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GLBTQ Domestic Violence Project

TRAUMA-INFORMED APPROACHES FOR LGBQT* SURVIVORS OF INTIMATE PARTNER VIOLENCE

A Review of Literature and a Set of Practice Observations

June 2016

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The production of this publication was supported by Grant Number 90EV0421 from the Administration on Children, Youth and Families, Family and Youth Services Bureau, US Department of Health and Human Services. The opinions, findings, conclusions and recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the Administration on Children, Youth and Families, Family and Youth Services Bureau, US Department of Health and Human Services.

Acknowledgements:

The authors wish to give special thanks to members of our Advisory Board, including the NorthEast Two-Spirit Society, Queer Muslims of Boston, Fenway Community Health, the Hispanic Black Gay Coalition, the Massachusetts Alliance of Portuguese Speakers, HarborCOV, and Massachusetts Asian & Pacific Islanders for Health. This literature review would not have been half of what it is without their considerable and thoughtful contributions.

Produced by
The GLBTQ Domestic Violence Project

For more information on supporting LGBQT* survivors of intimate partner violence, contact one of the organizations below:

The LGBTQ DV Capacity Building Learning Center
c/o The Northwest Network
A program focused on improving research, practice and policy regarding domestic violence in LGBTQ communities.
1-206-568-777 | info@nwnetwork.org | www.nwnetwork.org

FORGE
A transgender anti-violence organization, specializing in technical assistance for victim service agencies, with a focus on domestic violence, sexual assault, dating violence, stalking, and hate crimes.
1-414-559-2123 | AskFORGE@forge-forward.org | www.forge-forward.org

If you would like more information about accessible, culturally relevant trauma-informed approaches for survivors, contact:

The National Center on Domestic Violence, Trauma & Mental Health
A program providing training, support, and consultation to advocates, clinicians, attorneys and policymakers as they work to improve agency and systems-level responses to survivors and their children.
1-312-726-7020 | info@nationalcenterdvtraumamh.org | www.nationalcenterdvtraumamh.org

Contents

Executive Summary 1

Introduction 3

A Note on Language 3

Intimate Partner Violence in LGBQT* Communities 6

Prevalence of IPV in LGBQT* Comunities 6

Similarities of LGBQT* and Heterosexual IPV 7

Unique Characteristics of IPV in LGB communities 7

Unique Characteristics of IPV among Transgender People 8

Multiple Experiences of Violence in LGBQT* Communities 9

Unique Experiences of IPV among Specific Subgroups of LGBQT* Survivors 9

Trauma and Mental Health in LGBQT* Communities 12

Resilience in LGBQT* Communities 14

Help-Seeking Among LGBQT* Survivors 16

Trauma-Informed Practices 19

Trauma-Informed Practices with LGBQT* Survivors of IPV 22

Examples of Community-Specific Approaches to Trauma 22

Transformative Justice as a Trauma-Informed Practice 23

Conclusion 25

References 26

Appendix A: Table of Existing Trauma Informed Approaches 36

Appendix B: A Set of Practice-Based Observations for Trauma-Informed Practice with LGBQT* Survivors of Intimate Partner Violence 40

Executive Summary

In 2013, the Administration for Children, Youth and Families, Family and Youth Services Bureau, US Department of Health and Human Services, awarded a grant to the GLBTQ Domestic Violence Project in Boston, Massachusetts to help improve trauma-informed work with lesbian, gay, bisexual, queer and transgender (LGBQT*) survivors of intimate partner violence (IPV). The following document is a literature review that sets the context for thinking about trauma-informed practice (TIP) for these communities. We developed this review over the course of 2015, supported along the way by an Advisory Board comprised of the NorthEast Two-Spirit Society, Queer Muslims of Boston, Fenway Community Health, the Hispanic Black Gay Coalition, the Massachusetts Alliance of Portuguese Speakers, HarborCOV, and Massachusetts Asian & Pacific Islanders for Health.

This document helps inform a set of practice-based observations that are included in the Appendix (page 40) and are also available as a separate document. At present, there are few, if any, documented LGBQT*-specific models of trauma-informed practice. This literature review and the accompanying practice observations make a clear case for the need for such models, and for the implementation of culturally competent LGBQT* trauma-informed services.

Key takeaways from the literature review include:

- IPV occurs in LGBQT* relationships at rates equal to or higher than rates in heterosexual relationships. Different subgroups within the community may experience different rates or types of IPV, with bisexual and transgender individuals at particularly high risk.

- Although LGBQT* IPV shares many underlying dynamics with IPV in heterosexual couples, it also has unique characteristics, including the types of abusive tactics used and the context of discrimination and social stigma faced by LGBQT* individuals. Within LGBQT* subgroups, there may be additional complexities.

