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# The Long-Term Effects of Homophobia-Related Trauma for LGB Men and Women

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The Long-Term Effects of Homophobia-Related Trauma for LGB Men and Women

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### Abstract

A qualitative study was conducted to explore the long-term effects of homophobia-related trauma on lesbian, gay, and bisexual (LGB) men and women. Participants were recruited through a community mental health clinic. Those selected participated in individual one-hour recorded interviews. Participants identified experiences of physical, verbal, and sexual victimization and rejection from family members. Long-term effects were identified including internalized homophobia, hypervigilance, wounded resilience, and seeking safe spaces. Implications of the research include the possibility of incorporating strengths obtained from experiencing homophobia-related trauma during therapeutic treatment.

### The Long-Term Effects of Homophobia-Related Trauma for LGB Men and Women

Individuals within the lesbian, gay, and bisexual (LGB) communities often face prejudice and discrimination throughout the lifespan (Herek, Gillis, & Cogan, 2009; Pilkington & D'Augelli, 1995). For many of these individuals, the experiences with prejudice and discrimination can include traumatic experiences of victimization (House, Van Horn, Coppeans, & Stepleman, 2011). Homophobia-related traumatic events are particularly damaging when they are experienced during childhood and adolescence (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009). Research on trauma reflects the dynamic and wide-ranging effects that experiencing trauma can have on the individual, including mental health, social, and behavioral consequences (Rosenberg, 2000; Schneider et al., 2012).

There is a gap in the available research pertaining to trauma-related issues specific to LGB communities (Brown & Pantalone, 2011). The available research focuses primarily on the immediate and short-term effects of homophobia-related trauma with only a handful of studies considering the long-term effects (Carbone, 2008). Many individuals from LGB communities who have experienced homophobia-related trauma have presented with symptoms of depression, PTSD, and anxiety related disorders (Almeida et al., 2009; D'Augelli, Grossman & Starks, 1995). The self-concepts of LGB men and women have also been affected by trauma through the internalization of homophobic beliefs (Carbone, 2008).

For some LGB men and women who have sought therapeutic support from mental health services, the experiences have deepened the effects of the trauma. The available literature describes the history of the stigma that LGB individuals have faced from the mental health field (Lewes, Young-Bruehl, Roughton, Magee, & Miller, 2008). Today barriers to treatment include a lack of knowledge of the cultural contexts pertaining to members of LGB communities and

potentially harmful therapeutic techniques, such as conversion therapy (Bowers, Minichiello, & Plummer, 2010; Jenkins, 2010). One possible reason for the lack of knowledge pertaining to the therapeutic needs of LGB men and women is the focus on the negative effects of homophobia-related trauma despite available research on the resiliency of individuals.

A qualitative study was performed using an empirical phenomenological design with LGB participants receiving mental health services in a community mental health clinic. The current research explored the question of what the long-term effects are of homophobia-related trauma on LGB men and women. The purpose of the research is to broaden the understanding of how homophobia-related trauma continues to impact individuals from LGB communities. The exploration includes LGB men and women's needs within mental health settings, including any potential barriers to treatment and resiliency factors which could be used as strengths to build upon. The following section contains a literature review which surveys the current research on homophobia-related victimization and trauma, its effects on LGB populations, protective factors, and barriers to therapeutic support. The remaining sections will describe the qualitative methods utilized to gather and interpret data, the results of the research, and a discussion of the results and their implications for future research.

### **Literature Review**

The literature review will begin with an overview of trauma and its effects on the individual. Peer victimization related to sexual orientation will be explored as a specific form of trauma. After a broad summary of trauma, homophobia and heterosexism will be defined in the context of sexual stigma and its relationship to trauma experienced by LGB communities. Experiences with homophobia-related trauma will be detailed along with the various contexts in which it commonly takes place. The most commonly researched effects of homophobia-related

trauma will also be explored including negative mental health outcomes, behavioral effects, and the trauma's impact on the individual's self-concept and sexual minority identity. Coping strategies and protective factors will be reviewed as not every individual's response to homophobia-related trauma is maladaptive. Finally, barriers to therapeutic support and cultural shifts will be described to indicate the need for continued research and understanding of LGB communities' experiences with trauma to better serve the populations' therapeutic needs.

### **Trauma**

Before discussing the specific nature of homophobia-related trauma, this section will describe trauma and its effects in a broad context. These more universal experiences with trauma provide a foundational knowledge about the effects of trauma on the individual. Trauma is defined in the literature as an experience or event wherein an individual incurs a serious injury or perceives an imminent threat of death or injury (Schneider et al., 2012). Trauma can be a single event, such as a motor vehicle accident, being the victim of a hate crime, or being impacted by a natural disaster. Trauma can also be a prolonged series of events, such as experiencing continued emotional, sexual, or physical abuse or combat (Rosenberg, 2000).

Physical trauma is more recognizable than emotional trauma, which provides a possible explanation for why more emotionally related experiences with trauma are overlooked in the research. Research has explored physical trauma contrasted with emotional trauma. Emotional trauma is primarily responsible for the impact of trauma on individuals' mental health and quality of life (Schneider et al., 2012). In a study with survivors of a large fire, the levels of psychological distress were the same for both physical and emotional trauma despite the wounds from physical trauma being more easily identified (Schneider et al., 2012).

Emotional trauma can occur with individuals who are members of oppressed groups. Szymanski and Balsam (2011) used the term *insidious trauma* to describe the trauma sustained from belonging to a marginalized group. Their argument is that common diagnostic procedures for identifying posttraumatic symptoms focus on the threat of physical injury minimizing the impact of emotional injury. Within mental health settings, the impact of the type of subtle and pervasive trauma which minority groups, like LGB communities, experience is often underestimated (Szymanski & Balsam, 2011). While there is little research pertaining directly to the impact of homophobia-related trauma on LGB communities there is substantial research available on the general effects of trauma on the individual.

**Effects of trauma.** Rosenberg (2000) provided a concise and comprehensive outline of the fundamental effects of trauma which will now be discussed to demonstrate the wide-ranging and dynamic effects of trauma. His research on the existing trauma literature indicated that a primary effect of trauma on the individual is a sense of helplessness. An individual who experiences a traumatic event has no sense of control over the situation which disrupts the instinctual response to fight or flee from the situation. Losing a sense of personal control over the traumatic event can lead to feelings of shock and horror (Rosenberg, 2000). Feelings of helplessness often elicit a wide variety of behavioral responses. Someone who has experienced trauma may engage in compulsive behaviors or inhibitive behaviors, such as avoiding places which remind the individual of the traumatic event or avoiding intimacy for fear of retraumatization (Carbone, 2008; Rosenberg, 2000). Helplessness can also be expressed through emotional numbing, startle reactions, and flashbacks of the event (Carbone, 2008; Rivers, 2004; Rosenberg, 2000). Individuals who have experienced helplessness as a result of trauma often become hypervigilant and face sleep disturbances, physical illness, muscular tension, and sexual

dysfunction (Rosenberg, 2000). Some individuals have abused substances as a way to self-medicate against the disruptive effects of helplessness (Birkett, Espelage, & Koenig, 2009).

The second group of fundamental effects of trauma which Rosenberg (2000) describes pertain to an imbalance of awareness and feelings of dissociation. Because information processing is impacted by the traumatic experiences, some individuals will experience a blunting of awareness, similar to emotional numbing, while others will experience increased alertness, often associated with hypervigilance (Rosenberg, 2000). Awareness is also affected when the individual re-experiences the trauma in flashbacks or nightmares (Rivers 2004). The second effect in this group, dissociation, is the term for the detachment from a sense of reality that is experienced by victims of trauma. The detachment is felt through experiences of derealization and depersonalization (Rosenberg, 2000). The sense of separation or detachment often associated with dissociation can extend into an individual's interpersonal relationships which isolates the individual from others (Carbone, 2008; Hertzmann, 2011; Rosenberg, 2000).

Shattered meanings and cognitive distortions make up Rosenberg's (2000) third group of essential effects of a trauma. Individuals affected by trauma face an existential crisis as previously held assumptions about the world being a kind and predictable place are broken and perceptions about good and evil are upended (Rosenberg, 2000). Assumptions about others being trustworthy and the self being worthy can also be shattered following certain traumatic events, such as abuse or sexual assault (Kaysen, Lostutter, & Goines, 2005; Rosenberg, 2000). In the process of renegotiating their perspectives on the world around them, trauma survivors become disillusioned and struggle to find purpose and a sense of security (Rosenberg, 2000). Some individuals going through these processes begin to label themselves as "bad" and can begin to lose touch with their core selves (Rosenberg, 2000; Wright & Wegner, 2012).

The final group of effects of traumatic experiences, as outlined by Rosenberg (2000), is referred to as relationship disturbances and repetition compulsion. Traumatic experiences which transpire during early development disrupt the individual's attachment to others, which is recreated in strained relationships throughout the lifespan (Rosenberg, 2000). In situations of sexual abuse, some individuals engage in compulsive sexual behaviors and obsessions (Carbone 2008; Rosenberg, 2000). Having examined the broad range of effects which trauma can have on individuals the focus will now shift to traumatic experiences involving peer victimization.

