Resilience Across the Life Span: Adulthood

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Nathan Grant Smith

Resilience has been defined as successful adaption to adverse circumstances, including recovery from adversity and the ability to sustain well-being while facing adversity [1]. While it may seem reasonable to assume that trauma, discrimination, loss, and other adverse events will result in negative outcomes, resilience in the face of these stressors is commonly observed [1]. Such is the case with lesbian, gay, bisexual, and transgender (LGBT) individuals, who face similar adversities as people in the general population (e.g., adverse childhood experiences, employment insecurity, financial stress) as well as adversities that are more specific or unique to LGBT communities (e.g., anti-LGBT discrimination, coming out) [2, 3].

An important process in adapting resiliently to adversity is coping. In their cognitive theory of stress and coping, Lazarus and Folkman [4] stated that stress results when an environmental challenge exceeds a person's capacity to cope successfully. When an individual encounters such a challenge, they[1] engage in a process of primary cognitive appraisal in which the impact of the challenge on well-being is evaluated. If the encounter is deemed to be threatening, then the individual engages in a secondary appraisal process to identify coping strategies to mitigate the threat to well-being. One or more coping strategies may be selected; these strategies may be emotion focused, aimed at changing the way one feels about the challenge (such as minimizing the importance of the stressor or identifying positive aspects of the stressor), or problem focused, aimed at changing the challenge itself (such as engaging in problem solving or taking behavioral steps to address the stressor). In general, emotion-focused coping is more adaptive for stressors that are unchangeable, whereas problem-focused coping is more adaptive for stressors that are changeable. A coping strategy is deemed to be adaptive if it reduces the negative impact of an environmental encounter on an individual's well-being (see Fig. 7.1).

Resilience Resulting from Minority Stressors

Stress and coping theory is a useful framework to understand the impact of anti-LGBT stigma and discrimination on the well-being of LGBT adults. Studies comparing LGBT to heterosexual adults have revealed a number of health disparities, including increased risk for depressive and anxiety disorders; behavioral health problems such as tobacco, alcohol, and illicit drug use; suicidal ideation and attempts; non-suicidal self-injury; and access to healthcare [6]. However, the health professions have long noted that there is nothing inherently pathological about identifying as lesbian, gay, bisexual, or transgender. Indeed, homosexuality was declassified as a mental illness by the American Psychiatric Association in 1973. Further, in 1975, the American Psychological Association stated that "homosexuality, per se, implies no impairment in judgment, stability, reliability, or general social and vocational capabilities" [7] (p633). Rather, the heightened risk of poor health outcomes among LGBT populations is attributed to the stress of living in a society that stigmatizes nonheterosexual sexual orientations and gender identities that do not conform to binary and stereotypical notions of the concordance of sex and gender.

The stress of living in a stigmatizing society has been termed *minority stress*. Meyer [8] operationalized minority stress into five separate components: (a) prejudice events, (b) expectations of stigma/rejection, (c) internalized homonegativity (subsequent authors have expanded this component to include internalized binegativity and

[1] Note that "they" is used as a singular pronoun to avoid the false dichotomy of "he or she" that reinforces binary notions of sex and gender.

N.G. Smith, PhD (✉)
Department of Psychological, Health, and Learning Sciences, University of Houston, 3657 Cullen Boulevard, Room 491, Houston, TX 77204-5029, USA
e-mail: ngsmith@central.uh.edu

K.L. Eckstrand, J. Potter (eds.), *Trauma, Resilience, and Health Promotion in LGBT Patients*,
DOI 10.1007/978-3-319-54509-7_7

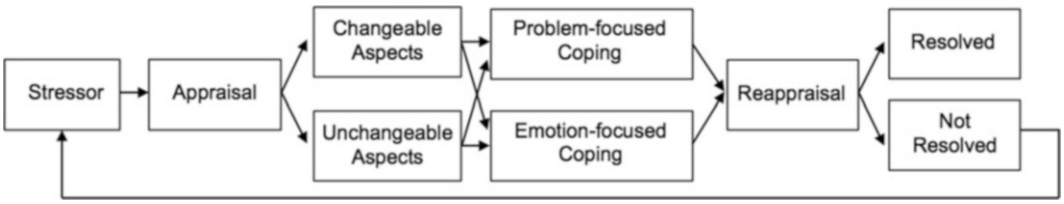

Fig. 7.1 The general stress and coping model (Adapted from Folkman et al. [5] with permission from Springer)

internalized transnegativity for bisexual and transgender persons, respectively), (d) sexual orientation concealment, and (e) ameliorative coping processes. Meyer [2] further noted that minority stress is (a) unique to sexual/gender minorities and thus additive to the stress experienced by all people, (b) chronic, and (c) socially based, meaning that the stress is due to social, institutional, and structural processes rather than due to any factors inherent in the LGBT person experiencing the stress.

While Meyer's [8] minority stress model focuses predominantly on the processes resulting from stigma and the negative outcomes of those processes, the fifth component of his model—compensatory coping, which includes social support and community affiliation—is of particular importance in understanding resilience among LGBT adults. As noted previously, when faced with a stressor, individuals respond by engaging in coping behaviors to mitigate the threat of the stressor; [4] this is also the case with LGBT adults faced with minority stressors. Indeed, Allport [9] noted the resilience of minority group members in engaging in coping strategies to deal with prejudice.