- LGBQT* survivors who are also part of other oppressed groups often face homophobia within their own cultural communities as well as racism, ableism, xenophobia, and colonialism in mainstream communities. Moreover, LGBQT* IPV often occurs in a landscape that includes other forms of abuse and trauma, including family violence, sexual violence, hate crimes, and police brutality. Such overlapping forms of trauma are often interrelated, rendering some members of the LGBQT* communities subject to abuse by more than one person at a time and at more than one point in their lifespans. In the face of these overlapping forms of oppression, LGBQT* survivors are forced to make particularly constrained choices about safety, often trading one kind of safety for another.

- Mental health difficulties are major concerns among LGBQT* people in general. LGBQT* individuals experience higher rates of traumatic events, and may be at greater risk for developing symptoms of PTSD, depression, and anxiety as well as experiencing suicidality and isolation. These concerns are amplified for LGBQT* survivors of IPV, especially transgender individuals and survivors of color. Nonetheless, LGBQT* survivors find strength and resilience through identity affirmation and social support.

- LGBQT* survivors exhibit unique help-seeking behaviors. Overall, they are less likely to seek services from law enforcement and mainstream providers and more likely to rely on informal social support and LGBQT*-focused programs. There also are differences in help-seeking *within* LGBQT* subgroups. For instance, trans individuals may have an especially difficult time accessing culturally competent and non-traumatizing services. For LGBQT* people of color, stigma, economic constraints, and the absence of community outreach are barriers to services.

- Service provision that is not rooted in an expansive understanding of the intersecting oppressions that LGBQT* survivors face may do more harm than good. The kind of harm done by those in a social service system designed to help has been referred to as *sanctuary harm*, which is antithetical to trauma-informed practice.

- Despite growing awareness of the impact of sanctuary harm on clients who experience multiple forms of oppression and of the unique needs of LGBQT* survivors, trauma-informed approaches tailored to LGBQT* communities have been slow to develop. To our knowledge, there are none in the academic literature. It was our Advisory Board that pointed to an alternative model of trauma-informed practice – transformative justice.[1] While the roots of trauma-informed practice grew out of mental health and substance abuse services, transformative justice emerged from activist communities and seeks to uproot the conditions that created traumatic experiences, ending oppression even (if not especially) within helping systems.

We hope that this document will facilitate thinking about how the core principles of trauma-informed practice can be applied to working with LGBQT* survivors and to ameliorating vicarious traumatization among service providers who do their best in difficult circumstances.
Although this document is intended primarily for staff in domestic and sexual violence organizations, it has broad applicability. The information provided can be used to enhance the work of practitioners, advocates, and administrators in other anti-abuse disciplines, homelessness services, mental health and healthcare circles, criminal legal systems, youth services, and an array of other human services disciplines and social change initiatives that seek to serve and ensure the inclusion of LGBQT* communities. The practice-based observations in the Appendix provide further framing for this important endeavor.

[1] The authors wish to thank Hales Burton, at the Fenway Violence Recovery Program, for first suggesting this conceptual shift.

Introduction

IPV refers to the physical and/or emotional abuse of an individual by a current or former intimate partner. It includes the full range of tactics used to create and maintain power and control over another person, including financial abuse, verbal abuse and intimidation, and cultural abuse. In this document, the phrases *intimate partner violence* and *domestic violence* are used interchangeably to denote partner violence. However, it is important to note that domestic violence (DV) is sometimes defined more broadly to include violence and abuse perpetrated by relatives. Although many LGBQT* individuals experience abuse and/or rejection from family and relatives, the dynamics of partner violence versus family violence may differ dramatically. When we discuss the latter, we use the term *family violence* to distinguish it from violence by an intimate partner.

Following a note on language, the literature review is organized into five sections. Section One focuses on the prevalence and dynamics of IPV in LGBQT* communities. Section Two focuses on trauma, mental health, and resilience among LGBQT* individuals to contextualize the critical need for trauma-informed practices for these survivors. Section Three focuses on the range of systemic, institutional, and individual-level barriers that thwart LGBQT* peoples' access to informal and formal support services. Finally, the last section reviews the core principles of a trauma-informed approach to practice, with attention to the needs of service providers who work with LGBQT* survivors, and provides examples of community-specific approaches to trauma.

A Note on Language

The authors wish to acknowledge at the outset the deep complexities of language. LGBQT* stands for lesbian, gay, bisexual, queer, and transgender. It is often used interchangeably with GLBTQ, LGBQT-TS, and similar acronyms to broadly refer to sexual and gender minorities. This document honors the current practice of including an asterisk after the "T" to signify the broad diversity of trans communities, including trans women – transgender individuals who identify as women, though assigned male at birth; trans men – transgender individuals who identify as men, though assigned female at birth; those transitioning from female to male (FTM); those transitioning from male to female (MTF); cross dressers; gender non-conforming individuals; and others who might self-identify as being members of trans communities. In this paper, transgender and trans are used interchangeably.