**Peer victimization.** Homophobia-related trauma often involves an individual's interactions with others. Therefore, it is critical to understand the processes of peer victimization and how they impact the individual experience. Peer victimization is identified as direct and indirect aggressive behaviors among children and adolescents which can be verbal, physical, sexual, or relational (Collier, van Beusekom, Bos, & Sandfort, 2013). The focus of the current work is to identify the long-term effects of homophobia-related trauma, therefore the literature review will cover experiences with trauma pertaining to developmental periods past adolescence. However, the research indicates that the effects of trauma experienced before adulthood are particularly powerful and enduring which indicates the need to understand how trauma is experienced during early developmental stages (Almeida et al., 2009; Carbone, 2008). Verbal victimization, the most commonly researched form of peer victimization, incorporates name-calling, teasing, and verbal threats of physical harm (Collier et al., 2013). Physical victimization occurs when an individual is beaten, threatened with a weapon, followed, or has property robbed or destroyed. Sexual victimization includes rape, sexual assault, sexual abuse, and sexual jokes, gestures, and remarks. The aforementioned forms of peer victimization are viewed as direct actions towards an individual (Collier et al., 2013).

Indirect forms of peer victimization include relational victimization, which is characterized by being shunned by others (Collier et al., 2013). Other indirect forms of peer victimization include spreading hurtful rumors about an individual and cyberbullying. Cyberbullying is the term for any bullying, teasing, or threats spread through electronic communications (Collier et al., 2013).

**Peer victimization related to sexual orientation.** Peer victimization related to sexual orientation is a common experience for LGB adolescents. Examples of this type of victimization include being labeled with homophobic epithets, tormented, or threatened with physical violence because of the individual's sexual orientation (D'Augelli, Grossman, & Starks, 2006). In a pioneering study performed by Pilkington and D'Augelli (1995), 83% of their LGB adolescent participants reported having been victimized because of their sexual orientation. LGB adolescents are often in hostile and invalidating environments where they experience prejudice and discrimination (Crowley, Harré, & Lunt, 2007). For many of these adolescents, there are few social supports or resources to address their experiences with peer victimization. Bullying related to sexual orientation is especially difficult for the victims to endure and can lead to more critical effects due to the lack of supports (Crowley et al., 2007).

There is a higher prevalence of peer victimization for individuals from LGB communities than for their heterosexual peers (Kessel Schneider, O'Donnell, Stueve, & Coulter, 2012). In Kessel Schneider's 2012 survey of Boston high schools, 42.3% of LGB participants reported having been bullied as opposed to 24.8% of the heterosexual participants. Additionally, 33.1% of their LGB participants reported having been cyberbullied while only 14.5% of the heterosexual participants stated that they had been the victims of cyberbullying. Of additional interest, participants who experienced both direct peer victimization and cyberbullying expressed greater

psychological distress and were more likely to engage in self-injury, report suicidal ideation, and attempt suicide (Kessel Schneider et al., 2012). The research indicating the greater prevalence and impact of peer victimization on LGB populations raises the question of what additional factor or factors are present that are responsible for these differences.

### **Sexual Stigma**

At the heart of peer victimization related to sexual orientation is the broad concept of sexual stigma, which includes both homophobia and heterosexism. Herek and colleagues (2009) outlined a comprehensive framework for conceptualizing sexual stigma which synthesized the existing research on the topic. Sexual stigma is composed of different types, such as structural stigma, enacted stigma, felt stigma, and internalized stigma. “The term *sexual stigma* is used to refer broadly to the negative regard, inferior status, and relative powerlessness that society collectively accords anyone associated with non-heterosexual behaviors, identity, relationships, or communities” (Herek et al., 2009, p. 33). Sexual stigma is established within society through heterosexism and homophobia (Wong & Poon, 2013). These concepts are manifested collectively using heterosexual behaviors and identities as the ideal and relegating non-heterosexual traits and behaviors to an undesirable status (Wong & Poon, 2013). Sexual stigma is fundamentally built upon collective knowledge and action (Herek et al., 2009; Wong & Poon, 2013). Members of the society accept both that homosexuality is degraded and that as a result individuals within LGB communities will experience hostility and marginalization (Herek et al., 2009). The concepts of heterosexism and homophobia provide insight into how sexual stigma is propagated within a society.

**Heterosexism.** Heterosexism shapes the environment in which homophobia takes place. Heterosexism is the structural form of sexual stigma and pervades the institutional constructs that

marginalize LGB people (D'Anna et al., 2012; Herek et al., 2009). This form of structural discrimination refers to the policies and social structures which regulate who receives what treatment or services within a society (D'Anna et al., 2012). Recognizing heterosexism as a form of structural discrimination differentiates it from the specific acts of homophobia against LGB individuals by acknowledging how prejudice and bias are woven into societal values and arrangements (Herek et al., 2009). Heterosexism rests on the presumption that all people are heterosexual. Such a concept marginalizes members of LGB communities because they do not receive recognition within society's laws, organizations, and institutions. When LGB populations are addressed, they are viewed as deviant and unnatural. This allows for prejudicial and discriminatory treatment. State laws banning same-sex marriage and the military's former "Don't Ask, Don't Tell" policy are prime examples of heterosexism within the United States (Herek et al., 2009).

Due to heterosexism, LGB individuals experience unrelenting microaggressions, small insults aimed at minority populations through verbal, behavioral, or environmental signals (Brown & Pantalone, 2011). These insults can be automatic and unconsciously imparted by an individual (Wright & Wegner, 2012). Examples of environmental microaggressions include the denial of LGB civil rights and anti-gay messages from various religious organizations (Brown & Pantalone, 2011). Similar to the indirect and direct forms of peer victimization, heterosexism is an indirect form of sexual stigma while homophobia is a direct form of sexual stigma.

**Homophobia.** Homophobia is the active expression of the internalized cultural values associated with sexual stigma and heterosexism (Herek et al., 2009). Often homophobia is conveyed within interpersonal interactions making it enacted sexual stigma as opposed to heterosexism's structural sexual stigma (Herek et al., 2009). The interpersonal discrimination

associated with homophobia involves both the actions taken toward an individual and the perceptions of those actions by the targeted person (D'Anna et al., 2012). Interpersonal discrimination incorporates the aforementioned verbal or physical behaviors associated with peer victimization and is intended to marginalize others for belonging to stigmatized groups (D'Anna et al., 2012).

Homophobia is a broad issue that affects all members of a society. For example, heterosexuals can be victims of homophobia (Herek et al., 2009). Simply the perception that an individual is non-heterosexual can initiate homophobic victimization. Likewise, members of LGB communities can perpetuate sexual stigma by enacting homophobic behaviors towards others (Herek et al., 2009). Recognizing that heterosexual and non-heterosexual individuals can be both perpetrators and victims of homophobic victimization reinforces the collective nature of heterosexist values and norms highlighting the pervasiveness of the problem.

The use of the word phobia within homophobia has led to some confusion about what the construct is and how it is experienced (Murphy, 2006). Homophobia differs from other phobias in that phobic people will not typically degrade or attack the objects of their phobia and instead will tend to avoid or flee from them. Homophobia has instead been described as the possession of irrational negative attitudes towards LGB people. One potential reason for this is that homophobia is often a shared attitude reinforced by like-minded individuals and heterosexist cultural structures. In some cases homophobia will be expressed through premeditated violence (Murphy, 2006). Homophobia can also be acted out through subtle methods. A study exploring homophobic microaggressions with participants from LGB communities reported that each of the participants identified having experienced microaggressions on a continual basis (Nadal, Wong, Issa, Meterko, Leon, & Wideman, 2010). The participants shared that many of the

microaggressions were intentional and obvious with some instances occurring within their family units (Nadal et al., 2010). Structural stigma, heterosexism, and enacted stigma, homophobia, describe the processes by which sexual stigma is externalized through environmental conditions and interpersonal behaviors. To begin to address how experiences with homophobia become traumatic for individuals within LGB communities, the literature review will now focus on how the events are internalized by those who experience the victimization.

**Self-Stigma.** Societal values condemning homosexuality exert pressures on individuals to conform to heterosexual standards (Herek et al., 2009). Heterosexism and homophobia become the methods by which anti-homosexual values are enforced. Individuals, both heterosexual and non-heterosexual, often internalize sexual stigma and alter their behaviors accordingly. Felt stigma and internalized stigma are both manifestations of self-stigma (Herek et al., 2009). Felt stigma refers to the self-monitoring and deliberate self-presentation that both heterosexuals and non-heterosexuals engage in to avoid being labeled as a sexual minority. Consequences of felt stigma include a restricted range of behavioral and emotional expressions. Examples include engaging in homophobic acts and limited closeness with others for fear of being labeled with a sexual minority identity. For LGB people another consequence of felt stigma is the concealment of their sexual minority identities which often results in social isolation (Herek et al., 2009).

Internalized stigma also affects both heterosexual and non-heterosexual individuals and is described as a personal acceptance of heterosexist and homophobic ideas and values (Herek et al., 2009). Sexual prejudice endorsed by heterosexuals is an example of internalized stigma. Enacted sexual prejudice, homophobia, reinforces the systems of sexual stigma and strengthens its power to discourage individuals from accepting non-heterosexual behavior. For LGB people

the process of internalizing sexual stigma is expressed in both internal and external thoughts and behaviors (Herek et al., 2009).

