature—that reactions to stressful events are inherently subjective. Moreover, studies consistently show that non-traumatic events can be associated with symptoms suggestive of PTSD

Table 1.1 Trauma-spectrum disorders in *DSM-5*

Trauma and stressor-related disorders in *DSM-5* include disorders in which exposure to a traumatic or stressful event is necessary to make a diagnosis
Reactive attachment disorder
Disinhibited social engagement disorder
Posttraumatic stress disorder
Specifiers:
With dissociative systems (depersonalization or derealization)
With delayed expression (full diagnostic criteria are not met until at least 6 months after the event)
Acute stress disorder
Adjustment disorders
With depressed mood
With anxiety
With mixed anxiety and depressed mood
With disturbance of conduct
With mixed disturbance of emotions and conduct
Unspecified
Other specified trauma and stressor-related disorder
Unspecified trauma and stressor-related disorder

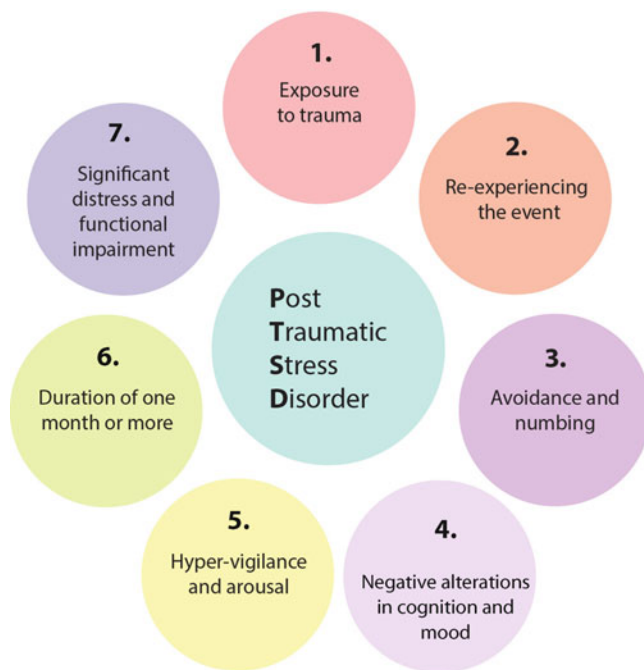

Fig. 1.1 Abbreviated *DSM-5* diagnostic criteria for posttraumatic stress disorder

[23, 28–31]. Specifically, in these studies individuals presented with the requisite number of symptoms from each *DSM-IV* cluster (re-experiencing, avoidance, and hyperarousal) to meet criteria for PTSD, although they were exposed to a non-traumatic event.

Given the potential pitfalls of using the stressor criterion, some suggested removing it from PTSD diagnostic criteria in *DSM-5* [32]. Doing so would have allowed clinicians and researchers to focus on the symptoms following a stressful event rather than whether the event met Criterion A1. However, others were concerned that removing the stressor criterion would increase PTSD prevalence and diffuse the suffering of those exposed to catastrophic events such as war, natural disasters, concentration camp imprisonment, and extreme violence [33]. Arguing in favor of retaining the stressor criterion, Friedman [24] explained that traumatic events are distinct from non-traumatic events because exposure to a traumatic stressor results in discontinuity between the way individuals view themselves before and after the event. However, exposure to non-traumatic events may also result in a similar process [34].

To address the validity issues related to Criterion A1, the *DSM-5* work group initially proposed adding a new adjustment disorder specifier that could be used when PTSD symptoms were present following exposure to non-traumatic events [23]. However, adding this specifier would not have resolved the ongoing conceptual problems because it still does not explain why symptoms considered unique to traumatic events also emerge following non-traumatic events [23]. Ultimately, the adjustment disorder specifier *with PTSD-like symptoms* was not included, although the *DSM-5* does indicate that an adjustment disorder is "diagnosed when the symptom pattern of PTSD occurs in response to a stressor that does not meet PTSD Criterion A (e.g., spouse leaving, being fired)" [20, p279]. While the adjustment disorder specifiers account for symptoms of anxiety and depression, they do not the capture the core symptoms of PTSD (re-experiencing, avoidance, and hyperarousal; for a comparison of diagnostic criteria between PTSD and adjustment disorder see Table 1.2). Furthermore, adjustment disorders must be diagnosed within 3 months of the onset of the stressor, and symptoms cannot persist longer than 6 months following the termination of the stressor [20]. In contrast, symptoms do not have to emerge within a specific time frame to diagnose PTSD, although a delayed expression subtype is used when individuals do not manifest the full set of PTSD symptoms until 6 months after the trauma [20]. Therefore, clinicians may overlook the symptoms suggestive of PTSD following exposure to a non-traumatic event, particularly if those symptoms emerge more than 3 months following exposure to the stressor.