These definitions belie the complexity of the terms, however. The words *lesbian*, *gay*, *bisexual*, *transgender*, and *queer* all carry particular historical, political and cultural meanings. To a great extent, these words have been shaped in white, Western contexts. Words such as lesbian, gay, and bisexual, for example, are uniquely English. There are seldom translations into other languages that carry the same understanding of LGBQT* identity as being an identity rather than a set of behaviors. Literal translations, into Spanish or Haitian Creole as but two examples, carry few if any of the presumptions that are inherent in English. In many parts of the Latin and Spanish-speaking world, men who engage in sex with

same sex partners are only considered "gay" in the English sense of the word if they are the receptive partner. It is not engaging in the acts that is the determinant of identity, so much as the role that an individual plays (traditionally read as *masculine* or *feminine*) in the conduct of that act. Similarly, men who marry women, but engage in same sex acts with other men, are frequently identified as heterosexual. In short, they are defined by their social role, rather than by their private, intimate acts. Hence the conception of *gay*, as defined in U.S. contexts, frequently fails to apply.

Precisely because identifiers such as LGBQT* were defined in white middle class and academic contexts, the limitations of LGBQT* labels and identifiers may be particularly acute in communities of color, Indigenous communities, and immigrant communities, among others. During the course of crafting this literature review, members of our Advisory Board taught us a tremendous amount. The Hispanic Black Gay Coalition (HBGC) suggested use of the term *same gender loving*, a community-specific phrase coined by Cleo Manago to distinguish African Americans, and in particular African American men, who do not self-identify as being part of the predominantly white gay movement in the U.S., but who nonetheless wish to affirm their same sex intimate relationships. Corey Yarbrough, one of the founding Executive Directors of HBGC, suggested that, for some same gender loving people, this language may be a form of racialized resistance to the racism of the mainstream LGBQT* movement in the U.S. In the alternative, Corey stated, some members of African American communities may be on the *down low*, engaging in same sex sexual activity, but rejecting LGBQT* identifiers as a result of internalized homo- and bi-phobia.

The NorthEast Two-Spirit Society (NETSS) in part echoed Corey's thoughts about the racism of the mainstream LGBQT* movement. In addition, Harlan Pruden, one of co-founders of NETSS, spoke about an "internal muddiness" that some Native peoples may experience when seeking to find language for their experience. Speaking of his own Cree inheritance as a registered member of the Saddle Indian Reservation, Harlan said that when he asked something of an elder, he knew to offer them tobacco, but never understood the spiritual dimension of the ceremony. Having been separated from too much of their own history by colonialism, genocide, and forced assimilation, Harlan stated, many Native people may use the words *Two-Spirit* when what they really mean is gay Indian.[2]

Harlan also spoke at length about the contextual nature of Native Two-Spirit identities. As Harlan put it, "When I am out on a Friday night in a gay club, I am a gay man. Yet when I am in rural Oklahoma at a Two-Spirit gathering, I am a proud Two-Spirit man." Alluding to the unique role and cultural responsibilities that Two-Spirit people often held (and may still hold) in the life of Native communities, Harlan pointed out the obvious differences in the spiritual role of Two-Spirit peoples, and

[2] Two-spirit is a contemporary term, adopted from the Northern Algonquin, and meant to signify the embodiment of both masculine and feminine within one person. Now embraced by many Native peoples as a pan-Indigenous umbrella term connoting both diverse gender expressions and sexual orientations, two-spirit (TS) generally speaks to the respect that Native peoples held for diversity, and the unique sacred and ceremonial roles that TS people held (and may still hold) within their own communities. Herein the phrase TS speaks not simply to a third gender, or to same gender attraction, but more broadly to the history of compulsory Christianization that sought to erase two-spirit peoples within their own nations. Notably, there is no single consensus definition of two-spirit, and the term means different things to different Native peoples.

the political and social function of people claiming LGBQT* identities in mainstream communities. Several members of the project's advisory board echoed this point,
speaking about the complex layering of cultural and spiritual value systems that accompanied their choice to self-identify in, with, and outside of their own communities.

These same Advisory Board members also acknowledged the landscape in which such decisions are made, and stated that individuals in their communities may shift how they self identify as a means of preserving their safety. As the rest of this literature review discusses, LGB, transgender, same gender loving, Two-Spirit, and queer-identified peoples make choices about how, when, and if to "out" themselves in a complex social and political landscape that is too often unsafe, if not violent. Hence, how any individual self-identifies may shift depending on who is asking, why, and in what context. As one Advisory Board member stated, "identities have to be fluid in order to be protective."