Individuals from LGB communities internalize sexual stigma by harboring negative attitudes towards themselves and their sexual orientations (Herek et al., 2009; Newcomb & Mustanski, 2010; Szymanski & Gupta, 2009). One of the most pronounced ways in which homophobia-related trauma impacts the self-concept is through the process of developing internalized homophobia (IH) (Newcomb & Mustanski, 2010). IH is the acceptance and integration of society's homophobic and heterosexist attitudes into the self-concept (Newcomb & Mustanski, 2010). Some of the consequences of IH include experiencing feelings of shame and worthlessness and developing a fractured self-concept (Herek et al., 2009; Szymanski & Gupta, 2009). Examples of outward expressions of internalized sexual stigma include harboring negative attitudes towards other sexual minority individuals. These examples can be seen in homophobic actions towards members of LGB communities by sexual minority individuals (Herek et al., 2009). It is notable that of LGB communities, bisexual men have reported the highest levels of self-stigma (Herek et al., 2009). Herek and his colleagues (2009) expressed the need for more research with bisexual men to explore why they present with greater self-stigma than other members of LGB communities. This idea is important for the literature review because stereotyping the experiences between LGB communities is another way that the specific needs of members within the groups are overlooked and heterosexism is perpetuated.

LGB individuals are born and raised into cultures where heterosexism and homophobia are the norm (Herek et al., 2009). "When an individual's internalized early objects are sadistic, cruel, self-attacking, or excessively harsh...societal stigma and anti-homosexual bias are incorporated into these negative introjects making the process of integration of one's homosexual

or bisexual orientation much more difficult and even fraught with danger” (Crespi, 2001, p. 78). These introjects, or the integration of sexual stigma into the self-concept, provide a basis for understanding how certain individuals are vulnerable to being greatly impacted by homophobia-related trauma.

### **Homophobia-Related Trauma**

There has been little research on the connections between experiences with homophobia and the psychological impact of trauma for the individuals who experience it (Dragowski, Halkitis, Grossman, & D’Augelli, 2011). Further, there is a dearth of research on LGB issues within trauma studies. Brown and Pantalone (2011) noted that research on trauma and research with sexual minority communities have been separate from each other despite growing evidence of continuous trauma within the lives of LGB people. Other researchers argue that heterosexism is an overlooked form of trauma within the mental health fields (Hyman, 2009). It is also noted within the research that does exist on the impact of sexual stigma that many members of the sexual minority communities who report experiencing homophobic events present with clinical symptoms equivalent to those required for a diagnosis of Posttraumatic Stress Disorder (PTSD) (Brown & Pantalone, 2011). Understanding the impact of homophobia-related trauma on members of LGB communities would help in creating legislation, organizational policies, and therapeutic interventions to alleviate the deleterious effects of social stigma (Brown & Pantalone, 2011).

**Experiences of homophobia-related trauma.** Children grow up in a heterosexist society and experience homophobia beginning in elementary school (Dragowski et al., 2011). By age 12, most children have internalized the message that homosexuality is shameful and that heterosexuality is normal (Hyman, 2009). In a study exploring lifetime victimization based on

sexual orientation with LGB youth, victimization began at the average of 13 (D'Augelli et al., 2006). Of the participants, 80% reported receiving verbal attacks, as early as age 6, and 14% reported having been physically attacked, as early as age 8 (D'Augelli et al., 2006). Experiences with homophobic victimization are not specific to childhood and adolescence. In a study with gay and bisexual adult males, 72% of the sample had reported experiencing homophobic victimization within the past 6 months (Martin & Alessi, 2012). The results of these two studies suggest that homophobic-related trauma begins at a young age and continues into adulthood. This supports the idea that LGB individuals experience cumulative trauma throughout the lifespan.

**Contexts.** Pilkington and D'Augelli's aforementioned 1995 study provides a foundational overview of the different contexts in which LGB individuals experience homophobia-related trauma. In their study, no context in an LGB adolescent's life was free of the risk of encountering homophobia-related trauma (Pilkington & D'Augelli, 1995). Homophobia-related trauma was identified across studies as commonly occurring within family settings (Crowley et al., 2007; Graziano & Wagner, 2011; Pilkington & D'Augelli, 1995; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Verbal victimization by a family member was reported from 36% of Pilkington and D'Augelli's (1995) sample and 10% reported having been physically victimized by a family member. In a study with lesbian and bisexual females, the researchers noted that LGB individuals experience parental rejection at greater frequencies than heterosexuals (Graziano & Wagner, 2011). It was more common for lesbians to be threatened and physically attacked after disclosing their sexual orientation to their families. Within the study, mothers were identified as being the perpetrators of the homophobic victimization (Graziano & Wagner, 2011). Graziano and Wagner's findings stand apart from the findings of

other researchers examining homophobia-related physical victimization. Typically physical attackers are male, which is indicative of the hetero-normative male behavior of aggression as a response to the disruption of traditional sex roles (D'Augelli et al., 2006). Most of the research claims that men are more likely to experience overall victimization than women regardless of the context (D'Augelli et al., 2006; McDaniel, Purcell, & D'Augelli, 2001).

Schools are one of the most common environments where LGB adolescents will experience homophobia-related trauma (Chesir-Teran & Hughes, 2008; Crowley et al., 2007; Ryan et al., 2010). The developmental challenges and changes during adolescence are stressful for the majority of teenagers, but LGB youth's developmental challenges are confounded by the homophobic insults and behaviors they encounter in school (Espelage, Aragon, Birkett, & Koenig, 2008; Hyman, 2009). In Pilkington and D'Augelli's (1995) study, 22% of the male participants and 29% of the female participants reported having been physically attacked by another person at school because of their sexual minority status. The invalidating school environments do not seem to have improved greatly since 1995. In a 2011 national school climate survey, almost one-fifth of LGB youth reported that they had been physically assaulted because of their sexual orientations (Gay, Lesbian, and Straight Education Network as reported by Panfil, 2013). During the school years, hearing comments such as "that's gay," "faggot," or "dyke" becomes a common experience for LGB adolescents (Hyman, 2009; Panfil, 2013).

Places of employment provide another context in which LGB individuals experience homophobia-related trauma (Pilkington & D'Augelli, 1995). According to Pilkington and D'Augelli's (1995) study, 35% of the participants indicated that they were "extremely troubled" by the idea of disclosing their sexual orientation to their employers and co-workers. Few participants also reported having actually been physically attacked at their places of employment

(Pilkington & D'Augelli, 1995). The low number of participants who reported having experienced physical victimization on the job suggests that in the workplace homophobia may be indirect or subtle.

Another context for homophobia-related trauma occurs within local communities (Pilkington & D'Augelli, 1995). In 2011, law enforcement agencies reported a total of 1,508 hate crime offenses which had been directed towards sexual minority individuals (Federal Bureau of Investigation, 2012). Due to their marginalized status, individuals within LGB communities who become victims to hate crimes are often disenfranchised from the legal system and may not feel empowered to take legal action against the perpetrators (Kaysen et al., 2005). Another way that LGB individuals may experience homophobia-related trauma within their communities is from proposed legislation which would further strip them of their rights. A study was conducted to investigate the long-term impact of anti-LGB politics on members of LGB communities (Russell, Bohan, McCarroll, & Smith, 2011). The study focused on the campaigning for and passage of Colorado's Amendment 2 which prohibited legal recourse for LGB individuals who experienced homophobic or heterosexist discrimination. LGB participants reported having experienced PTSD, anxiety, and depression as a result of the passage of the amendment. For many of the participants, the effects were felt even over 10 years after the amendment had been repealed (Russell et al., 2011a).

Belonging to the global community also provides opportunities for LGB individuals to experience homophobia-related trauma (Brice, 2011; Reading & Rubin, 2011). For example, homosexuality is discouraged in many countries with 76 outlawing consensual same-sex relations (Reading & Rubin, 2011). Many cultural values systems and dominant religions also forbid or discourage homosexuality (Reading & Rubin, 2011). As of May 2010, individuals who

engage in homosexual acts can face the death penalty in five countries (Brice, 2011). As emphasized in this section, homophobia-related trauma can be experienced in an individual's personal contexts and in broader, global contexts.

### **Effects of Homophobia-Related Trauma**

Experiencing homophobia-related trauma can lead to profound effects on LGB individuals' mental health, behaviors, and self-concepts. The traumatic events threaten beliefs about the safety of the world around them and their own beliefs that they are good and whole leaving feelings of fear and shame in their place (Rosenberg, 2000). Meyer (2013) proposed using a minority stress model when attempting to understand the issues facing many within LGB communities. Minority stress model with LGB communities postulates that alienation from the heterosexist culture elicits a sense of anomie within sexual minority individuals who already face the non-LGB-specific life stressors of their cultures. The additional stress of living in a society whose norms and values often conflict with the experience of being a sexual minority then increases the chances of experiencing psychological distress and negative mental health outcomes (Meyer, 2013).

**Mental health outcomes.** In one of the earliest studies conducted to explore the effects of antigay crimes, Herek, Gillis, Cogan, and Glunt (1997) collected questionnaires from LGB participants. Of the participants, 77% of the women and 88% of the men reported having had experienced victimization due to their sexual orientation since the age of 16, and half the sample reported experiencing verbal harassment within the past year. For the groups who had been victimized, the researchers reported significantly higher rates of PTSD symptoms, depressive symptoms, and anxiety. Groups who reported having experienced bias-related crimes also reported lower self-esteem and higher perceived vulnerability (Herek et al., 1997).

*PTSD.* Experiences with PTSD are recognized across trauma research as a common mental health outcome from having experienced traumatic events. Therefore, PTSD and its connection to having experienced homophobic events will be explored to provide support for the argument that homophobia can be traumatic for LGB men and women. Some researchers have attempted to address the gap in trauma work which does not always acknowledge the cumulative trauma of homophobia and heterosexism when providing diagnostic criteria for PTSD. Symptoms of PTSD were commonly reported throughout the existing literature on the mental health effects of homophobic victimization (Carbone, 2008; D'Augelli et al., 2006; Dragowski et al., 2011; Szymanski & Balsam, 2011). Symptoms of PTSD include re-experiencing the traumatic event, flashbacks, nightmares, memory disturbances, avoiding stimuli associated with the trauma, social withdrawal, insomnia, startle responses, and vigilance (American Psychiatric Association, 2000).