Minority Stress

The marginalized status of sexual and gender minorities increases their vulnerability to traumatic and non-traumatic stressors; therefore, understanding the effects of PTSD and trauma-related disorders among LGBT people is critical for providing culturally sensitive health and mental health care. Prejudice related to homophobia and transphobia characterize the social environment for LGBT people and precipitate stressful events, commonly referred to as minority stress. Meyer [35] proposed a model of minority stress in which sexual minorities encounter stress "along a continuum from distal stressors, which are typically defined as objective events and conditions, to proximal personal processes, which are by definition subjective because they rely on individual perceptions and appraisals" (p676). Four specific minority stress processes provide the framework for Meyer's [35] minority stress model: (a) external, objective stressful events, (b) the expectation of minority stress and the vigilance this expectation requires (stigma), (c) the internalization of negative societal attitudes (internalized homophobia), and (d) sexual orientation concealment. Scholars initially used minority stress-based hypotheses to explain the higher prevalence of mental health problems among sexual minorities as compared to heterosexuals; in recent years, however, minority stress theory has also been used to explain negative mental health outcomes among gender minorities [36, 37].

Table 1.2 Comparision of trauma- and stressor-related disorders in *DSM-5*

Criteria for trauma and stress-related disorders in *DSM-5*[a]	Posttraumatic stress disorder (PTSD)[b]	Acute stress disorder	Adjustment disorders
Time frame			
Duration of disturbance is more than 1 month	✓		
Symptom duration of 3 days to 1 month after traumatic event		✓	
Symptoms develop within 3 months of onset of stressor(s); when stressor and consequences cease, symptoms do not persist for more than an additional 6 months			✓
Symptoms			
Exposure to actual or threatened death, serious injury, or sexual violence (i.e., traumatic event)	✓	✓	
Development of emotional or behavioral symptoms (e.g., anxiety, depression) in response to stressor of any severity			✓
Intrusion symptoms associated with traumatic event	✓	✓	
Persistent avoidance of stimuli associated with traumatic event	✓	✓	
Negative alterations in cognitions and mood associated with traumatic event	✓	✓	
Alterations in arousal and reactivity associated with traumatic event (i.e., angry outbursts, reckless behavior, sleep disturbance)	✓	✓	
Symptoms persist more than 1 month after traumatic event	✓		
Significant distress or impairment in major areas of functioning	✓	✓	✓
Disturbance is not due to medication, substance use, developmental disability, or other disorder	✓	✓	✓

[a]All criteria are further specified in *DSM-5*; this figure is not all-inclusive, but highlights important features of each disorder
[b]Separate diagnostic criteria for children and adolescents and for children age 6 or younger

To explain how particular minority stress processes influence the well-being of LGBT identities, we draw from microsociological theorists such as Charles Horton Cooley and Erving Goffman. Their theories were critical to the development of Meyer's minority stress model [35]. Cooley's [38] concept of the looking-glass self suggests that the way in which individuals see themselves is determined by how others view them. Cooley questioned the concept of the self, since one's feelings are always connected to the ways in which others think about him or her. According to Cooley, the self is really a social self consisting of three principal components: how we imagine our appearance to another person, the way we imagine another person judges our appearance, and the specific self-feeling that results from this judgment such as pride or mortification (Fig. 1.2). Thus, the formulation of our self-concept is dependent on the ways in which others perceive us. Since LGBT people are likely to face discrimination based on their sexual orientation and/or gender identity, Cooley's theory may help to explain why these experiences contribute to hypervigilance, insecurity, shame, avoidance, and self-loathing. For instance, homophobic and transphobic attitudes are constantly being communicated to sexual and gender minority individuals. These negative societal attitudes are then reflected onto sexual and gender minority people, which in turn influence how they feel about themselves.