Finally, the leadership of HarborCOV, an LGBQT*-affirming DV organization in Boston that specializes in serving communities facing cultural or linguistic barriers, has noted that some cultures may not have the variety or depth of language that words such as LGB, transgender, same gender loving, and Two-Spirit convey. Indeed, Kourou Pich, Co-Executive Director of HarborCOV has observed that people from some cultures and communities may have difficulty finding language for themselves in their own communities, and that that invisibility is intentional – a function both of denial of the existence of sexual minorities in those communities, but also perhaps protectiveness of gender queer and same gender attracted people.

Language is power. We authors, therefore, have put a great deal of thought into the words we use to name peoples' experiences. At the same time, we know that we can never be as inclusive or sensitive as we want to be. We have done our best to honor the range of experiences we are writing about in this document.

Intimate Partner Violence in LGBQT* Communities

Prevalence of IPV in LGBQT Communities*

Historically, DV has been seen primarily as a problem of cisgender[3], heterosexual men abusing cisgender, heterosexual women. Because of this limited framework, research on the prevalence of DV and IPV among LGBQT* and non-female-identified individuals has been scarce and often limited by the use of non-probability sampling, cross-sectional data that precludes causal inference, and inconsistent definitions of IPV and sexual orientation (Brown & Herman, 2015; Finneran & Stephenson, 2012). Recently, however, there has been an increase in studies that provide more rigorous estimates of IPV in LGBQT* communities. The majority of these studies suggest that IPV occurs in LGBQT* relationships at rates equal to or higher than heterosexual, cisgender relationships (Balsam, Rothblum, & Beauchaine, 2005; Duke & Davidson, 2009; Langenderfer-Magruder, Whitfield, Walls, Kattari, & Ramos, 2016; Messinger, 2011; Walters, Chen, & Breiding, 2013). Herein, we briefly present prevalence estimates of LGB IPV before turning to the limited research on prevalence among trans individuals. For a more detailed review of IPV prevalence in LGBQT* communities, see Brown and Herman (2015).

Currently, the best prevalence estimates on partner abuse in LGB communities come from the nationally representative 2010 National Intimate Partner and Sexual Violence Survey (NISVS) conducted by the U.S. Center for Disease Control & Prevention (Walters et al., 2013). Findings suggest higher rates of lifetime IPV experiences (defined as physical violence, sexual violence, or stalking) among lesbians (43.8%), bisexual women (61.1%), and bisexual men (37.3%) – but not gay men (26%) – compared to heterosexual women (35.0%) and heterosexual men (29%). In addition, findings from the California Health Interview warrant mention. Based on a probability sample of California residents ages 18 to 70, this study found that lifetime and 1-year IPV prevalence was higher in sexual minorities compared with heterosexuals, but this was significant only for bisexual women and gay men.

Determining IPV prevalence based on gender identity is difficult due to a lack of studies with representative or even large samples. The National Transgender Discrimination Survey is one of the largest studies of transgender individuals' experience of discrimination with 6,456 participants (Grant, Mottet, & Tanis, 2011). This study did not focus on IPV in particular, but did measure related phenomena. The researchers found that 19% of respondents reported experiences of violence at the hands of a family member specifically due to their gender identity. This statistic is likely an underestimate because it excluded DV perpetrated by non-family intimate partners as well as DV unrelated to gender identity. A much higher percentage of participants reported experiencing actions that may or may not be part of abusive behavior: 29% reported an ex-partner limiting their contact with their children, 45% reported having a relationship end when they came out as trans to their partner, and 57% experienced family rejection (Grant et al., 2011). However, these are unreliable proxies for IPV.

[3] Cisgender is a term that refers to individuals for whom the gender they were assigned at birth matches their gender identity. It can be thought of as meaning "not transgender."

Only one study to date has compared IPV among transgender to IPV among cisgender individuals. Analysis of data from One Colorado's anonymous 2011 LGBT Health Survey (n= 1,193) found that 31.1% of trans respondents reported experiencing IPV, compared to 20.4% of cisgender respondents (Langenderfer-Magruder et al., 2016) – findings that suggest transgender individuals experience higher rates of IPV than their cisgender, LGB counterparts. Furthermore, preliminary evidence suggests that different subgroups within transgender communities experience different rates or types of IPV (Chestnut, Jindasurat, & Varathan, 2012; Clements, Katz, & Marx, 1999). Future studies should examine these differences, particularly with regard to differences between trans men and trans women and with attention to intersecting identities for all participants (e.g., race, sexual orientation, disability, socioeconomic status).