Many studies have explored the impact of homophobia on LGB adolescents (D'Augelli et al., 2006; Dragowski et al., 2011; Pilkington & D'Augelli, 1995; Ryan et al., 2010). In one such study, LGB youth had reported experiencing posttraumatic stress symptoms using the Trauma Symptoms Checklist. Results indicated that homophobic victimization was a greater predictor of PTSD symptoms than other variables, which included childhood gender atypicality, internalized homophobia, and stressful life events unrelated to sexual orientation (Dragowski et al., 2011). While gender atypicality is second to homophobic victimization in the development of PTSD symptoms, individuals who are gender atypical in childhood are more likely to experience PTSD (D'Augelli et al., 2006). Perceived negative peer and parental responses to atypical gender presentations have been identified as a major contributing factor to the development of PTSD. Researchers have stressed the importance of gender role expression in the development and

adjustment of LGB youth (D'Augelli et al., 2006). The aforementioned research in this section has primarily focused on adolescents which is indicative of the lack of research on the long-term effects of homophobia-related trauma.

Few studies have examined the prevalence of PTSD symptoms across the lifespan for LGB men and women (Carbone, 2008; Rivers, 2004; Szymanski & Balsam, 2011). Carbone (2008) conducted a study with adult gay men who had experienced ridicule and ostracism due to their sexual orientation during childhood and adolescence. The researcher noted that the effects of the trauma were expressed in the participants' adult lives through heightened social anxiety and self-destructive coping strategies. In his study the men all met the criteria for a PTSD diagnosis (Carbone, 2008). Studies with lesbians have also demonstrated a connection between homophobic victimization and PTSD. A sample of adult lesbians had reported experience with homophobic hate crimes and heterosexist discrimination. Results indicated that for the sample recent sexual-orientation-based hate crimes and recent heterosexist discrimination were both significantly positively correlated with symptoms of PTSD (Szymanski & Balsam, 2011). Together, these two studies indicate that PTSD affects both non-heterosexual men and women. This suggests that symptoms of PTSD are present following experiences with homophobia-related trauma throughout LGB communities. Rivers' (2004) study with LGB participants supports this claim. LGB adults reported experiencing intrusive memories and flashbacks of homophobic victimization which occurred during adolescence. Participants in this study also reported experiencing depressive symptoms (Rivers, 2004).

***Depression and suicide.*** Depression and suicidal ideation and attempts are common mental health outcomes for LGB individuals who have experienced homophobia-related trauma. LGB individuals who have experienced sexual orientation victimization are at a great risk for

suicide (Russell, Ryan, Toomey, Diaz, & Sanchez, 2011; Rutter, 2008a). Sexual minority youth experience higher levels of depressive symptoms, self-harm, and suicidal ideation than their heterosexual peers (Almeida et al., 2009). LGB adolescents and adults have reported increases in depressive symptoms as a result of homophobic victimization (Almeida et al., 2009; Josephson & Whiffen, 2007). For lesbian and bisexual female respondents, discrimination accounted for the increase in depressive symptoms but not for increases in self-harming behaviors or suicidal ideation (Almeida et al., 2009).

Depressive symptoms and suicidal ideation following homophobia-related trauma were reported across studies with LGB participants (House et al., 2011; Nadal et al., 2010; Russell et al., 2011b). Participant responses indicated that individuals who had experienced interpersonal trauma and discrimination based on sexual orientation were more likely to engage in both suicidal and non-suicidal self-injurious behaviors (House et al., 2011). Participants at the highest risk of engaging in self-harm and suicide attempts experienced both interpersonal trauma and homophobic discrimination (House et al., 2011). Experiences of victimization were also associated with lower levels of life satisfaction. LGB individuals who had experienced high levels of homophobic victimization also had increased odds of suicide attempts which required medical attention (Russell et al., 2011b). Responses from members of LGB communities have suggested that victimization does not have to be overt to generate symptoms of depression (Nadal et al., 2010). Nadal and colleagues' (2010) participants reported experiencing such symptoms as a result of homophobic microaggressions. Because microaggressions can be subtle, some LGB individuals suffer depressive symptoms as a result of exposure to them without recognizing the relationship between the microaggressions and their symptoms (Nadal et al., 2010).

**Anxiety.** Symptoms of anxiety are commonly reported by LGB individuals who had experienced homophobia-related traumatic events (Cramer, McNeil, Holley, Shumway, & Boccillari, 2012; Nadal et al., 2010; Pilkington & D'Augelli, 1995). The sexual orientation of the victims of violent crime appears to be related to the severity of anxiety symptoms (Cramer et al., 2012). Rates of anti-LGB crimes increased over the last decade. LGB individuals are at greater risk of being sexually assaulted than heterosexuals and when compared to heterosexual victims of violent crimes, sexual minority victims report higher anxiety symptoms and acute stress symptoms. Additionally, sexual minority relational assault victims reported more panic symptoms than the other violent assault victims. While, heterosexual participants who had experienced low levels of trauma reported significantly fewer anxiety symptoms than heterosexual participants with high levels of trauma, LGB respondents reported equivalent anxiety symptoms regardless of the severity of the trauma they had experienced (Cramer et al., 2012).

**Behavioral effects.** Mental health outcomes are not the only ways in which the effects of homophobia-related trauma are manifested by the sexual minority individuals who experience it. LGB individuals who have encountered victimization due to their sexual orientation exhibit behavioral effects as well. Some of these behavioral effects include risky behaviors, such as substance use, criminal activity, violence, and high-risk sexual practices (Birkett et al., 2009; Carbone, 2008; Graziano & Wagner, 2011; Tigert, 2008). LGB individuals who reported having experienced homophobia-related trauma reported higher frequencies of alcohol and marijuana use than heterosexual peers who had also experienced homophobic peer victimization (Birkett et al., 2009). Graziano and Wagner (2011) noted the connection between experiences with

homophobia-related trauma and an increased risk for justice system involvement in their review of lesbian and bisexual female youth's interactions with the juvenile justice system.

In terms of violent behaviors, just like heterosexual couples, same-sex couples experience domestic abuse (Tigert, 2008). Research exploring the nature of abuse within lesbian relationships indicates that incidents of intimate partner violence were reenactments of experiences with homophobia-related trauma, cultural oppression, and shame. Tigert (2008) argues that oppression is a violent act and that violence is traumatizing to individuals. Individuals who have yet to heal from the pain of the homophobic oppression may act-out the patterns of violence they have experienced within their intimate relationships (Tigert, 2008).

Behavioral effects of homophobia-related trauma are often associated feelings of shame (Herek et al., 2009; Szymanski & Balsam, 2011). The shame of having experienced homophobic and heterosexist victimization can alter the ways in which LGB individuals socialize with others (Wong & Poon, 2013). Traumatized individuals often distance themselves from close relationships and experience social isolation (Wong & Poon, 2013). Josephson and Whiffen (2007) identified that many LGB individuals react to homophobic victimization by developing unassertive and submissive interpersonal behaviors. A pattern of unassertive behaviors with others placed LGB individuals at risk for encountering further harassment. These patterns of hostile interactions experienced by unassertive individuals within LGB communities are related to the development of the aforementioned depressive symptoms (Josephson & Whiffen, 2007).

Many LGB individuals who have experienced homophobia-related trauma choose to keep their sexual orientations concealed (Schrimshaw, Siegel, Downing, & Parsons, 2013). Bisexual men unwilling to disclose their sexual orientations with others experienced greater negative mental health outcomes. The act of keeping their sexual orientations a secret provided an

additional stressor in the already stressful lives of the bisexual male participants in Schrimshaw and colleagues' (2013) study. Conversely, participants who had disclosed their sexual orientations to friends and family did not have any significant negative mental health outcomes related to the disclosure (Schrimshaw et al., 2013). This finding suggests that concealing behaviors actually worsens the negative mental health outcomes experienced by individuals in LGB communities who have experienced homophobia-related trauma.

**Self-concept and sexual minority identity.** Homophobia-related trauma has a lasting impact on LGB individuals' self-concepts (D'Augelli et al., 2006; Russell et al., 2011b). In a case study with a man who had experienced assault due to his sexual orientation, he described the incident as an assault to his identity (Kaysen et al., 2005). Homophobic victimization and microaggressions have been associated with low self-esteem (Russell et al., 2011b; Wright & Wegner, 2012). LGB individuals who have experienced current and past homophobic microaggressions reported having greater difficulties surrounding the development of their sexual minority identities (Wright & Wegner, 2012).

**Internalized Homophobia.** One outcome of having experienced homophobia-related trauma is the development of negative feelings towards homosexuality which then are integrated into the self-concept (Carbone, 2008; Herek et al., 2009; Newcomb & Mustanski, 2010; Szymanski & Gupta, 2009). This process describes how an individual develops the previously defined internalized homophobia (IH). IH is closely connected to the feelings of shame which many who have experienced homophobic victimization develop (Tigert, 2008). IH is not solely related to LGB individual's view of his or her own sexual orientation but is generalized negative attitude towards homosexuality (Newcomb & Mustanski, 2010). Individuals who have developed attitudes of IH are less comfortable disclosing their sexual orientation to others, may distance

themselves from other LGB individuals, and become uncomfortable with same-sex sexual activity (Newcomb & Mustanski, 2010).