Fig. 1.2 Visual representation of Cooley's looking-glass self which proposes that an individual's sense of self develops from interpersonal actions with and perceptions of others

Goffman's work also increases our understanding of how stigma affects the lives of LGBT people. According to Goffman [39], stigmatized individuals are likely to interpret their interactions as being undermined by the dominant group, as they may justifiably anticipate rejection based on their marginalized status. Consequently, they must continually discern what others think about them [22]. Those who

do not adhere to heterosexual and cisgender norms are therefore ascribed deviant status. The deviant is “cleanly stripped of many of his [sic] accustomed affirmations, satisfactions, and defenses, and is subjected to a rather full set of mortifying experiences” [39, p365]. For LGBT people, mortifying experiences can include harassment and hate crimes, alienation from family and friends, termination from certain types of employment, and exposure to propaganda portraying LGBT persons as sick or mentally ill [22]. As a result of these mortifying experiences, LGBT people may have difficulty sustaining any of their previously assumed roles, such as student, worker, friend, spouse, or partner. The only role society acknowledges is the deviant one [40]. Essentially, mortifying experiences result in a withdrawal of environmental support for LGBT people, and to cope, they may use avoidance, isolation, and/or conceal their identities, to protect themselves from further experiences of prejudice. Although these strategies serve an adaptive function by fostering a greater sense of control, their use may also result in feelings of disconnection, or lead LGBT people to overestimate danger in contexts in which they are free to express their authentic selves [41, 42].

Empirical research has demonstrated the relationship between social stigma and negative health and mental health outcomes among sexual minorities [43–45] as well as gender minorities [36, 46]. Because sexual and gender minority people grow up in homophobic and transphobic environments, they inevitably internalize these negative attitudes or direct them inward. When applied to lesbian, gay, and bisexual (LGB) people, these internalizations have commonly been called internalized homophobia [47]; other terms include internalized heterosexism and internalized sexual stigma (see [48]). Internalized homophobia has been connected to psychological distress in this population and has been shown to predict PTSD symptom severity in lesbian and gay survivors of child abuse [49] as well as sexual assault [50, 51]. More research is needed to understand the influence of internalized transphobia among transgender populations [37], though emerging evidence suggests that internalized stigma mediates the relationship between gender identity and a host of negative health outcomes as well as depression among transgender older adults [52].

Even sexual minority individuals who “pass” as heterosexual must contend with the consequences of concealing their stigmatized status [22]. Pachankis [53] contends that those who conceal their stigmatized identity must cope with the constant threat of being discovered, which leads to four psychological responses: cognitive (vigilance, suspiciousness, preoccupation), affective (shame, guilt, anxiety, depression), behavioral (social avoidance, the need for feedback, impaired relationships), and self-evaluation (identity ambivalence, negative view of self, diminished self-efficacy). Interestingly, these psychological consequences also are associated with PTSD, indicating that concealing a stigmatized identity may in and of itself be traumatic [22]. Researchers have begun to use population-based studies to investigate the effects of concealing a stigmatized identity, with one study revealing that women who were recently out were less likely to be depressed than closeted women, although this was not the case for men who were out when compared to closeted men [54]. Men who were recently out were more likely to have major depressive disorder or generalized anxiety than men who were closeted, suggesting that because of strict gender norms, men who are out may experience greater minority stress than women who are out, which in turn negatively impacts their mental health [54]. There is limited research on the effects of concealing a stigma among transgender individuals, though one study of transgender adults aged 50 and older showed that identity concealment explained the effect of gender identity on perceived stress, with concealment being related to higher levels of stress [52].