Research on coping in LGBT adults has predominately focused on maladaptive coping processes and the ways in which minority stress activates maladaptive coping (e.g., substance use), in turn increasing negative health outcomes. Indeed, Hatzenbuehler's [10] psychological mediation framework posits that minority stressors (including distal stressors, such as discrimination and violence, and proximal stressors, such as internalized homonegativity) lead to coping, emotion dysregulation, social isolation, and negative cognitive processes. These coping processes, in turn, lead to such outcomes as substance use, depression, and anxiety (see Fig. 7.2). This view of the relations between stress, coping, and outcomes is consistent with Lazarus and Folkman's [4] cognitive theory of stress and coping, which states that maladaptive coping strategies will increase risk for negative outcomes. However, stress and coping theory also states that effective coping strategies are likely to result in resilience. For example, in a qualitative study of 40 gay and lesbian couples, Rostosky et al. [11] found that couples engaged in four types of coping to deal with minority stress. These coping strategies included reframing negative experiences, concealing the relationship to avoid rejection from others, accessing social support, and affirming the self and the couple. Moreover, the couples viewed these coping strategies as instrumental in allowing them to overcome adversity. However, despite viewing concealment of the relationship as a helpful survival technique, it caused additional stress for couples where differences existed in the level of outness between the partners. In another quantitative study, Lehavot [12] examined almost 1400 lesbian and bisexual women and found that adaptive coping strategies (i.e., active coping, planning, positive reframing, acceptance, humor, religion, and using emotional and instrumental social support) were negatively associated with depression, mental health concerns, and physical health concerns. Similarly, in a sample of Latinx lesbian women and gay men, active coping was negatively associated with depression and positively associated with self-esteem [13].

By engaging in adaptive coping strategies, LGBT adults are able to experience stress-related growth (SRG), a term from positive psychology that explains the occurrence of favorable outcomes following stress [14]. Vaughan and Rodriguez noted that the "link between SRG and psychological wellbeing indicate that SRG may serve as an important pathway by which other strengths develop. In this context, these strengths may go on to serve as protective factors that buffer future experiences of minority stress" [15] (p328).

General Strengths Using a Positive Psychology Framework

With the rise of the positive psychology movement, scholars have recently begun to explore the positive aspects of, or strengths associated with, being LGBT. Positive psychology as a discipline focuses on the strengths of human beings and includes positive individual traits (e.g., forgiveness), positive subjective experiences (e.g., sense of well-being), civic virtues (e.g., altruism), and institutional factors (e.g., workplaces that promote employee growth) that help individuals reach their potential [16]. Vaughan and colleagues [3] recently examined the published literature to identify positive psychology topics explored in LGBT research. The positive psychology themes identified in

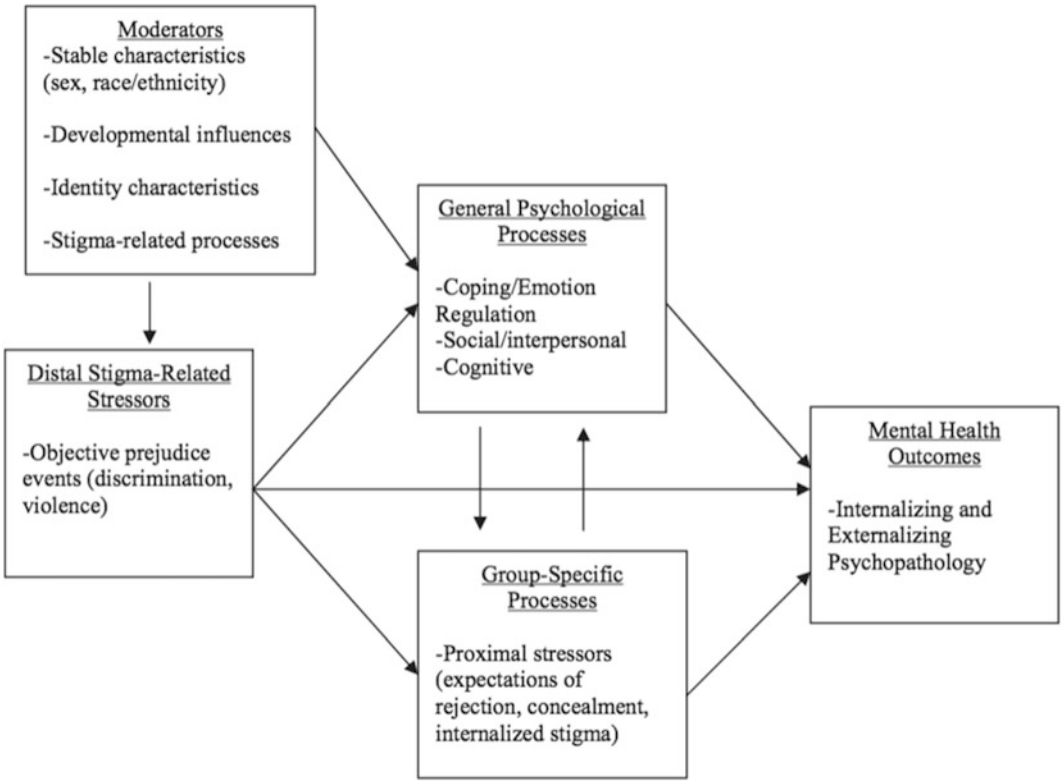

Fig. 7.2 Hatzenbuehler's psychological mediation framework [10]

their review included creativity in creating one's identity and in redefining ideas of family; self-acceptance and living honestly, in regard to being authentic both to self and to others; positive affect; love and support in the context of interpersonal relationships; community building and advocacy that is inclusive of a range of marginalized groups (e.g., people of color); connection to community; self-regulation; spirituality; and positive adaptation in the face of adversity. Despite the importance of these topics, the authors found that only one in six LGBT-focused articles included positive psychology themes, pointing to the need for additional research examining strengths in LGBT samples.

Many of these broad positive psychology themes identified in the literature also emerged in the first empirical study to directly ask participants about the positive aspects of being lesbian or gay. Riggle and colleagues [17] asked 553 lesbians and gay men (this study did not examine positive aspects of being bisexual or transgender) to identify the positive aspects of being LG. Only 1% of the sample reported that there were no positive aspects to being LG. Of the remaining 99% who identified positive aspects, their responses fell into three broad categories: disclosure and social support, insights into and empathy for self and others, and freedom from societal definitions. In the disclosure and social support category, positive aspects of being LG included community belongingness, the ability to create families of choice, deeper connections with others, and being a positive role model. Within the insights into and empathy for self and others domain, participants identified a number of positive aspects of being LG. These included authenticity and honesty with self and others, a deeper sense of self, increased empathy for other people who are oppressed, more cultural sensitivity, and the promotion of social justice and activism. Finally, the freedom from societal definitions theme included ideas such as not being bound by rigid gender role stereotypes, the ability to explore sexuality and ways of being in intimate relationships, and having more egalitarian relationships.