Individuals with IH demonstrate greater self-conflict, self-blame, and lower levels of self-respect when compared to individuals who have not internalized homophobic and heterosexist attitudes (Newcomb & Mustanski, 2010). Newcomb and Mustanski (2010) state that IH may lead those who have been victimized to identify with the aggressor. IH can also jeopardize the creation and sustaining of a satisfying same-sex relationship (Hertzmann, 2011). For some, the negative attitudes surrounding homosexuality and the self are triggered by homosexual desires throughout the lifespan which would make establishing an intimate relationship with a prospective partner challenging (Carbone, 2008).

Multiple internalized oppressions can affect an LGB individual's reactions to homophobia-related trauma if they also belong to another minority group (Szymanski & Gupta, 2009). African-American individuals who identified as LGB participated in a study which measured the constructs of internalized racism (IR), IH, self-esteem, and psychological distress. The participants' responses indicated that IR and IH were both independently significant negative predictors of self-esteem. In terms of psychological distress, only IH was indicated as a positive predictor. The actual interaction of IR and IH did not significantly predict self-esteem or psychological distress (Szymanski & Gupta, 2009). Szymanski and Gupta's (2009) study was one of the few studies to have explored the multicultural differences within LGB communities which highlights an additional weakness of the existing literature pertaining to homophobia-related trauma. This section has primarily addressed potential negative outcomes of having experienced homophobia-related trauma for LGB individuals. It is important to mention that not all outcomes of homophobic peer victimization are negative.

### **Coping with Homophobia-Related Trauma**

Often it is the way individuals cope with the trauma paired with the protective factors in their lives that determine what effects homophobia-related trauma will have on members of LGB communities. In the above section, concealment of sexual orientation and substance use were identified as negative coping strategies to address homophobia-related trauma (Birkett et al., 2009; Schrimshaw et al., 2013). Pilkington and D'Augelli (1995) report that LGB youth will also verbally confront the perpetrator, fight back against the aggressor, and modify their behavior to avoid further victimization. Panfil (2013) conducted a study with gay men who chose to fight back against the victimization. Participants reported that they would fight back to prevent future victimization and to establish a reputation that would discourage other potential victimizers from targeting them. Intervention from the law, a lack of consistent social supports, and the presence of risk factors for violence combined with homophobic victimization which maligned essential features of the gay men's identity influenced the participants' decisions to use violence to resolve the conflicts (Panfil, 2013). The coping strategies identified above in this lead to other potential consequences for the individuals who engage in them.

Research has also identified effective coping strategies employed by LGB individuals who have experienced homophobia-related trauma. Madsen and Green (2012) performed a qualitative study with adolescent gay men who had experiences with homophobic discrimination and victimization to assess what effective coping strategies the participants used. Participants identified one group of coping strategies that utilized actions and behaviors. These strategies included participation in activism to promote equality for LGB populations, pursuing distracting activities, addressing the perpetrator of the homophobic victimization, and seeking out support from someone else in LGB communities or from a partner. The participants identified another

group of coping strategies that dealt with the thoughts and emotions they experienced after the incidents of victimization. Discounting the source of the victimization was one of the coping mechanisms utilized in this group along with analyzing the event for severity and personal relevance, regulated the immediate emotional reaction in context of the situation, and engaging in positive thinking that things will improve. Participants shared two other coping strategies that did not fit into a category which were seeking support from authorities and seeking out LGB-affirming media (Madsen & Green, 2012). The two major reviewed in this section explored the coping strategies of gay men. The inclusion of all three LGB communities is inconsistent across studies included in this literature review. This makes generalizing research findings to all sexual minorities challenging and highlights the importance of conducting more inclusive research to investigate the similarities and differences between communities.

### **Protective Factors**

Protective factors which lessen the impact of homophobia-related trauma are important to consider when exploring the effects of homophobia-related trauma on LGB men and women. Much of the available research on the impact of homophobic victimization with LGB communities has overlooked protective factors and how they help defend individuals from negative outcomes (Espelage et al., 2008). The available research which does explore the protective factors which aid LGB individuals in coping with the experiences with homophobia-related trauma indicates a wide-array of factors which shield people from potential negative outcomes (Espelage et al., 2008; Josephson & Whiffen, 2007; Smith & Gray, 2009; Szymanski & Balsam, 2011). Social support has been identified as an important protective factor against the negative outcomes of homophobic victimization (Josephson & Whiffen, 2007; Rutter 2008b; Ryan et al., 2010). Social support has been identified as an alleviating factor against feelings of

hopelessness and suicidal ideation for LGB individuals who have experienced victimization (Rutter 2008b). Support networks can have a positive impact on LGB individuals' development of healthy self-concepts (Carbone, 2008).

In particular, family support has been linked to greater positive outcomes following exposure to anti-homosexual events (Josephson & Whiffen, 2007; Ryan et al., 2010). LGB individuals with family support reported higher levels of self-esteem, social support, and general health (Ryan et al., 2010). Family support was also identified as a protective factor against depression and suicidal ideation and attempts for LGB adolescents who had experienced homophobia-related trauma (Espelage et al., 2008; Ryan et al., 2010). LGB individuals who had strong family support also reported less substance use when coping with homophobic victimization (Espelage et al., 2008). Conversely, parental rejection has been associated with an increase in high-risk sexual behaviors among LGB adolescents (Ryan et al., 2010).

Having high levels of self-acceptance and self-esteem are identified as additional factors which protect individuals from homophobic victimization (Josephson & Whiffen, 2007; Szymanski & Balsam, 2011). Both concepts are broad enough to warrant further investigation into what factors support a person's development self-acceptance or self-esteem. Personal hardiness is one construct which has been studied in relation to LGB individuals' responses to homophobic victimization (Smith & Gray, 2009). Personal hardiness refers to an individual's traits which aid them in persevering through adverse situations, sustaining beliefs in a benevolent world, and maintaining the ability to not be immobilized by setbacks (Smith & Gray, 2009). Specific to situations involving heterosexism and homophobia, personal hardiness allows LGB individuals to challenge and dispute homophobic messages instead of internalizing them and encourages resilience through incidences of victimization (Smith & Gray, 2009). Smith and Gray

(2009) developed a 'Courage to Challenge' scale which measures LGB individuals' levels of personal hardiness.

Personal hardiness may also shed light on why some LGB individuals who experience some of the negative mental health outcomes of homophobia-related trauma recover from them more quickly than others. Rivers (2004) noted that the participants in his study who experienced PTSD symptoms were more accepting of their sexual orientations than participants who did not present with those symptoms. The researcher hypothesized that for some, bullying may actually push people to develop a stronger sense of self-acceptance (Rivers, 2004). An individual's acceptance of their LGB identity, personality type, the context of the victimization, and the individual's personal history all play a role in how an individual copes with homophobia-related trauma (Nadal et al., 2010).

Another identified protective factor for LGB individuals who have experienced homophobic victimization is having safe spaces to go to (Crowley et al., 2007; Zubernis, Snyder, & McCoy, 2011). LGB adolescents reported that having a safe space to express themselves was highly important when coping with homophobia and developing a sexual minority identity (Crowley et al., 2007). Within the setting of a LGB specific summer school, participants reported that they had the opportunity to be equals with their classmates and discuss issues and topics relevant to their experiences (Crowley et al., 2007). Unfortunately, LGB individuals seeking therapeutic support to work through the effects of homophobia-related trauma often encounter barriers to treatment and in those cases the therapeutic settings themselves may become unsafe spaces.

### **Barriers to Therapeutic Support**

Individuals from LGB communities who have experienced homophobia-related trauma risk being re-traumatized when encountering discriminatory practices while seeking therapy. Heterosexism and homophobia have both been present in the history of psychoanalysis and the development of the mental health fields (Lewes, Young-Bruehl, Roughton, Magee, & Miller, 2008). Around the 1930's non-heterosexual orientations and behaviors began to be viewed as a pathological condition which was synonymous with perversion and was viewed as a borderline condition in published works of the time. Homosexuality was denied as a natural way of being and instead was attributed to maladaptive psychic development (Lewes et al., 2011). While homosexuality is no longer seen as a pathological condition within the mental health professions, some therapeutic techniques maintain a barrier to therapeutic support for individuals within LGB communities. Same-sex couples are hesitant to seek psychoanalysis for their relationship issues due to psychoanalytic theory's deterministic views on sexual orientation (Hertzmann, 2011). Hertzmann (2011) reports that same-sex couples found the use of the Oedipus complex when exploring homosexuality to be damaging to the therapeutic experience.

Despite LGB-affirmative practices receiving support from the major international professional organizations for the mental health fields, clients still encounter homophobia within counseling (Bowers, Minichiello, & Plummer, 2010; Willging, Salvador, & Kano, 2006). In one study, some counselors expressed uncertainty over how to work with LGB clients (Bowers et al., 2010). Anti-gay religious beliefs, attitudes, and behaviors have led to retraumatization for clients through both unintentional and intentional homophobic communications by the mental health practitioner (Bowers et al., 2010). Individuals from LGB communities seeking therapeutic support in rural settings are more likely to experience anti-LGB sentiments in the pursuit of support (Willging, Salvador, & Kano, 2006).