Similarities of LGBQT and Heterosexual IPV*

In general, IPV experienced by LGBQT* individuals follows patterns similar to heterosexual and cisgender individuals (Ristock, 2005). Specifically, abuse can take the form of physical or sexual violence as well as emotional, financial, or verbal abuse. Messinger's (2011) analysis of the National Violence Against Women Survey revealed that the prevalence of various types of abuse in GLB communities mirrored prevalence rates among heterosexuals: Both groups reported prevalence rates that went in descending order from verbal abuse to controlling behavior to physical violence to sexual abuse. However, as described next, there are also unique aspects of IPV in LGBQT* communities, and potentially important differences among LGBQT* subgroups.

Unique Characteristics of IPV in LGB communities

IPV occurs in a larger societal and systemic context of homo-, bi-, and transphobia, heterosexism, misogyny, and patriarchy. These factors can influence abuse tactics and relationship dynamics for LGBQT* survivors, making their experiences different from those of heterosexual survivors. For example, sexual minority victims of IPV may be subject to abusive tactics that leverage systemic and cultural discrimination (i.e., identity abuse; Ard & Makadon, 2011; Balsam, 2001; Balsam & Szymanski, 2005; FORGE, 2014; Gay Men's Domestic Violence Project, 2014; National Center on Domestic & Sexual Violence, 2014; West, 2012). Examples of identity abuse include denying or belittling an individual's LGBQT* identity (e.g., refusing to use preferred gender pronouns), restricting access to a supportive LGBQT* community (NCDSV, 2014), or threatening to disclose a survivor's sexual orientation, gender identity, or HIV/AIDS status (Ristock, 2005). People who use violence against their LGBQT* partners may also use threats to authenticity as a method of control, making survivors feel that they are not "queer enough" or do not understand how LGBQT* relationships are supposed to be (Bornstein, Fawcett, Sullivan, Senturia, & Shiu-Thornton, 2006). Controlling behavior, in general, may be a particularly important aspect of DV among LGBQT* couples, and may result in even higher levels of psychological harm than physical abuse alone (Frankland & Brown, 2014).

IPV in LGBQT* survivors can also be minimized in a variety of ways: For example, common portrayals of DV in the media – usually depicting heterosexual relationships, specifically men abusing women – can render invisible even to themselves experiences of underrepresented survivors (Holt, 2011). Pervasive beliefs that LGBQT* relationships are more egalitarian or that gay and lesbian individuals are better able to defend themselves against partners who use violence also serve to render IPV invisible in these communities (Bornstein et al., 2006; Holt, 2011; Walters, 2011).

Finally, although isolation is a commonly used tactic in heterosexual as well as in LGBQT* relationships, it may be more difficult to overcome in tight-knit LGBQT* communities in which relationships and resources are often shared with the abusive partner (Bornstein et al., 2006). The level of isolation is even more pronounced for LGBQT* survivors from rural and immigrant communities (Ristock, 2005).

Unique Characteristics of IPV among Transgender People

There is limited research on the characteristics of IPV in transgender communities. The National Coalition of Anti-Violence Programs 2014 annual survey of its member programs reported that, compared to people who did not identify as transgender, transgender survivors were two times more likely to face threats/intimidation, nearly two times more likely to experience harassment, and over four times more likely to face police violence in response to reporting IPV (National Coalition of Anti-Violence Program, 2015b). Transgender women were at highest risk of experiencing threats/intimidation, harassment, and injury (NCAVP, 2015a), and transgender people of color were the most likely to report experiencing threats of intimidation in their intimate partnerships.

Generally high rates of violence, trauma, and discrimination in the lives of transgender individuals may have a compounding effect, influencing transgender IPV survivors' willingness to identify abuse or seek help. FORGE's safety planning guide remarks that transgender individuals may feel unwanted, or "believe that they are lucky to ever find love, even if that love turns violent" (Guadalupe-Diaz, 2013, p. 3). In a study of transgender relationship violence, some participants could not even conceptualize their trans partner's behavior as abusive because they viewed these partners as being so oppressed themselves (Ristock, 2011).

Multiple Experiences of Violence in LGBQT Communities*

Because of the fragmented nature of research on violence and abuse in the lives of LGBQT* individuals, the prevalence of "polyvictimization"[4] – that is, multiple kinds of violence and abuse committed by different people – in this community is still unknown. However, evidence suggests that LGBQT* individuals are more likely to experience multiple types of violence (e.g. sexual abuse, physical abuse, and exposure to domestic violence during childhood; sexual assault, physical assault, and stalking during adulthood) at the hands of many different types of individuals (family, partners, community members, legal actors, strangers) and at multiple points in their lifetime (Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010; Grant et al., 2011; Stotzer, 2009).