Developmental Impact of Homophobia and Transphobia

To gain a comprehensive understanding of trauma among LGBT people we must consider the impact of minority stress on childhood and adolescent development. Growing up in an environment where one’s experiences of gender and sexuality do not conform to societal standards contributes to conditions in which there is a high potential for trauma and identity to intersect. Studies demonstrate that sexual and gender minority youth experience high numbers of victimization events and that these events are associated with negative mental health outcomes such as depression [55, 56] and PTSD [57, 58]. Given the increased levels of stress encountered by sexual and gender minority youth, it is not surprising that they have a higher prevalence of mood and anxiety disorders [59] – as well as depressive symptoms and suicidality [60, 61] – than heterosexual youth. Even sexual and gender minority children and adolescents who grow up in supportive environments must deal with structural forces that marginalize those who do not conform to heterosexual or cisgender identities. Therefore, they too may be at greater risk for negative mental and physical health outcomes. In fact, evidence suggests that age may be an important modifier of physical health disparities among sexual minority individuals. A study using a general population sample in Sweden revealed that LGB individuals had more physical health symptoms and conditions as compared to heterosexual individuals and that these disparities differed by age, with adolescents and young adults reporting worse self-rated health than older individuals, indicating that minority stress may be exacerbated for youth [62].

Institutional heterosexism and binary gender bias can be especially traumatic for LGBT children and youth who are in the beginning stages of formulating their sexual and gender identities. Evidence suggests that children who experience traumatic events are predisposed to depressive and anxiety disorders and that they are at risk for developing PTSD in adulthood [63, 64]. Parsing out the impact of abuse and other traumatic events on sexual and gender minority children and adolescents is essential for understanding how these events may contribute to adult functioning in LGBT individuals. Roberts and colleagues [65] found that increased prevalence of PTSD among sexual minority individuals was related to greater exposure to child abuse and interpersonal violence. Previous studies that investigated the victimization experiences of sexual minority individuals have reported similar findings. For example, Balsam, Rothblum, and Beauchaine [66] compared 557 lesbian/gay and 163 bisexual individuals with 525 of their heterosexual siblings and found that sexual orientation predicted victimization throughout the lifespan. Sexual minority individuals reported more experiences of child psychological and physical abuse by parents and child sexual abuse, as well as more adult experiences of intimate partner violence (IPV) and sexual assault. Additionally, heterosexual and nonheterosexual men who displayed gender-nonconforming behavior in childhood were more likely to report child sexual abuse than their gender conforming counterparts [67].

Prolonged exposure to trauma, particularly during childhood, suggests that some LGBT people may be at higher risk for developing complex PTSD. Complex PTSD refers to a distinct trauma syndrome that can emerge due to repeated instances or multiple forms of trauma [68, p615]. Herman [69], one of the first scholars to discuss complex trauma syndromes, proposed that diagnostic criteria for PTSD did not fully capture the symptoms exhibited by victims of prolonged interpersonal trauma, such as intimate partner violence and child abuse. Individuals with complex PTSD typically manifest symptoms of PTSD *in addition to* severe dissociation, difficulty relating with others, somatization, and alteration in affect and impulses, in self-perception and perception of the perpetrator, and in systems of meaning [70, 71]. The *DSM-5* has expanded PTSD criteria to include some symptoms of complex PTSD, including negative changes in cognition and mood (Criterion D), and aggressive, irritable, self-destructive, and suicidal behavior (Criterion E). It also added a new dissociative subtype [24]. However, complex PTSD was not included in the *DSM-5* because field trials showed that mostly everyone who met criteria for complex PTSD also met criteria for PTSD [24]. Therefore, the *DSM-5* considers complex PTSD to be a severe form of PTSD.

Research on complex PTSD among LGBT populations is limited, although emerging evidence suggests that LGBT individuals who have fled persecution based on sexual orientation or gender identity may be at a greater risk for developing this disorder [72, 73]. LGBT refugees and asylees report a history of multiple traumatic events, including physical and emotional abuse, assault, shunning, blackmail, forced heterosexual marriage, corrective rape, and pressure to participate in conversion therapy [73]. A retrospective study of LGBT refugees and asylees revealed that they encountered severe child and adolescent abuse (e.g., harassment, public humiliation, and physical and sexual abuse) at home, in school, and in the community [72]. Furthermore, they had little protection from family members or authority figures, and in many cases an adult perpetrated the abuse.