A number of these factors have been identified in qualitative and quantitative research. For example, Russell and Richards [18] found five resilience factors among LGB adults facing anti-LGB stressors: social support, connection with the LGB community, emotional coping, coming out/self-acceptance, and positive reframing. Other strengths identified in the literature include hope and optimism [19], emotional expression [20], and having a positive LGB identity [21]. All of these factors have been shown to be related to positive mental health outcomes among LGB adults. Moreover, while research examining positive psychology constructs specifically in LGBT samples remains scarce, a number of authors (e.g., Hill and Gunderson [22]) have suggested that the strengths predictive of resilience in the general population, such as coping styles and personality traits, should be similarly adaptive among sexual and gender minorities.

Coming Out Growth

As noted in minority stress theory, LGBT individuals have unique stressors. In addition to needing to engage in adaptive coping to successfully overcome these stressors, there is evidence that LGBT-specific stressors can provide opportunities for SRG. Thus, resilience in the face of minority stress may encompass both successful adaptation to adversity and growth as a result of adversity—growth that might not have occurred in the absence of adversity. One such example of LGBT-specific SRG is growth related to coming out. The idea that adopting an LGBT identity and coming out to self and others is adaptive has been discussed in the literature for decades. Indeed, early authors noted that sexual minorities have "our own special, life-affirming gay growth track" [23] (p12). For example, lesbian and bisexual women who completed a measure of SRG regarding the growth they experienced as a result of "coming to terms with [their] sexual identity" (p10) on average scored between 38 (for lesbian women) and 34 (for bisexual women), which approached the maximum for the scale of 45 [24]. Moreover, sexual-orientation-related SRG was positively associated with participants' connectedness to the LGB community and their feelings of generativity (i.e., efforts to promote the next generation). In addition, the original version of the SRG scale was positively associated with optimism, positive affect, and social support in a college sample [14].

Vaughan and Waehler [25] identified five domains of coming out growth in the theoretical and empirical literature: gains in honesty and authenticity, growth in social and personal identity, increases in mental health and well-being, better social and relational functioning, and development of advocacy efforts (see Fig. 7.3). They developed a scale to measure the growth associated with coming out as LG. Their scale included individualistic growth—including gains in mental health, self-acceptance, and social support/relationship satisfaction—and collectivistic growth, including gains in advocating for self and the LG community, community connection, and positive views of the LG community. Both individualistic and collectivistic growth were positively associated with optimism, involvement with the LGBT community, and outness. Moreover, they found a positive relationship between coming out growth and time since beginning the coming out process, where those who had been out longer reported more growth.

The finding that coming out growth increased commensurate with more time elapsed since beginning the coming out process highlights the iterative nature of the coming out process. Coming out to others is a continual process, with each new interpersonal situation (e.g., family/friend interactions, new job) representing a new opportunity to come out; those who have navigated multiple different iterations of coming out may attain the greatest benefits from this process. This explanation is consistent with research indicating that LGB adolescents and young adults evidence greater health disparities than older LGB adults [26, 27]. Thus, LGB adults and those who have had more time to progress through the coming out process may fare better in terms of health outcomes and the growth associated with coming out, although a direct link between the duration of outness and long-term health outcomes has not been studied.

While there is evidence that coming out results in growth, it is important to note that disclosure of a nonheterosexual orientation is not always associated with positive outcomes. While most studies have demonstrated positive associations between outness and health [28], some found no significant relationships [29]. In addition, McGarrity and Huebner [28] found worse physical health outcomes related to outness among gay and bisexual men of lower socioeconomic status (SES). While outness among high SES GB men was associated with fewer physician visits and less perceived stress, levels of outness were associated with more nonprescription drug use, physical symptoms, and perceived stress among low SES GB men. Thus, the benefits of sexual orientation disclosure may not be applicable for those of lower SES, although the degree to which the challenges associated with coming out and disclosure of sexual orientation are related to SRG in lower SES adults is unknown. Moreover, a population-based study of California adults revealed sex differences in the relationship between outness and mental health, with women who were out being less depressed than those who were closeted but men who were out being more depressed than those who were closeted [30]. Thus, it will be important for researchers and care providers to be cognizant of the complex interplay of outness, SRG, resilience, and demographic characteristics such as SES and sex among LGBT adults.

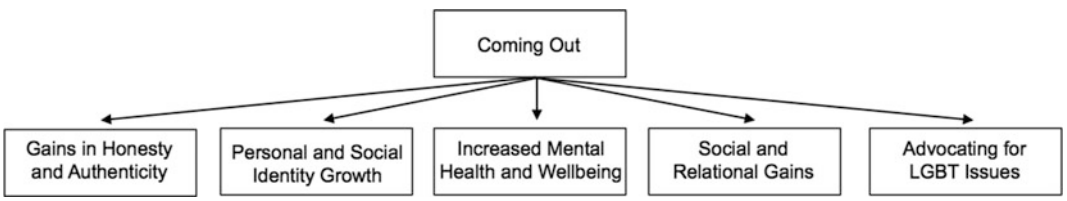

Fig. 7.3 Five broad domains of coming out growth identified in the theoretical and empirical literature by Vaughan and Waehler [25]