Specific subgroups of LGBQT* survivors are at especially high risk for multiple forms of victimization. One notable example is LGBQT* homeless youth, highly overrepresented among homeless populations (Durso & Gates, 2012; Grant et al., 2011; Hunter, 2008). Evidence indicates that family and partner violence are major drivers of such homelessness (Cochran et al., 2002; Durso & Gates, 2012; Grant et al., 2011; Risser & Shelton, 2002). Homelessness in turn may render LGBQT* peoples increasingly vulnerable to other forms of violence including harassment, hate crimes, police brutality, and sexual exploitation (Amnesty International, 2005; Durso & Gates, 2012; Keuroghlian et al., 2014; Mogul, Ritchie, & Whitlock, 2012; NCAVP, 2015a; NCAVP, 2015b; Reck, 2009). Layered onto these experiences are other types of oppression such as housing, employment, and healthcare, which are themselves traumatogenic and which also act as barriers to help seeking (D'Augelli, 1998; Durso & Gates, 2012; Grant et al., 2011; Tyler, 2008).

Unique Experiences of IPV among Specific Subgroups of LGBQT Survivors*

The experience of IPV for specific subgroups may be quite different than that of White, middle-class LGBQT* survivors (Chavis & Hill, 2009). The intersections of various identities result in unique social contexts shaped by multiple systems of power and oppression (Chavis & Hill, 2009; Feltey, 2001). These systems may shape the way that IPV is enacted and experienced, and the way it is addressed by service providers. Although attention to all intersections would be beyond the scope of this document, here we focus on three subgroups that have received especially scant attention: sexual minorities in Native communities, immigrant and refugee communities, and faith-based communities. Although there is virtually no research on IPV within these subgroups, it is nevertheless instructive to understand this context when considering the experience of IPV for people within these communities. Later sections touch on specific aspects of the help-seeking experience of African-American and Latin@ LGBQT* survivors.

[4] "Polyvictimization" refers to experiences of multiple kinds of violence and abuse, at the hands of multiple people at multiple points in the lifespan. The authors have chosen to put this word in quotes because some have understood it to imply that the victim is somehow responsible for for these experiences. This would obviously be inaccurate and inappropriate. Indeed, there is now a rich literature on the ways that people who use abusive behaviors target individuals with prior trauma histories.

Two-Spirit and LGBT Native Peoples. In general, there is scant research on the experiences of Two-Spirit and LGBT Native individuals. However, the fact that rates of violence and abuse against cisgender, heterosexual Native women are so high suggests that Two-Spirit Native women might be at especially high risk compared to their non-Native sexual minority counterparts (Lehavot, Walters, Simoni, 2009). Consistent with this view, one study showed that 78% of Two-Spirit women reported experiencing physical assault and 85% reported experiencing sexual assault (Lehavot et al. 2009).

These statistics are all the more alarming given that Native women, regardless of Two-Spirit or LBT status, are more likely to experience physical brutality, and therefore injury, during rapes and sexual assaults (Amnesty International, 2007). Further, some Native researchers have noted the disproportionate impact of homo/transphobia that occurs within the Native community given that Two-Spirit survivors may need cultural support from their own people in the face of violence and trauma (Frazer, Somjen, & Pruden, 2010). Not surprisingly then, violence against Two-Spirit and Native LGBQT* individuals also contributes to the development of a range of health and mental health conditions, such as liver disease, substance abuse, PTSD, as well as to behaviors that increase the risk for HIV (Balsam, Huang, Fieland, Simoni, & Walters, 2004; Centers for Disease Control and Prevention, 2001; Evans-Campbell, Lindhorst, Huang, & Walters, 2006; Simoni, Seghal, Walters, 2004). Clearly, more research is needed on IPV in the lives of Two-Spirit and LGBQT* Native peoples.

Immigrants and Refugees. The experiences of LGBQT* immigrant and refugee survivors of IPV are largely invisible in the academic literature. The broader research on DV in heterosexual, cisgender immigrant communities is complex, indicating that they experience lower rates of IPV, but higher rates of IPV homicide compared to non-immigrants (Bohn, 2003; Tjaden & Thoennes, 1998).