PTSD Among LGBT Individuals

Because sexual minorities are exposed to more acute stressors, including prejudice-related events [74], they may be at higher risk for PTSD. Additionally, LGBT individuals contend with many of the risk factors associated with PTSD, such as prior trauma exposure [75, 76], preexisting anxiety and affective disorders [77, 78], and life stress [79–81]. Although findings are mixed [23, 82], research tends to show that sexual minorities are more likely to have PTSD than heterosexuals [65, 83]. The increased risk for PTSD may be even higher for gender minorities who are at especially high risk for violence throughout their lives, including sexual assault [84]. One study showed that 91% of transgender participants ($N = 97$) had encountered multiple traumatic events and 17.8% manifested clinically significant symptoms of PTSD [85]. Potentially traumatic events include experiencing, witnessing, or being confronted with life-threatening events such as hate crimes.

The Federal Bureau of Investigation defines a hate crime as a "criminal offense against a person or property motivated in whole or in part by an offender's bias against a race, religion, disability, ethnic origin or sexual orientation" [86]. Using a probability-based sample ($N = 662$), Herek [87] found 13.1% of sexual minority adults living in the United States experienced at least one hate crime, or incident of violence due to sexual orientation bias, in their adult life. Approximately 14.9% of the sample experienced property crimes, while 20% experienced both a property crime and an incident of physical violence [87]. In 2013, approximately 20.8% of the 5922 single-bias hate crimes reported to the Federal Bureau of Investigation (FBI) involved sexual orientation bias, with antigay male bias accounting for the majority of cases [86].

Although only 0.5% ($n = 31$) of the single-bias hate crimes reported to the FBI in 2013 were due to transgender or gender-nonconforming bias [86], this may be due to the underreporting of such crimes. According to the National Coalition of Anti-Violence Programs [88], which collected data across 14 US states from 16 of its member programs, transgender women were 1.6 times more likely to experience physical and sexual violence compared to lesbian, gay, and bisexual (LGB) and HIV-affected people. Transgender individuals were also 5.8 times more likely to experience police violence than LGB and HIV-affected people. Additionally, although transgender people are only about 8% of the LGBT population, more than half (55%) of the 20 documented homicides in the report were transgender women, with 50% being transgender women of color [88]. Of course, LGBT people may also be victimized because of their race, religion, or gender, and they can experience multiple-bias hate crimes as well [89, 90]. The least affluent LGBT people of all – those who are homeless – experience particularly high prevalence of victimization [91].

In addition to experiencing assaultive violence related to sexual orientation and gender identity, LGBT people may encounter violence within their intimate relationships. Although relatively understudied in comparison to heterosexual partner violence, increased societal acceptance of LGBT people has resulted in greater awareness of this serious problem [92–94]. A systematic review of research on domestic violence indicated that the prevalence of domestic violence among sexual minorities and heterosexuals was similar (i.e., between 25% and 75% [95]). Because domestic violence tends to be underreported among sexual minorities, prevalence might even be higher in this population. Fear of discrimination, inequality in legal protection, and feelings of shame may contribute to apprehension about reporting or seeking services [95], suggesting a critical need for health and mental health providers to conduct assessments that specifically ask LGBT people questions about intimate partner violence (IPV). IPV tends to be higher among gay men, LGBT people of color, bisexual women, LGBT youth, and transgender individuals [95]. In fact, one study showed that transgender individuals were two times more likely to face threats/intimidation, and 1.8 times more likely to experience harassment, than LGB and HIV-affected people, with transgender women and people of color being at particular risk for IPV [96].

Non-traumatic Events and PTSD-Like Disorder

PTSD-like disorders may also be present after experiencing non-traumatic events, especially those involving prejudice. LGB individuals [87, 97, 98], as well as trans individuals [46, 52, 99, 100], experience a high prevalence of nonviolent forms of victimization, such as verbal assault, harassment, and employment and housing discrimination. Experiencing these types of events has the potential to precipitate PTSD-like disorders among LGBT people.

Current knowledge about the relationship between non-traumatic events and PTSD is informed by attempts to understand the psychological effects of prejudice events among people of color [34, 101–103] and women [104]. For example, events motivated by racial prejudice—regardless of whether these events involve actual or threatened death—can be considered cognitive and affective assaults on one's identity, and therefore they "strike the core of one's selfhood" [34, p480]. Thus, scholars have proposed that exposure to nonlife-threatening racism-related events can also contribute to posttrauma symptoms, such as avoidance and numbing, self-blame, feelings of shame, and hypervigilance [34, p480].