Possible explanations for the equivocal findings regarding the adaptiveness of outness include the risk of experiencing discrimination as a result of coming out and subsequent fears of rejection. An early empirical study examining the impact of anti-LGB discrimination on psychological well-being found that individuals who were more out in their workplace were more likely to experience overt or blatant experiences of discrimination [31]. More recent research has examined outness, rejection, and fears of rejection based on sexual orientation. A study of gay men asked participants to indicate whether they had come out to their parents and, if so, how accepting their parents are of their sexual orientation. Participants also completed a measure of gay-related rejection sensitivity by responding to a number of ambiguous hypothetical situations (e.g., not being invited to a party, being seated in a remote part of a restaurant) as to how concerned they were that the situation was a result of their sexual orientation. Those with more rejecting parents had more gay-related rejection sensitivity (i.e., they were more likely to attribute potential rejection to their sexual orientation). Moreover, parental rejection was related to more internalized homonegativity, which mediated the relationship between parental rejection and gay-related rejection sensitivity [32]. Similar findings were observed in a sample of lesbian women and gay men: Experiences of discrimination were related to more LG-related rejection sensitivity and more internalized homonegativity [33]. It appears that experiences of rejection or discrimination may contribute to the development of cognitive distortions and faulty schemas. However, clinicians can work to address these distorted schemas. As the authors of the study focusing on gay men's rejection sensitivity note: "Although gay men's expectations of rejection may not always be inaccurate, rejection-sensitive gay clients may benefit from therapeutic techniques that have proven effective for promoting schema revision, especially if internalized homophobia drives their rejection sensitivity" [32] (p313). Thus, while outness can be resilience promoting, being out also puts one at risk for being rejected or experiencing discrimination, which increases negative feelings about one's sexual orientation and increases the potential for cognitive distortions. Healthcare providers are in a unique position to help sexual minority patients navigate both the risks and rewards of coming out.

Interpersonal Factors Implicated in Resilience

Social support has been studied extensively and shown to be associated with well-being [34]. Research on LGBT adults has explored the role of social support in resilience and well-being via studies examining LGBT individuals' engagement with and connection to the LGBT community, family of origin, and couple/family of choice.

In general, connection to one's community helps to satisfy humans' powerful need to belong and is associated with positive outcomes [35]. LGBT adults who feel connected to an LGBT community are able to compare themselves positively to others in their ingroup, as opposed to comparing themselves negatively to heterosexuals in their outgroup. Positive community connection is believed to be protective against the negative impact of minority stress on health [8]. Frost and Meyer [36] noted that community connection has been linked in a variety of studies to mental health and well-being, increased safer sex practices and decreased sexual risk, and medication adherence and effective coping among HIV-positive individuals. In addition, they found that community connection was positively associated with psychological well-being and negatively associated with internalized homonegativity. Moreover, individuals who were active members of LGBT clubs, organizations, gyms, and/or religious congregations felt more strongly connected to the LGBT community. Connectedness to the transgender community has been shown to be related to less depression and anxiety for transwomen, though a similar relationship was not observed for transmen. However, both transmen and transwomen benefit from general social support, with greater general social support (regardless of the gender identity of the members of the support network) related to less depression and anxiety [37]. For lesbian women, sense of belonging to the lesbian community was a protective factor that reduced the strength of the relationship between body image dissatisfaction and depression [38]. Among gay and bisexual men, engagement in the LGBT community has been conceptualized as a protective factor against HIV risk behaviors. Ramirez-Valles [39], based on a review of the literature, proposed a framework in which LGBT community involvement (a) lessens the impact of poverty, homophobia, and racism on HIV risk behaviors and (b) increases positive peer norms, self-efficacy, and positive self-identity, which all lead to reductions in sexual risk behaviors among GB men.

While engagement with and feeling connected to an LGBT community have been shown to promote resilience in LGBT adults, engagement with and connection to one's family of origin can serve both as a resource and as a source of stress. Whereas LGBT adults can and often do create families of choice [40] made up of supportive individuals who may or may not be biologically related, they cannot choose their families of origin. As such, reactions of family members to the disclosure of an LGBT identity can vary greatly, from distancing of an LGBT person from their family of origin when the reactions are negative, or deepening family cohesion when the reactions are positive [41]. Families that are supportive of their LGBT family members may engage in a number of processes to promote resilience. Oswald [42] categorized these processes into

intentionality and redefinition. Intentionality refers to efforts of LGBT persons and their families (of origin and chosen) to engage in strategies that legitimize and support LGBT identities, in the absence of larger societal support for these identities. These intentional behavioral efforts include integrating LGBT and heterosexual family members, providing social support, engaging in the LGBT and ally communities (e.g., PFLAG [Parents, Families, and Friends of Lesbians and Gays] provides resources and education to family members of LGBT individuals), and taking part in supportive rituals (e.g., family members attending pride events or same-sex weddings). Redefinition refers to meaning-making processes that create affirming linguistic and symbolic structures. Such processes include understanding the broader context of heterosexism and transphobia that impact LGBT people's lives, developing and using inclusive language (e.g., family members calling co-mothers by their chosen names, such as one mother being called "mommy" and the other being called "mama"), integrating LGBT identities into other cultural identities, and re-envisioning ideas of what it means to be family.

In addition to supportive families of origin, LGBT adults create families of choice. These include friends, partners, and "gay families." Whereas tight-knit groups of friends become families of choice for a variety of LGBT adults [40], "gay families" or "houses" have emerged in communities of color, predominately among African American and Latino LGBT-identified individuals. Both gay families and houses tend to have family structures that often consist of a gay man or transwoman who is regarded as a role model serving as the parent, with younger gay men and transwomen (and to a lesser degree lesbian women and transmen) as the children. Houses tend to have a performance focus, as is the case in the ballroom community (which was depicted in the 1990 film *Paris Is Burning*), whereas gay families may not have a performance focus [43]. Research has found that houses and gay families serve as important sources of resilience by providing social support, strategies to cope with hetero/cissexism and racism, and tools for safer sex [43, 44].