Although there is a need for more prevalence research, it is well documented that sexual minority immigrants face challenges resulting from historically homophobic immigration policies (Chung & Lee, 1999). Under the Immigration and Nationality Act of 1917, LGBQT* immigrants were strictly prohibited from entering the United States on the grounds that they were "mentally or physically defective." The Immigration & Naturalization Act of 1952 similarly prevented LGBQT* immigrants from entering the U.S. based on the idea that they were "afflicted with psychopathic personality" (Foss, 1994). Even up to 1990, Public Health Service physicians barred entrance to those immigrants suspected to be LGBQT*, labeling them as "sexual psychopaths." In addition to contending with these oppressive policies, LGBQT* immigrants were also isolated within their own communities and shunned by white, non-immigrant LGBQT* communities because of their immigration status (Cantú, Hurtado, & Anzaldúa, 2012; Moraga & Anzaldúa, 1981). Even today these interpersonal and institutional challenges echo in the lives of sexual minority immigrants and likely create unique challenges for LGBQT* immigrant and refugee survivors of IPV.

Religious or Spiritual LGBQT Survivors*. LGBQT* people have both positive and negative experiences of faith, possibly even simultaneously. Researchers and practitioners highlight the healing value of religious communities and practices for this community (e.g., Queer Muslims of Boston,

FaithTrust Institute; Ryan, Huebner, Diaz, & Sanchez, 2009). Yet, institutionalized religious policies and principles continue to be a major source of social oppression for many LGBQT* people (Clarke, Brown, & Hochstein, 1989; Davidson, 2000; Hilton, 1992; McNeill, 1993; Morrow & Gill, 2003; Spong, 1991; Spong, 1998). For example, many religious practices condemn non-heterosexual behavior (Bouhdiba, 1998; Jaspal & Cinnirella, 2010) and view LGBQT* people as immoral and spiritually corrupt (Morrow & Gill, 2003). For many religious LGBQT* people, family and societal rejection is therefore compounded by the loss of religious communities (Mahaffy, 1996).

Sources of conflict for religious LGBQT* people include anti-gay religious teachings and scriptural interpretations, homo/bi/transphobic church atmospheres, fear of being "outed" in non-affirming religious settings, and microaggressions (i.e., subtle forms of oppression) from people within their religious communities (Brown & Pantalone, 2011; Shuck & Liddle, 2001). Not surprisingly, receiving homophobic messages through a religious medium has been found to be associated with internalized shame among LGBQT* individuals (Herek, 1987; Ream, 2001).

The challenges of participating in a faith community that is not LGBQT*-affirming may be particularly acute for LGBQT* individuals of color and immigrants since the support role of faith-institutions is particularly crucial in these communities due to the lack of other available social supports. For example, Christian religious institutions have served a range of healing functions within African American communities, where faith has been an important source of strength in the face of ongoing racialized violence and oppression (Billingsley, 2003; Cone, 1997; Cone, 2010; Higginbotham, 1994; Lincoln & Mamiya, 1990). Yet, for African American young men, churches are the primary source of anti-gay messages in their communities (Stokes & Peterson, 1998). The loss of access to one's faith community under such circumstances may be particularly wounding. These challenges are real and ongoing, but their effects on LGBQT* survivors of IPV remain unexplored. Most research on the experience of IPV survivors in relation to their faith communities focuses on the spiritual lives of heterosexual, cisgender women. Clearly, more research is needed in this area.

In sum, violence – be it by intimate partners, family and community members, or society at large – is a common occurrence in the lives of many LGBQT* individuals. Because such polyvictimization is rooted in and exacerbated by the larger context of homophobia and transphobia, the experiences of LGBQT* survivors differ in many ways from those of heterosexual, cisgender survivors. Given that experiences differ, so too does the impact of experiencing IPV. We turn next to the research on the mental health consequences of IPV among LGBQT* survivors as well as protective factors that promote resilience.

Trauma and Mental Health in LGBQT* Communities

The emerging literature on how IPV affects the mental health of LGBQT* survivors is mixed, with some studies indicating that the impact is similar for LGBQT* and non-LGBQT* survivors, and others indicating that adverse effects are more common among LGBQT* survivors (Edwards, Sylaska, & Neal, 2015). This section reviews that literature, focusing especially on depression and PTSD – two common mental effects of abuse. As this section will show, emerging research indicates that bisexual and transgender survivors may be at particularly high risk for experiencing adverse mental health effects.

Depression. LGBQT* survivors of IPV, similar to their heterosexual and cisgender counterparts, are particularly at risk of depression. One longitudinal study examining data from a nationally representative survey of adolescents between the ages of 18 and 27 (227 gay and lesbian, 345 bisexual, and 13,490 heterosexual) found that across all three groups, exposure to IPV was significantly related to increased depression – even after controlling for exposure to childhood physical or sexual abuse and homelessness or expulsion from one's home by caregivers (McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012). This is consistent with a more recent meta-analysis examining 19 studies, which found that men who are victims of IPV at the hands of other men are more likely to use substances, suffer from depressive symptoms, have an HIV positive diagnosis, and engage in unprotected sex (Buller, Devries, Howard, & Bacchus, 2014). As a whole, this body of literature suggests that LGBQT* IPV survivors are at greater risk for experiencing depression than LGBQT* individuals without IPV experience.