Initial studies of trauma, beginning in the early twentieth century, focused primarily on white men who had served in combat [104]. Although these studies played a major role in how scholars currently conceptualize traumatic stress, they failed to consider how differences in socialization between white men and other marginalized groups could impact their responses to stressful events [104]. Despite these differences, these early formulations continued to inform how trauma was understood over time, especially when renewed interest in understanding trauma emerged during the 1960s and 1970s due to the Vietnam War, women's movement, and struggle for civil rights [104]. Consequently, the original conceptualization of trauma was inappropriately generalized to women, and minority groups such as people of color and LGBT individuals. Doing so failed to take into account that the way in which marginalized groups experience and respond to stress may be influenced by a number of social and cultural factors.

The way in which traumatic stress was initially conceptualized led to a narrow definition of trauma that mainly focused on direct traumas such as war experiences, natural disasters, childhood sexual abuse and stranger rape, and life-threatening illnesses [104]. When individuals are exposed to an isolated direct trauma (i.e., an event considered traumatic by the *DSM*) it is easier for researchers and clinicians to connect individuals' symptoms to the traumatic event. However, this is not the case when it comes to those who have been exposed to insidious trauma, which is "associated with the social status of an individual being devalued because a characteristic intrinsic to their identity is different from what is valued by those in power, for example, gender, color, sexual orientation, physical ability" [104, p240]. Repeated exposure to prejudice-related events contributes to feelings of insecurity, which in turn may lead to the feeling that one needs to remain alert to physical harm or to experiences of enacted homophobia and transphobia [104].

The effects of nonlife-threatening sexual prejudice have been discussed by Brown [105], who argued that coming out can be traumatic for sexual minority individuals when the experience involves the loss of support of one's family or religious community. Drawing from the work of Janoff-Bulman [106], Brown proposed that this loss might be traumatic because it shatters an LGB person's three basic assumptions about the world—benevolence of the world, meaningfulness of the world, and sense of self-worth. Because prejudice-related events have the potential to occur unexpectedly, sexual and gender minority individuals must constantly readjust to living in a hostile social environment. According to Brooks [107], "'readjustment' becomes, in a sense, adaptation to a perpetual state of stress" (p78). When adaptation fails, a pathological stress response such may result [22]. The consequences of trauma involving homophobia and transphobia can be enduring, and sexual and gender minorities often have little awareness of how exposure to this type of trauma may influence their current thoughts, feelings, and behavior [108].

Empirical studies do indicate that sexual minorities manifest PTSD-like disorder in response to non-traumatic events such as verbal harassment [57] and heterosexist discrimination (e.g., being treated unfairly by a friend or boss or being rejected by a family member or friends) [109]. In our study [110] that examined associations between PTSD and prejudice-related events motivated by race, sexual orientation, physical appearance, or social class, we found that sexual minority individuals were more likely than heterosexual individuals to experience a prejudice-related event. Furthermore, of the 19 LGB participants who experienced a prejudice-related event, 8 participants developed a disorder suggestive of PTSD following exposure to a nonlife-threatening prejudice event, including physical assault, child abuse, harassment, and termination from employment [110]. Given the high exposure of transgender individuals to stigma and discrimination, it is likely that they too would be at risk for developing trauma-related syndromes after exposure to nonlife-threating prejudice events.

Conclusion

Despite the major advances toward equality for sexual and gender minorities over the last 40 years, LGBT people continue to face marginalization and encounter victimization at alarming rates, even in relatively accepting parts of the world [1]. Growing up in a society that privileges heterosexual and cisgender norms contributes to a social environment in which there is high potential for trauma and identity to intersect. LGBT individuals are exposed to minority stress from an early age, and minority stress-based hypotheses are now used to explain, in part, the higher prevalence of anxiety, depression, and PTSD among in LGBT populations. Conceptualizing trauma in ways that move beyond existing psychiatric nomenclature can help healthcare professionals to identify LGBT people who develop symptoms suggestive of PTSD following non-traumatic events. Given their culturally specific experiences of stress, and the subsequent development of trauma-related disorders, promoting culturally relevant resilience practices for LGBT populations is critical. One way for healthcare professionals to bolster resilience in LGBT people is to acknowledge the struggle of living in an environment that privileges heterosexual and cisgender norms. Healthcare providers should address the trauma precipitated by oppressive social conditions with the same care and concern offered to survivors of other traumatic experiences [34]. Doing so has the potential to not only help LGBT people recover from trauma but also to thrive in social environments that continue to marginalize their identities.