Creation of families of choice in the LGBT community has redefined the meaning of family in the United States. In addition, rapid political change at the beginning of the twenty-first century has resulted in the increased legitimization of LGBT families. In June 2015, the US Supreme Court ruled in *Obergefell v. Hodges* [45] that all states must recognize marriage between two same-sex individuals, thus allowing for same-sex marriage nationwide. This decision allowed same-sex couples access to federal and state benefits, including employer-sponsored spousal health insurance (*United States v. Windsor* [46] provided some of these benefits, but not necessarily nationwide). Research into the impact of *Obergefell* on same-sex couples is needed to determine if these changes will translate into increased resiliency. However, Perone [47] reviewed the research showing the negative health impacts of denying same-sex couples access to marriage and concluded that *Obergefell* "moves LGBT persons one step closer to better health by affirming marriage equality and thus the dignity of LGBT couples to have equal rights as their opposite-sexed peers in this legal arena" (p197).

Legalization of same-sex marriage and increasing public recognition of LGBT families notwithstanding, Patterson's 2000 review of the literature on same-sex couples and their children "yield[ed] a picture of families thriving, even in the midst of discrimination and oppression. Certainly, [the research] provide[s] no evidence that psychological adjustment among lesbians, gay men, their children, or other family members is impaired in any significant way" [48] (p1064). Indeed, research to date suggests that lesbian and gay couples fare just as well, and in some cases better, than heterosexual couples. A 5-year longitudinal study demonstrated no differences between married heterosexual couples and cohabitating lesbian and gay couples in relationship satisfaction both at initial assessment and over time. In addition, lesbian couples reported more intimacy, autonomy, and equality than heterosexual couples. Gay male couples reported more autonomy than heterosexual couples; levels of intimacy and equality were also greater, though not significantly different. Moreover, lesbian and gay couples were both similar to heterosexual couples in using constructive problem solving to address conflict resolution [49]. Thus, despite additional minority stress and a long history of lack of recognition of their relationships, lesbian and gay families demonstrate resilience.

Individual Difference Factors Implicated in Resilience

A number of individual difference factors that predict resilience in LGBT adults have been explored in the literature. These include, but are not limited to, faith, religion, and spirituality; personality-related factors; and cultural factors. Religious traditions vary in their attitudes toward LGBT persons, with some viewing sexual and gender minorities as abnormal and sinful and others viewing them as normal and/or morally neutral [50, 51]. For example, Unitarian-Universalist, Unity, United Church of Christ, Episcopalian, and Metropolitan Community churches, among others, adopt an affirming view of LGBT issues [52]. As such, faith and religion may be sources of stress or of strength for LGBT adults. When viewed through a resilience lens, faith and religion can offer social support, adaptive coping strategies, and meaning for some LGBT persons. For example, Bowleg et al. [53] found that Black lesbian adults

viewed spirituality as a resilience-strengthening factor. Similarly, among Black LGB young adults, for those with high levels of internalized homonegativity, religious faith was associated with more resilience [54]. Among White LGB adults, personal spirituality was positively associated with psychological health. In addition, spirituality mediated the relationship between affirming faith experiences (e.g., feeling welcomed by a religious community, belonging to an LGB-affirming faith community) and psychological well-being. Likewise, affirming faith experiences decreased internalized homonegativity, which was a risk factor for poor psychological health [55]. A qualitative study of transgender female Christian adults revealed a number of positive, as well as negative, experiences with organized religion and spirituality [56]. One participant said, "I go to a very evangelical church ... where I transitioned. I am accepted by the people, and indeed was baptized by immersion there several years ago as my new self" (p27). Other participants discussed the ways in which their faith provided support as they struggled with their gender identity and grew stronger as a result of identifying as transgender. Thus, spirituality and religious engagement, especially engagement with LGBT-affirming religious communities, may be sources of resilience for LGBT adults.

A number of personality-related factors have been examined to explain resilience in LGBT adults. For example, Carter and colleagues [57] found that locus of control moderated the relationship between workplace-based heterosexist discrimination and psychological distress among LGB adults (see Fig. 7.4). For those with a stronger *internal* locus of control (i.e., the belief that outcomes of one's behavior are determined by internal factors, such as one's own actions), workplace discrimination was not significantly correlated with distress, while for those with a stronger *external* locus of control (i.e., the belief that outcomes of one's behavior are determined by external factors, such as the actions of others), there was a significant and positive relationship between discrimination and distress, such that more discrimination was related to more distress. Thus, it appears that an internal locus of control can buffer the effects of heterosexist discrimination on psychological function among LGB adults. As noted previously, hope, optimism, and emotion regulation have also been examined among LGBT adults. Kwon [20] developed a research-based theoretical model that included emotional openness and hope and optimism (collectively referred to as future orientation) as predictors of psychological health. Specifically, this model posited that emotional openness and future orientation both lead to lower emotional reactivity to anti-LGB prejudice, which in turn lead to better psychological health outcomes. Additional research is needed to fully test Kwon's model; however, existing data support a role for future orientation in explaining individual variation in LGB resilience.

Finally, the impact of cultural factors on LGBT resilience has also been investigated. Moradi et al. [58] noted that in both theoretical and empirical literature, LGB people of color have been conceptualized as having both more risk and more resilience than White LGB people. The assumption is that communities of color are more heterosexist and, as a result, LGB persons of color are exposed to more