Some LGB individuals have sought support in changing their sexual orientation through what are termed “reparative” or “conversion” therapies (Jenkins, 2010). There have even been success stories although the scientific rigor within the studies which report the positive outcomes has been called into question (Jenkins, 2010). Reparative therapies have been linked to increased suicide risk for LGB clients and have been labeled unethical because homosexuality is not considered to be a disorder or an illness by any of the mental health professions (Jenkins, 2010). For victims of homophobia-related trauma who may already be at increased risk for suicide, reparative therapies pose a significant threat to their well-being. Despite present barriers to treatment, the research indicates that many individuals who have experienced homophobic victimization receive more overall health services, social support, and social services than individuals who not been victimized. This finding indicates a need for further research to bring awareness to the therapeutic needs of LGB communities (D’Anna et al., 2012).

### **Cultural Shifts**

Research on LGB individuals’ experiences with homophobia-related trauma will need to continue as societies across the globe continue to evolve in their perspectives on and treatment of homosexuality. As of December 1<sup>st</sup>, 2013, 16 states within the United States now allow same-sex couples to marry while Canada and the European Union are also increasing the freedoms and rights of LGB communities in their nations (Freedom to Marry, 2013; Brown & Pantalone, 2011). LGB individuals may now serve openly in the United States military and openly gay and lesbian politicians have been elected to government positions (Brown & Pantalone, 2011). In the United States, bullying has been receiving more attention at the same time that LGB communities are getting more widespread exposure (Collier et al., 2013).

Research on the impact of homophobia on individuals within LGB communities demonstrates that, for many, homophobic victimization is traumatic. The focus on the immediate impact of homophobia-related trauma within the research indicates a need for further research on the long-term outcomes of the experiences. Preliminary research on the long-term effects of homophobia-related trauma reveals that LGB men and women's adult lives continue to be affected. A clearer understanding of the long-term effects on LGB individuals' mental health outcomes and self-concepts will help to identify the therapeutic needs of sexual minority adults and reduce the barriers to mental health treatment. Inclusive research which incorporates all three LGB communities offers opportunities to explore the similarities and differences between the groups to identify additional factors which influence individual reactions to homophobia-related trauma. The ever-changing cultural landscapes underscores the need for future research on the effects of homophobia-related trauma to explore how the gradual attainment of civil rights and increasing societal acceptance influences LGB individuals' responses to homophobic victimization. Further research which includes a focus on the strengths, resilience, and coping strategies which LGB men and women bring to therapy will offer insight into how to create holistic and wellness-based interventions to better serve the populations' needs.

### **Method**

This study intends to explore how experiences with homophobia-related trauma impact the individual in the long-term. Due to the exploratory nature of the research question, participants partook in semi-structured interviews offering the opportunity for each participant to share experiences from his/her unique perspective. The investigator aimed to identify themes from participant responses related to how the homophobia-related trauma has continued to

impact their mental health, coping strategies, and strengths which may have developed in response to trauma.

### **Participants**

Participants were selected from a purposive sample of eligible clients at a community mental health clinic that serves diverse populations with a variety of presenting issues. By recruiting participants through a mental health clinic there was the chance to explore how participants' past experiences impacted their current treatment. Participants were recruited through their primary therapists. Criteria for eligibility in the study were that participants needed to identify as lesbian, gay, or bisexual and to have experienced homophobia-related trauma. Participants would not be included if they were deemed to be at an elevated risk for suicide, decompensating emotionally, or experiencing psychosis, to minimize the risk of retraumatization through the telling of their stories. Three participants were recruited including two gay men and one lesbian. Participants ranged in age from late 30's to early 50's. Saturation for the data was not reached but relevant themes did emerge.

### **Instrumentation**

An interview guide was developed to collect data from the semi-structured interviews (see Appendix A for complete interview guide). Questions were created with feedback from an experienced qualitative researcher and the managers at the community mental health clinic to focus on the issues central to the research question and to minimize potential risks. The interview guide contained questions pertaining to incidents of homophobia-related trauma, its immediate effects, how the individual has processed the experiences since the trauma, and what impact the experiences continue to have. The interview questions were supported by the literature review. The open-ended questions afforded the participants an opportunity to expand on the topics. The

final question of the interview solicited feedback from the participants on their comfort level after finishing the interview. The purpose of this question was to assess whether participation in the interview elicited any discomfort. Had any participants expressed having experienced increased discomfort following the interview, an appointment would have been arranged with the participant's primary therapist.

### **Procedures**

An empirical phenomenological research design was used to explore participants' experiences with homophobia-related trauma. Due to the dynamic and unique experiences each individual brought to the interview, the semi-structured interview opened the discussion for each participant to share his/her personal stories. More structured research designs may have restricted participant responses to set choices or pre-determined themes. The guided interview both honored each participant's subjective experience and created the opportunity for themes to emerge that may have not appeared in the literature review on the effects of homophobia-related trauma.

Recruitment for the study began with the researcher e-mailing the primary therapists who work within the community mental health clinic. The e-mail provided the therapists with the details of the study, criteria for participation, a copy of the informed consent, and a copy of the interview guide. The e-mail also informed the therapists that their clients could decide how they would prefer to be contacted if they were interested in participating. The researcher then shared the details of the study with the therapists at staff meetings and answered any questions that the therapists had about the study or who would qualify to participate. The therapists also informed participants that the interviews would be audiotaped, but that the participants had the option to

opt-out of the taping. The researcher contacted those who chose to participate to schedule the interview. The interviews were scheduled for sixty minutes.

The individual interviews were conducted in the researcher's office at the mental health clinic. The setting for the interview allowed for privacy and reinforced a sense of confidentiality for the participants in a welcoming environment. The researcher's role as the interviewer was to support the participants through the telling of their stories, using the interview guide to structure the discussion. The interviewer described the process of the interview to the participants and explained that the audio recordings would be kept in a locked file cabinet in the researcher's office and destroyed after the interviews had been transcribed. The interviewer reminded participants that they had the right to opt-out of being taped at any moment, and that they could also opt-out of the interview altogether without negative consequences to their treatment at the clinic. Participants were then instructed to read and sign the informed consent form, a permission to audiotape form, and a release for medical information per clinic policy regarding privacy of client's personal information (see Appendix B for the Informed Consent form). The interviewer reminded participants that confidentiality would be honored by not including their names or identifying information in the write-up of the research. At the conclusion of each interview the researcher offered each participant the opportunity to receive a copy of the transcribed interview or completed research study.

## **Results**

Following the guided interviews the author transcribed each audio recording. Using the transcriptions, participant responses were coded and condensed into categories to begin to identify how experiences with homophobia-related trauma impacted the participants in the long-term. Through this process, four major themes of effects of homophobia-related trauma emerged

including internalized homophobia, hypervigilance, wounded resilience, and seeking safe spaces. A research log was maintained to track the process by which the data were categorized and grouped into themes. This provided the researcher with a resource to observe connections and differences between participant responses. Themes that emerged after coding the interviews were internalized homophobia, hypervigilance, wounded resilience, and seeking safe spaces.

### **Internalized Homophobia**

All three participants described how their experiences with homophobia-related trauma continued to impact them through internalized homophobia (IH). Most responses regarding IH included how the trauma had a negative impact on the participants' self-concepts and identities. Participants described feelings of hopelessness and worthlessness and a sense of a crushed self-worth that would manifest in situations where their stigmatized sexual minority statuses were salient. Participants also shared that they have believed that there was something intrinsically wrong with them due to their sexual orientations and one participant described the feeling as that of being "subhuman."

One participant stated that he had internalized his mother's message that homosexuality is akin to bestiality and pedophilia. The participant reported that now that he has a son he sometimes worries about "damaging or warping" him. He stated that he has thought "I'm defective; I shouldn't be around children," and that he has found himself "wondering if I am a good dad or a good person." The participant stated that he grew up in a religious community, and that while he does not follow any particular faith he wonders whether or not he is passing down the "right morals" to his son. He shared that it took him many years to have a successful romantic relationship because he used to feel "icky" and "dirty" being in relationships due to the homophobia-related traumas that he had experienced, including rejection by his family.

Participants described an internal dialogue in which they perceived their sexual orientations as contributing to challenging situations. A participant shared that at a young age his first knowledge about what homosexuality was came from a now-dated medical book describing the orientation as aberrant sexual behavior and a disease of the mind. The participant shared that he currently faces medical issues and that he finds himself attributing his conditions to his sexual orientation, stating that “God hates my ilk” and questioning, “Is it because I’m a faggot? Bad things happen to bad people.” He also shared that when he has had positive opportunities he questions whether or not he deserves the good fortune and he wonders if being gay makes him weak of mind.

A participant stated that he finds himself questioning his worthiness as a result of having been victimized for his sexual orientation, even though he can question and rationalize the validity of the internal dialogue. He continued stating that he sometimes questions whether or not he deserves to live. One participant described the internal dialogue that he experiences as a result of IH as being a “self-imposed prison” and a “poison.” Another participant shared similar insight into how IH can perpetuate the trauma experienced in the past by stating “baggage becomes manufactured baggage.” The author notes that the male participants shared more negative self-talk than did the female participant.

All three participants shared that they have concealed their sexual orientations as a result of having experienced homophobia-related trauma and IH. One participant shared that during therapy she has even concealed her experiences of physical and sexual victimization due to the shame of having gone through them. She also shared that she has difficulty trusting others, including family and romantic partners, due to her experiences with IH. Another participant stated that, because he feels pressure to conceal his sexual orientation, he has experienced limited

closeness within friendships and has struggled in social situations trying to be aware of which pronouns he uses and what gender cues he is giving off. The third participant stated that he has missed important job opportunities due to concealing his sexual orientation. One participant stated that “‘I’m gay’ means rejection and loss.”