Case

Renaldo is a 33-year-old Hispanic male who was referred to you for outpatient psychotherapy by his primary care physician, who is concerned that the antidepressant medication she prescribed 6 weeks ago has not helped to improve his mood. He continues to report insomnia, irritability, anxiety, and ruminative thoughts, which began after he ended a 3-month intimate relationship with Paul, a heterosexually identified married man whom he met at church (Fig. 1.3).

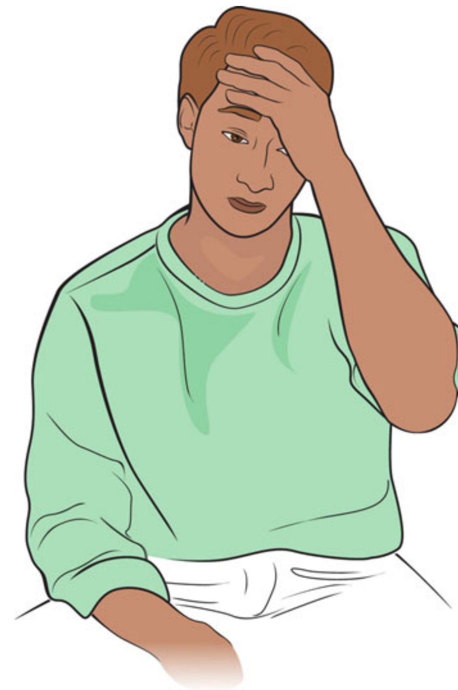

Fig. 1.3 Renaldo is a 33-year-old Hispanic male who was referred to you for outpatient psychotherapy by his primary care physician

Renaldo began attending church 6 months ago at the suggestion of his mother and sister, who believed that it could help him to live a heterosexual lifestyle. However, he doesn't think he will be able to resist his same-sex desires, even by attending church. Renaldo has felt different than others since he was young, and his family has always had trouble accepting him. While growing up, they were concerned about him being too effeminate and about his voice being too soft. And when he came out in his early 20s, they refused to speak with him for a few months. Being with Paul was the first time in his life that Renaldo felt really connected to anyone. He is devastated over the recent break-up and wants to reach out to Paul to talk. At the same time, Renaldo feels this is a bad idea because Paul is still married. He is very confused about his situation and hopes you can tell him what to do.

Discussion Questions

1. How is the loss of family support potentially traumatic for Renaldo?
2. How do structural sources of oppression (e.g., religious ideology) and intersectional factors (e.g., race/ethnicity) influence Renaldo's mental health?
3. Explain how a therapist can help Renaldo connect his current symptomatology to previous trauma related to his sexual orientation.
4. Describe the ways in which Renaldo manifests resilience. How can a therapist draw Renaldo's attention to these strengths throughout treatment?
5. What community resources are available for Renaldo?

Summary Practice Points

- Sexual and gender minorities encounter traumatic events throughout the life span in the form of verbal, physical, and sexual victimization, and these events are associated with physical problems, depression, anxiety, and traumatic stress.
- Emerging evidence suggests that structural forms of oppression, as well as non-traumatic events involving discrimination, have the potential to precipitate a traumatic stress response among LGBT individuals.
- LGBT individuals may not be able to connect their traumatic experiences, especially those of a nonlife-threatening nature, to their current emotional state. Mental health practitioners should help them to make this link.
- Healthcare professionals should account for within-group differences among LGBT populations (age, race/ethnicity, gender, socioeconomic status), as well as their impact on mental health.
- Acknowledging the role of culture (e.g., religious and familial influences) among LGBT populations may help to facilitate treatment engagement and to bolster resilience.

Resources

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