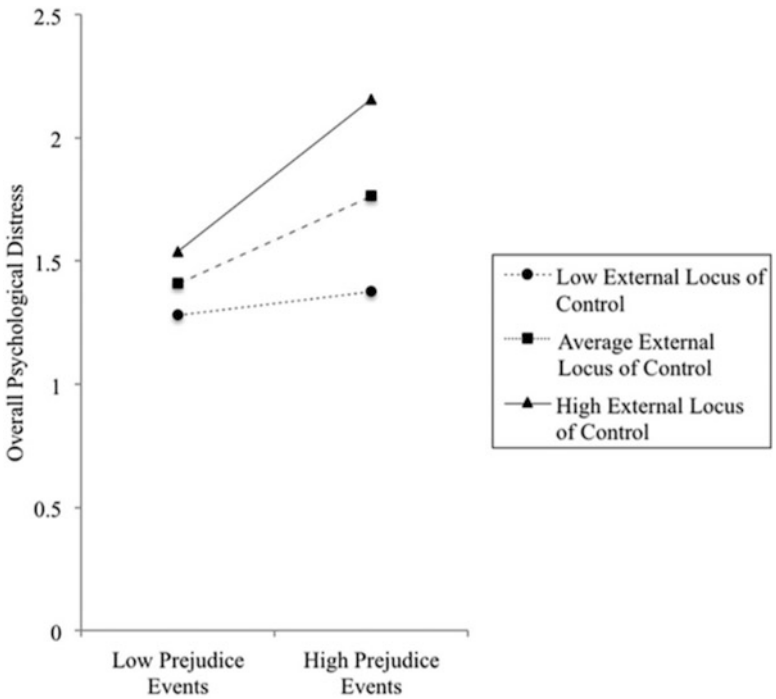

Fig. 7.4 The moderating role of locus of control in the relationship between workplace-based prejudice events and psychological distress among LGB adults, as presented in Carter et al. [57]

heterosexism, thus placing them at greater risk. In addition, LGB individuals of color are assumed to have greater resilience because of strong faith traditions in communities of color, increased skill in coping with racism translating into skill in coping with heterosexism, and greater flexibility in terms of outness and disclosure. To test these assumptions, Moradi and colleagues directly assessed whether LGB persons of color had more risk and resilience than White LGB persons. There were no group differences between participants of color and White participants on perceived heterosexist stigma, internalized homonegativity, or level of comfort with sexual orientation disclosure; however, White participants were more out than participants of color. The authors suggested that concealment of sexual orientation may be a "reasonable self-protective strategy in the face of widespread heterosexist stigma" (p413) that may be reflective of role flexibility. In addition, the relationship between perceived heterosexist stigma and internalized homonegativity was nonsignificant for persons of color but was significant and positive for White persons. Thus, participants of color appear to be fairly equal in terms of risk, but do show some evidence of heightened resilience in response to heterosexist stigma. Similar results were found in a sample of racially diverse young (18–25) lesbian and bisexual women: there were no racial differences in sexual-orientation-based victimization, depression, anxiety, or heavy drinking [59].

While these studies suggest that there are more similarities than differences between LGB adults of color and White LGB adults in terms of risk and resilience, qualitative studies have revealed specific resilience factors in various LGB racial communities. For example, Sung and colleagues [60] examined resilience factors in Asian American lesbian and bisexual women. Their qualitative results identified a number of coping strategies participants used to deal with challenges associated with being Asian American and lesbian/bisexual (i.e., having multiple minority identities and experiencing heterosexism), including engaging in activism and seeking social support. Participants also identified a number of positive aspects to being Asian American lesbian/bisexual women, such as belonging to multiple (Asian American, LGBT, Asian American lesbian/bisexual female) communities, as well as using Asian cultural values as sources of strength and increased empathy for others. Increased empathy with minority status was also seen in a sample of White gay and bisexual men, who reported more racial empathy toward people of color and more positive racial attitudes than White heterosexual men; moreover, experiences of heterosexist discrimination led to increased empathy, which in turn led to more positive racial attitudes [61]. Similar to findings among Asian American lesbian/bisexual women, a qualitative study of Black lesbians revealed several resilience themes including confronting oppression, engaging in social support, finding strength in the Black community, and using internal strengths such as humor and spirituality [53].

Resilience Against Suicidality

One outcome of minority stress is an increased risk for suicidal ideation and behavior. Indeed, in a systematic review of the literature, King and colleagues [62] found that the 12-month prevalence of suicide attempts was 2.5 times greater among LGB persons than among heterosexuals. Likewise, lifetime suicidal ideation was twice as common among LGB individuals compared to heterosexuals. A convenience sample of LGB adults in New York City found that 8.7% of LGB adults aged 18–29, 5.9% of LGB adults aged 30–44, and 15.6% of LGB adults aged 45–59 had made a serious suicide attempt [63]. A population-based study in California found that bisexual women were almost six times as likely as heterosexual women to have attempted suicide; bisexual men were almost three times as likely as heterosexual men to have attempted suicide [64]. Rates of suicidality are even more alarming among transgender adults, with studies reporting suicide attempt rates between 23 and 32% [65–67]. In addition, a recent national survey of 6450 transgender adults found a lifetime suicide attempt rate of 41% [68].

In the face of these high rates of suicidal ideation and attempts, it is heartening that protective factors against suicidality have been identified. These factors include social support [69], cognitive reappraisal of suicidal thoughts (i.e., the ability to regulate suicidal thoughts and not act on them) [70], problem solving/coping [69], and identifying reasons for living (i.e., responsibility to others) [71], among others. Most research examining suicide protective factors in LGB samples has focused on youth, described in detail in Chap. 6. While research on suicide resilience in LGB adults is lacking, recent research has explored suicide resilience among transgender adults. In a quantitative study, Moody and Smith [72] found that social support from family, emotional stability, and concern related to one's children (i.e., concern for the effect one's death would have on one's children) were all negatively associated with risk for suicidal behavior in a sample of Canadian transgender adults. Though social support from family was protective against suicidal behavior, the authors found that the amount of perceived social support from family was significantly less than the amount of perceived social support from friends. Thus, interventions aimed at fostering support and acceptance among family members of transgender adults may be lifesaving.