### **Hypervigilance**

Each of the participants shared experiences of continued hypervigilance regarding further traumatization. They each reported that they perceive homophobic messages being conveyed through microaggressions, cultural values, regional values, and certain religious institutions. One participant stated that she continues to experience verbal victimization when among certain family members or when she returns to her hometown in the south. She also reported having been present when an acquaintance was shot and killed in a homophobic hate crime. The participant expressed some relief in having moved to a northern state with less salient homophobic rhetoric but stated “I think the worries will always be there.” Another participant also reported experiencing continued verbal victimization from family members. He shared that the reinforcement of homophobic messages has made healing difficult and has contributed to his own internal dialogue of negative self-statements.

All of the participants shared that they still live in fear of further victimization. One participant stated that his reason for seeking therapy was to address PTSD symptoms, including flashbacks to experiences of relational victimization. The three participants all described a fear of their sexual orientation being exposed in invalidating environments. A participant cited examples of being fearful when seeking employment, starting a new job, or looking for housing. He stated that he has witnessed and experienced discrimination in each of those settings. The participants were each aware of hate crimes in the local area and perceived a lack of protection for LGB

communities. A participant related a story in which she and her partner were physically and sexually victimized by a group of men and, when the police arrived, she believed that she and her partner were more likely to be arrested than the perpetrators of the hate crimes. One participant mentioned a desire to increase support for LGB communities by strengthening local advocacy groups.

### **Wounded Resilience**

The participants explored ways in which they were resilient in the face of homophobia-related trauma. All three participants reported having acquired some strengths as a result of having experienced homophobia-related trauma. Participants shared coping strategies that they developed to either reprocess traumatic experiences or to work through continuing experiences with homophobia. The most common coping strategy shared was turning the tables on their victimizers. One participant stated that he was proud to have responded to homophobic insults with statements that increased awareness and that he believes that he has helped to change some minds. In addition he will turn the tables by “killing them with kindness” and neutralizing potential confrontations. Another participant shared turning the tables on a group of men who had been targeting LGB communities when the group she was with sent drag queens out to intimidate the men who in turn ran away.

The third participant stated that he had turned the tables on others by using humor, making the other person feel vulnerable, and gaining power in the exchange. Humor was used as a coping strategy by all three participants. They each shared that humor helped to reframe the memories of the trauma and bring light to otherwise painful experiences.

Discrediting the source was another commonly used coping strategy across participants. A participant whose siblings frequently verbally victimize him, stated that he looks at them as

people who have done little with their lives, and it takes some of the power away from their words and actions. Another participant said that she discredits the source by labeling her former victimizers “rednecks” and saying to herself, “Just because some assholes think one way does not make it fair or right.”

Participants shared that one of the reasons why homophobia-related trauma was painful was because of the reinforcement of traditional gender roles placed upon them by the larger society. Two of the participants stated that redefining gender roles and challenging social norms have been effective coping strategies for them. One participant stated that he was challenged by a father at his son’s soccer game for exposing his son to a “sick” lifestyle to which the participant replied, “Two dads are better than none.” Other coping strategies shared by the participants included accepting the limitations of others, detaching from situations, and reframing irrational beliefs.

Enhanced personal hardiness was consistent across participants. For one participant this was defined as “emotional self-reliance.” He stated that having gone through experiences with physical and verbal victimization he was more able to confront adverse situations without feeling as much of a need to reach out for support as he had when he initially experienced the trauma. Participants all expressed an increased ability to self-advocate and to speak up against homophobia. Therapy had been helpful in empowering all of them to start trusting themselves and others more. One participant shared that in the past he would conceal his relationship at work-related functions, but that he now expresses himself openly and does not use any hidden language to avoid discomfort. He stated, “This is the way I am. If you can’t accept it that’s your problem.” Another participant stated that she is beginning to learn how to focus on the positives in her experiences and not dwell on experiences where homophobia has negatively affected her.

She communicated that, despite recognizing that her past experiences will always have pain associated with them, she has a choice about how she views her current situations and makes decisions regarding them.

### **Seeking Safe Spaces**

Participants spoke at length about consciously seeking out safe spaces because of the homophobia-related trauma that they had experienced. One way that participants described doing this was in finding a chosen community. Participants shared having found support in local LGB communities when their own families or neighborhoods rejected them. Over time, participants stated that they have begun using social networking sites to maintain supports and reach out to others. All three participants stated that one of the most important protective factors they had while experiencing homophobia-related trauma was a connection with a “mentor,” typically an older person from the LGB community who offered support, advice, and a form of emotional protection. Participants all expressed a desire to be that person for others who may be currently experiencing victimization due to their sexual orientations. The participants described their chosen communities as being like families. One participant stated that he prefers to spend holidays with his chosen community and lean on them for support - “the phrase ‘blood is thicker than water’ is bullshit.”

Participants also reported having sought out safe spaces by finding validating environments. One participant stated that for years he feared finding employment because he was afraid of being “outed” and ridiculed for his sexual orientation. Finding employment in a welcoming and accepting company has helped him to heal and begin to move forward past some of the trauma he has been carrying. Two of the participants discussed finding gay bars to be accepting places where they were free to express themselves and also seek out companionship

and relationships without the fear of ostracization. All participants described therapy as a safe place to share. Even though one participant stated that she had not disclosed everything that she had experienced due to homophobia, she did state that therapy had helped her to regain some confidence and develop her strengths. Participants made some mentions about how recognizing the evolving culture and growing acceptance for the LGB communities has been affirming for them. One participant discussed how a study like this would not have been available for him to read when he was experiencing homophobia-related trauma. Another participant discussed how she felt validated and comforted as public figures have been open about their sexual orientation and have initiated a national dialogue about homosexuality.

Notably, two of the participants moved to western New York from southern states and mentioned how they have felt more freedom to be themselves after the move. They shared that they have found more acceptance in New York than their home states. One participant shared that because of the newfound freedom she experiences in New York, “I feel like I could stand in a parking lot and scream ‘I’m a lesbian’ and not be killed or beat to death. I think people would clap and stuff, that kind of freedom.”

### **Evidence of Quality**

To assure the accuracy of the data being collected and reported, the themes were drawn from significant findings within the literature review. The researcher also attempted to create a welcoming environment for participants to respond honestly about their experiences by opening up the interview to questions at the beginning and by sharing honest responses about the purpose of the study. Follow up questions were asked in accordance with the research questions and protocol (See Appendix C for an example of participant responses.)

### **Discussion**

This study intended to explore the long-term effects of homophobia-related trauma on adult men and women from LGB communities. The existing research on the impact of trauma related to sexual orientation included effects on individuals' mental health, social relationships and interactions, and self-concepts (Carbone, 2008; Rosenberg, 2000; Schneider et al., 2012). Experiences with homophobic victimization occur within a cultural context of heterosexism which reinforces the message that homosexuality is undesirable (D'Anna et al., 2012). The majority of available research on how homophobia-related trauma impacts individuals from LGB communities focuses on the immediate impact of the events indicating a need for research on how these experiences continue to affect individuals in the long-term (Carbone, 2008).

The researcher conducted semi-structured interviews with three participants, two gay men and one lesbian, who were recruited through a community mental health clinic to explore how their past experiences with homophobic victimization continue to impact their lives. Empirical phenomenology was used to delve into the participants' responses to draw out patterns and themes related to the effects of the traumas. Four major themes emerged including internalized homophobia, hypervigilance, wounded resilience, and seeking safe spaces.

### **Findings**

The three participants all described how their past experiences with homophobic victimization had a profound impact on their identities as they internalized the homophobic messages. Their responses reinforce previous research findings which indicated that many individuals from LGB communities who experience homophobia-related trauma integrate internalized homophobia (IH) into their self-concepts (Herek et al, 2009; Tigert, 2008). In the long-term, the participants' responses suggest that IH continues to impact their experiences by creating a filter through which they process new experiences, such as searching for employment,

applying for housing, and navigating new social settings. It is notable that all three participants described a sense of IH while also being able to recognize how the related thoughts and feelings were potentially irrational or distorted, suggesting that over time individuals may develop more insight into how homophobia has impacted their self-concepts. This insight could potentially be used in therapeutic settings to alleviate the negative impact of IH.

The sense of hypervigilance which all three participants experienced coincides with Rosenberg's (2000) research, suggesting that following a trauma individuals continue to remain alert for potential experiences of further traumatic events. For members of LGB communities, the results from this study suggest that the culture of heterosexism and homophobia, with their encoded messages, reinforce the fear of continued homophobia-related trauma. All participants shared how they have continued to experience homophobia either through continued verbal victimization, witnessing or hearing about hate crimes, and observing homophobic microaggressions in their daily interactions with others. These results indicate that the continued fear of homophobic victimization is an experience that LGB individuals will continue to experience throughout their lifetimes. Further research is needed to assess how hypervigilance would impact the individuals' abilities to heal from past traumas.

Participants described having attained certain strengths as a result of experiencing homophobia-related trauma. The increased sense of personal hardiness which all three participants shared is consistent with Smith and Gray's (2009) research which suggested that experiencing and working through experiences with homophobia can increase an individual's willingness to work through adverse events. All participants stated that despite the negative impact and continued pain that they carry as a result of being victimized due to their sexual orientations that they are more likely to dispute homophobic rhetoric and self-advocate in

situations where they are being victimized. The increase in personal hardiness that the participants reported could be incorporated into therapeutic interventions to develop self-efficacy in addressing presenting issues. Participants also shared a willingness and desire to advocate for others who have experienced similar situations which relates to the theme of seeking safe spaces.