Social support was also an important suicide protective factor in a qualitative study of Canadian transgender adults,

in which participants who had experienced suicidal ideation were asked why they had not acted on those thoughts [73]. The authors analyzed participants' answers and grouped their responses into five broad categories: (a) social support, (b) transition-related factors, (c) individual difference factors, (d) reasons for living, and (e) gender identity-related factors. Social support from friends and family, as well as from mental health and community service workers, was viewed by transgender adults as protective. For those participants who wished to transition, disclosing one's gender identity, hope of being able to transition, and actually transitioning were all seen as protective. Next, a number of individual difference factors were protective against suicidal behavior, including coping and problem solving, optimism, and the capacity to withstand suicidal ideation without acting upon it. Reasons for living included feelings of responsibility to others, including children; religious, spiritual, or personal objections to suicide; fear of suicide; desire to keep living; and wanting to be a positive role model to other transgender persons. Finally, a number of gender identity-related factors emerged as protective. Realizing oneself to be transgender eased the pain and confusion related to questioning one's gender identity, thereby reducing suicidality. Establishing a stable sense of one's transgender identity, gaining self-acceptance of one's identity, and having the opportunity to live authentically were also protective against suicide. In regard to self-acceptance, participants discussed a process of moving from distress and discomfort to feeling comfortable with themselves. Participants reported feelings of distress prior to identifying as transgender; however, once they began to express their gender identity and identify themselves as transgender, they were able to better accept themselves for who they are. Subsequently, their feelings of distress decreased. Taken together, these results suggest numerous ways to reduce suicide risk among transgender adults (e.g., improve access to transition-related care and encourage patients to seek social connection and identify reasons for living). More research is needed to continue to identify suicide protective factors in both transgender and LGB adults.

Emerging Data

As discussed in Chap. 4, emerging data examining stress biomarkers, such as cortisol, show promise for the exploration of resilience among LGB adults. Cortisol is the stress hormone produced as a result of hypothalamic-pituitary-adrenal (HPA) axis activation in response to stress. Cortisol production in response to an acute stressor mobilizes the body for "fight or flight," but continued exposure to stress and the resulting HPA axis activation cause wear and tear on the body, known as allostatic load. Researchers in Montreal, QC, Canada [74], found that gay and bisexual men had lower cortisol concentrations than heterosexual men in response to a laboratory-induced stressor (i.e., a mock job interview and engaging in mental arithmetic in front of a one-way mirror). While it is unclear whether this blunted cortisol response is adaptive or maladaptive, the same researchers found that gay and bisexual men had lower allostatic load and less depression than heterosexual men [75]. In addition, in a US-based sample of young LGB adults, those who had grown up in more LGB-accepting environments showed a less blunted acute cortisol response to a laboratory-induced stressor than those who had grown up in more stigmatizing environments [76]. While more research is needed to fully explore the clinical implications of cortisol responses on stress reactivity and resilience in LGBT adults, these emerging data suggest that resilience may be evident in biological markers of stress.

Emerging data regarding LGB-affirmative treatment approaches have shown promise for integrating resilience-fostering strategies into clinical treatment. Pachankis and colleagues [77] developed a cognitive-behavioral therapy for young adult gay and bisexual men that focused on providing participants with skills to manage the impact of minority stress on cognitive, affective, and behavioral processes (e.g., development of emotion regulation skills, assertive communication skills, and cognitive restructuring skills). A total of 63 participants were randomized to the treatment or to a waitlist control group. Results indicated that those in the treatment group had reduced depression, alcohol use problems, sexual compulsivity, and condomless sex. My colleagues and I [78] developed a similar intervention focused on helping young adult gay and bisexual men develop effective coping strategies for dealing with minority stress. We presented three case studies that each demonstrated reductions in condomless sex at 3-month follow-up. In addition, we found reductions in alcohol use, number of sex partners, loneliness, and internalized homonegativity, combined with increases in self-esteem [79]. These new affirmative treatment models offer specific guidelines for promoting resilience in gay and bisexual men. Additional affirmative interventions with LGBT clients have been discussed in the literature, but few studies have actually examined the efficacy of specific treatment approaches. For a recent overview of the state of LGB-affirmative psychotherapy, see Johnson's [80] 2012 review of existing meta-analyses and systematic reviews.

Resilience Promotion in Patient/Provider Relationships

Because of experiences or fears of discrimination by healthcare workers, some LGBT patients are concerned about receiving poor care and thus may not disclose their

sexual orientation or gender identity to providers [81]. However, like all patients, LGBT individuals want and deserve competent and effective healthcare. For example, a study of lesbian women found that participants wanted, but did not always receive, healthcare that is comprehensive, person centered, free from discrimination, and integrative of their lesbian identities [82]. Moreover, when patients are provided with this type of healthcare, they are more likely to be open about their sexual orientation and gender identity with healthcare providers and to engage more actively in seeking and utilizing healthcare. A study of Canadian lesbian adults found that women who were more open about their sexual orientation were more likely to disclose to their healthcare providers, which in turn was related to greater healthcare utilization. In addition, those who were more comfortable with their healthcare providers were more likely to seek routine preventive care [83]. In order to promote resilience in LGBT adult patients, healthcare providers must be knowledgeable about LGBT issues and create a welcoming healthcare environment. Indeed, establishing an accepting and supportive provider-patient relationship can provide the cornerstone for the development of additional social connections in the future, and the guidance of a knowledgeable provider can help direct patients toward community supports and affirmative coping practices.

A number of professional organizations have developed guidelines or standards for working effectively with LGBT patients; provider knowledge and healthcare environment are central to these guidelines. For example, the American Psychological Association has published guidelines for psychological practice with both LGB [84] and transgender [85] patients. Though focused on psychologists, these guidelines are applicable to a variety of healthcare providers as they provide a frame of reference and basic information for working with LGBT patients. Similarly, the Association of American Medical Colleges (AAMC) Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development developed competencies that all physicians should be able to demonstrate when working with LGBT patients [86]. The guidelines direct healthcare providers to be knowledgeable about the issues facing LGBT patients, including issues of stigma, family and partner issues, workplace issues, cultural diversity, and unique issues facing bisexual and transgender patients. The guidelines also discuss the important role that provider attitudes and knowledge have in the care they provide to LGBT patients. Provider bias and lack of knowledge can negatively impact the care they provide and subsequent patient outcome.

The Gay, Lesbian, Bisexual and Transgender Health Access Project [87] produced standards for the provision of healthcare services to LGBT patients. The standards include administrative and service delivery components, including personnel, patient rights, intake and assessment, service planning and delivery, confidentiality, and community outreach and health promotion. The standards focus on the knowledge base of providers and agency staff, nondiscriminatory treatment of patients and agency employees, and culturally appropriate intake and assessment procedures, as well as other foci including methods of health promotion and outreach.

GLMA: Health Professionals Advancing LGBT Equality [88] published guidelines for care of LGBT patients, which include suggestions for creating a welcoming environment for LGBT patients, ways to make paperwork and patient-provider interactions more inclusive, staff training suggestions, and specific considerations when working with lesbian and bisexual women and when working with gay and bisexual men. Suggestions for creating a more welcoming climate include having visible displays of LGBT-inclusive materials in offices, such as brochures about LGBT health, posters that include LGBT people, and nondiscrimination statements that include sexual orientation and gender identity; avoiding using heterosexist language in intake forms or in in-person assessments, such as using gender-neutral language such as "partner" rather than "husband/wife"; avoiding asking transgender persons unnecessary questions; mirroring patients' language; avoiding making assumptions; and having at least one gender-inclusive restroom that is not labeled as "men" or "women." The guidelines also provide some basic information about health issues facing LGBT persons, such as minority stress issues; tobacco, alcohol, and drug use; safer sex and sexually transmitted infections; and violence. Finally, the guidelines contain specific recommendations for working with sexual minority women, such as pap screening, and sexual minority men, such as hepatitis immunization.

Summary

LGBT adults show remarkable resilience in the face of societally based adversity. Sources of resilience include effective coping strategies; focusing on positive aspects of being LGBT; growth resulting from stress; support from family, community, and partners; and individual strengths. Healthcare providers wishing to help promote the resilience of their LGBT adult patients need to be knowledgeable about the issues facing their patients and to create a welcoming environment in which to see their patients. LGBT-affirmative healthcare practice can help to promote resilience in sexual and gender minority patients and facilitate better healthcare utilization and health-promoting behaviors.

While LGBT adults have the capacity for resilience, focusing solely on individual resilience ignores the important role that policies and institutions have in reducing the

stigma and discrimination faced by people with diverse sexual orientations and gender identities. If LGBT people lived in a more affirming social context, they would not need to expend as many resources on developing and maintaining their resilience. Thus, healthcare providers are encouraged to foster the resilience of their LGBT patients while simultaneously working to accomplish structural changes to alleviate the pathogenic social environment that causes health disparities in the first place [89]. As Meyer [8] (p691) noted in laying out his minority stress theory:

> As researchers are urged to represent the minority person as a resilient actor rather than a victim of oppression, they are at risk of shifting their view of prejudice, seeing it as a subjective stressor—an adversity to cope with and overcome—rather than as an objective evil to be abolished.

Given their important role in society at large, healthcare providers are well situated to advocate for LGBT patients and to work to abolish the evils LGBT people face.

Case Scenario

Wanda is a 40-year-old Black female who presents for her yearly physical. During initial discussion, she reveals that she has been feeling more stress than usual at work and as a result has been drinking alcohol and smoking cigarettes more often (Fig. 7.5). She perceives that alcohol and tobacco use are relaxing and help her to cope with the stress of her job. She is concerned about her weight and knows that the alcohol is contributing to her weight gain, but also notes that the cigarettes help to decrease her appetite. When you inquire about the stress at work, she states that coworkers have been "targeting" her and describes a colleague who has been cold to her and gives her "funny looks" ever since Wanda mentioned her girlfriend of several years. She was initially hesitant to come out at work given the prior negative reaction of her mother to her identifying as a same-gender-loving woman, but wanted to participate in office discussions regarding families and children. In addition, she complains of low energy and often not wanting to get out of bed.

Fig. 7.5 Wanda is a 40-year-old Black female who presents for her yearly physical

Discussion Questions

1. What adaptive and maladaptive coping strategies are more frequently observed among LGBT adults in response to discrimination and rejection?
2. How does minority stress impact the mental and physical health of LGBT adults? How does this vary by race, ethnicity, and religion?
3. What interpersonal and individual resilience strategies support improved health among LGBT adults?
4. How do affirmative treatments help to foster resilience development in LGBT adults?
5. What strategies can health professionals utilize to promote resilience and positive health outcomes among LGBT adults?

Summary Practice Points

- Maladaptive coping strategies in response to interpersonal rejection and/or discrimination observed among LGBT adults include behaviors (such as tobacco, alcohol, and/or substance use, higher-risk sexual practices, self-injury, or suicide attempts) or thought processes including suicidal ideation, rumination, or internalization of rejection.
- Anti-LGBT stigma and rejection are associated with depression, anxiety, and physical health sequelae of maladaptive behaviors including STIs, hepatitis, certain cancers, and chronic obstructive pulmonary disease.
- Bias and discrimination can affect LGBT adults across the life span; for example, 38% of LGB and 78% of transgender adults report LGBT-related workplace discrimination.
- Adaptive coping and resilience-enhancing strategies used by LGBT adults include engaging family and/or chosen social support networks, cognitive reappraisal of rejection or suicidal thoughts, strengthening self-acceptance, positioning an internal locus of control, and forward thinking.
- Health professionals can accept and affirm the experiences of LGBT adults, explore and strengthen adaptive coping strategies with patients, and openly discuss treatment options for addressing maladaptive coping strategies that individuals are motivated to change.

Resources

1. Resources from the Gay and Lesbian Medical Association at http://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageId=534.
2. Gay and Lesbian Medical Association. Guidelines for care of lesbian, gay, bisexual and transgender patients. San Francisco, CA: Gay and Lesbian Medical Association; 2006. Available from: http://glma.org/_data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf.
3. LGBT resources from the American Medical Association at http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/glbt-resources.page.
4. LGBT resources from the American Psychological Association at http://www.apa.org/pi/lgbt/.

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