Throughout their lifetimes, participants reported seeking out safe spaces and social connections with accepting people in relation to experiences with invalidating environments and traumatic experiences with physical, verbal, and sexual victimization. Crowley and colleagues (2007) had discussed the importance of adolescents from LGB communities finding safe spaces to develop their self-concepts and form secure connections with others. The participants in the current study shared similar experiences, especially in having an older mentor that he or she could turn to for support after experiencing trauma. What is of significance in the current study is that participants shared continuing to seek safe spaces in their adult lives, including validating work environments and involvement with local LGTBQ community organizations. Participants also added that having found supportive and safe environments provided opportunities for healing from past traumas. That is another factor that could be considered when developing therapeutic treatment plans with individuals who have experienced homophobia-related trauma. Supportive environments could include mental health facilities making an effort to demonstrate that the therapeutic setting is a welcoming and accepting environment for clients to explore issues surrounding sexual orientation and related trauma. Acceptance could be conveyed using relevant signage and icons of acceptance, such as inverted pink triangles surrounded by green circles which are recognized within LGBTQ communities as denoting spaces of tolerance.

### **Limitations**

Limitations within this study included a small sample size and limited time to collect the data. Saturation had not been reached by the third interview. Having the opportunity to have interviewed additional participants would have strengthened the results of the study and possibly introduced more themes. It is also noted that no bisexual participants were included in the study. Therefore, the results may not reflect their unique experiences. The researcher's own experience with homophobia-related trauma is an additional potential limitation to the current study. To minimize any personal bias, themes were linked to existing research on the subject and a research journal was maintained to note and address any subjective reactions that followed the interviews.

### **Recommendations for Future Research**

The results of this study touched upon various strengths that participants had acquired as a result of having experienced homophobia-related trauma. Future research on this subject could focus on how to incorporate those strengths and resiliencies into therapeutic work with clients who have been victimized due to homophobia. Each participant in this study had expressed a desire to be a "mentor" or advocate for the younger generations of LGB individuals who may currently be experiencing homophobia-related trauma. Future studies could explore the potential benefits of connecting LGB adult survivors of homophobia-related trauma to younger mentees or the development of programs which facilitate these kinds of interactions and supports.

The researcher notes that the primary therapists at the community mental health clinic had difficulty identifying potential participants from LGB communities who had experienced homophobia-related trauma. As prior research indicates, physical, verbal, and sexual victimization of a homophobic nature is a common experience for LGB individuals. However, there appears to be a challenge in identifying clients who have experienced such events

(D'Augelli et al., 2006). Future research could explore potential barriers for LGB victims of homophobia-related trauma in seeking treatment or disclosing their experiences within therapeutic relationships. Research could also explore whether or not mental health practitioners believe that they are adequately trained and comfortable in assessing for homophobia-related trauma.

### **Conclusion**

The wounds which individuals from LGB communities experience from having experienced homophobia-related trauma do not entirely heal as they continue to process and grow past the events. However, it does appear that having persevered past the traumatic events, individuals do develop unique strengths and coping skills that may provide support in recovery from various presenting issues that bring them to therapy. Mental health practitioners who recognize the strengths and resilience in their clients who have experienced homophobic victimization can utilize those traits to develop holistic interventions to not only address their presenting issues but also to aid in the continued healing from past homophobia-related trauma.

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## Appendix A

### Interview Guide:

- 1) How would you identify your sexual orientation? At what age did you begin to recognize your sexual orientation? Have you shared your sexual orientation with others? If so, describe that experience. If members of your family know about your sexual orientation, how has it affected your relationships with them?
- 2) Have you experienced events in your life where you were persecuted, attacked, or judged by others because of your sexual orientation that would describe as traumatic? Describe those events.
- 3) What was the impact of those experiences at that time? What helped you to get through that time?
- 4) How would you say that your past traumatic experiences with homophobia impact you today? What are some of the ways that you currently cope with the past trauma?
- 5) Are there any strengths that you believe you have acquired as a result of having gone through homophobia-related trauma?
- 6) Is there anything that you want to share with me that I haven't asked you?
- 7) How was it for you to talk about your experiences? What was your level of comfort at the beginning of the interview compared with your level of comfort now?

## **Appendix B**

### **STATEMENT OF INFORMED CONSENT**

You are invited to participate in a research study conducted by Eric Goodwin, from The College at Brockport, Department of Counselor Education.

#### **WHAT THE STUDY IS ABOUT**

The purpose of this study is to explore the impact of past homophobia-related trauma with lesbian, gay, and bisexual (LGB) men and women.

#### **WHAT YOU ARE BEING ASKED TO DO**

Your participation involves an interview where you will be invited to talk about your traumatic experiences with homophobia and heterosexism, how they have affected you, and how you have coped. It is estimated that the interview will take approximately 45 to 60 minutes to complete.

#### **HOW YOUR INFORMATION IS KEPT CONFIDENTIAL**

Subject identities will be kept confidential by not requiring any identifying information throughout the interview. All completed forms will be kept in a locked file cabinet at the researcher's office at [REDACTED] and all forms and tapes will be destroyed 30 days after the research has been completed. You may elect not to be voice recorded to further ensure your confidentiality.

#### **BENEFITS AND RISKS OF PARTICIPATION**

There are potential risks to you as a participant. Discussing traumatic experiences may trigger painful emotions and memories. To address this risk I will work with your primary therapist to set up an appointment should the interview bring up unresolved feelings.

Participation in the study may prove beneficial to you. The research offers you an opportunity to share your experiences as part of a study aimed at understanding the therapeutic needs of LGB people who have experience with homophobia-related trauma.

There is a small risk of breach of confidentiality which is being minimized by the procedures described in the section above entitled "How Your Information is Being Kept Confidential."

The data collected for this evaluation are being used as part of a student project and are solely for use as an educational tool. Any publications resulting from this research will be reported in aggregate form, and you will not be identified.

There are no costs incurred by you as a participant and no one involved in this study is being compensated in any way.

**COMPENSATION FOR INJURY**

No financial compensation will be made to cover lost earnings, or impairment of your ability to earn, as a result of any physical injury resulting from or solely due to your participation in this study. No physical injury is anticipated from participation in this study. [REDACTED] or the study coordinator do not assume any responsibility of injuries occurring during your travel to and from the study site.

**TAKING PART IS VOLUNTARY**

Your participation is voluntary. Your decision whether or not to participate in this research will not affect your relationship with [REDACTED]. If you decide to participate, you are free to withdraw your consent and discontinue participation at any time.

**IF YOU HAVE ANY QUESTIONS**

If you have any questions about the study, please feel free to contact Eric Goodwin at 585-233-3308 or at [egoodwin@\[REDACTED\]](mailto:egoodwin@[REDACTED]) or contact my Brockport College faculty advisor Patricia Goodspeed-Grant at 585-395-5493 or [pgoodspe@brockport.edu](mailto:pgoodspe@brockport.edu). You will be offered a copy of this form to keep.

If you have any questions about your rights as a research subject, you may contact the Office of the Institutional Review Board [REDACTED], Monday thru Friday 8:15am to 5:00pm.

**STATEMENT OF CONSENT**

Your signature indicates that you have read and understand the information provided above, that you willingly agree to participate, that you may withdraw your consent at any time and discontinue participation without penalty, that you will receive a copy of this form, and that you are not waiving any legal claims.

**Participant**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Appendix C

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| <p>Resilience<br/>Safe spaces</p> <p>Hypervigilance</p> <p>Hypervigilance</p> <p>Coping<br/>Trust issues</p> <p>Freedom<br/>Safe spaces</p> | <p>me and I didn't want anything out of the ordinary. For it was trust, finding people I could trust.</p> <p>EG: Supports?</p> <p>█: Yeah. Like when my coach said I could come to talk to her. And I learned then, which I didn't follow through with it on every occasion, that talking through things really helps a lot.</p> <p>EG: And looking back today, in your current life, when you look back at those traumatic experiences. How would you say they impact you now?</p> <p>█: Number one, I feel like I'm a much stronger person today living in New York. Because if I was still living in █, in █, if I still went out where I went that night, I'd still be scared! That's no way to live. I appreciate the true honesty of folks I have met here, I've only been to one bar here, but I've met some really nice people. Because it's the same in there...I just had, the way I visualize gay people, at first I thought I was in the wrong bar. That I was in a straight bar. So I went and asked and they said "No this is a gay bar." I shared what happened down south and they said "No you don't have to worry about those things up here." Yeah you don't have to worry but a few things have happened.</p> <p>EG: So the worries are still there but less? Is that what you're saying?</p> <p>█: Yes it is. I think the worries are always going to be there.</p> <p>EG: How do you cope when you get those feelings of worry, or kinda looking over your shoulder?</p> <p>█: That's a work in progress.</p> <p>EG: Fair enough.</p> <p>█: I'm being honest because that coincides with some other things that are going on right now that I'm working on. And um, I'm having to learn to make the right choices today for me, where it benefits me. My head and my heart's pulling me this way, I have to listen to the right one. It will be something I work on the rest of my life. Because I have big trust issues. I don't think no one can break through my trust issues. Because the rednecks are the ones that, I mean I know they're rednecks here, there are rednecks everywhere. I have to be on my guard. I'm all the time still looking, I am.</p> <p>EG: From what you said when we had started it sounds like you're feeling more freedom from it.</p> <p>█: Here it is freedom. Due to the nature of some things that happened, besides this, I'm always on my guard. As far as, I feel that I could go in Wegmans parking lot and scream "I'm a lesbian!" and not be killed or beat to death. I think people would clap and stuff, that kind of freedom.</p> |
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