Looking more closely within the LGBQT* community, there is some evidence indicating that bisexual individuals may have disproportionately high rates of depression as compared to gay and lesbian individuals (Bostwick, Boyd, Hughes, & McCabe, 2010). Interestingly, theoretical work has posited that the relatively high mental health difficulties within the bisexual community may be attributable to the additional stressors of experiencing bi-negative attitudes from both heterosexual and LGTQ communities. The National Epidemiologic Survey on Alcohol and Related Conditions, which compared rates of major depression among lesbian, gay, bisexual and heterosexual adults (*n*=34,653), found that both male and female individuals who reported bisexual behavior had higher lifetime rates of all mood disorders, including depression (Bostwick et al., 2010). By extension, one might expect bisexual survivors of IPV to be at particular risk for depression.

Likewise, there is scant research on depression and other mental health effects of IPV for transgender survivors. There is, however, literature on the relationship between interpersonal violence more generally and symptoms of depression in this community. For example, in one cross-sectional study of over 591 MTF participants from the New York City area, 63% had depression scores in the clinical range. Further, in this same sample, violence that was related to one's gender identity, or gender abuse, was predictive of depression (Nuttbrock et al., 2014). These findings are consistent with another study of 6,436 transgender-identified individuals, in which 19% of respondents had experienced violence at the hands of a family member because of their chosen gender identity. This exposure was associated with over twice the rate of suicidality, with 65% of those who experienced family violence also reporting

having attempted suicide, compared to 32% of those who did not experience family violence (Grant et al., 2011). Overall, though the literature remains inconclusive, it raises questions about whether transgender survivors of IPV could be at increased risk for depression.

PTSD. IPV exposure also increases the risk of PTSD symptoms in the LGBQT* community. According to the CDC's 2010 IPV report described previously (i.e., NISVS) 19.5% of lesbian women, 46.2% of bisexual women and 22.1% of heterosexual women report experiencing at least one symptom of PTSD – defined as having nightmares and intrusive thoughts of the traumatic experience; feeling constantly on guard, watchful or easily startled; and feeling numb or detached in response to an experience of IPV (Walters et al., 2013). Data from bisexual, gay, and heterosexual men were excluded from the analysis due to small sample sizes. Evidence from other research, however, suggests that that the relationship between IPV and PTSD may extend to gay and bisexual male survivors (Pantalone, Hessler, & Simoni, 2010).

Consistent with the findings on IPV and depression, there is initial evidence that bisexual survivors of IPV have higher rates of PTSD than gay and lesbian survivors. According the CDC's NISVS, more than half of bisexual women (57.4%) who experienced physical or sexual violence or stalking reported at least some form of negative impact (e.g., experiencing PTSD symptoms, missing a day of school or work, feeling fearful or concerned for their safety) as compared to a third of lesbian women (33.5%), and a fourth of heterosexual women (28.2%) (Walters et al., 2013). Significantly more bisexual women (46.2%) reported experiencing at least one symptom of PTSD as compared to lesbian (19.5%) and heterosexual women (22.1%) (Walters et al., 2013). These results suggest that bisexual women may be at disproportionately high risk for developing PTSD after experiencing IPV.

Again, literature on the relationship between IPV and PTSD in transgender communities is limited. As noted earlier, transgender individuals are especially likely to experience violence and discrimination in the domains of education, health, family life, and work which may shape their responses to partner violence (Grant et al., 2011). These risks are not equally distributed among trans individuals. Trans women experience higher rates of violence than trans men, probably because they are less able to "pass" (i.e., be perceived as the gender they identify as) (Dean et al., 2000; Mizock & Lewis, 2008). The risks may also be explained by the concept of trans-misogyny: the idea that there is a particular brand of discrimination that combines transphobia with sexism and applies specifically to trans women (Serano, 2007).

In addition, trans people of color are at particularly high risk (Richmond, Burnes, & Carroll, 2012). In a study of MTF youth of color in Chicago, major life stressors included lack of transportation, difficulty finding a job, sex in exchange for resources, being frequently bothered by police, forced sexual activity, difficulty finding a safe place to sleep, difficulty accessing healthcare, and history of incarceration and homelessness (Stieglitz, 2010). Given that multiple experiences of trauma are more likely to result in the development of clinical PTSD (Scott, 2007), it is not surprising that in one study of MTF transgender individuals, 17.8% reported clinically significant symptoms of PTSD (Shipherd, Maguen, Skidmore, &

Abramovitz, 2011). As a whole, the literature on bisexual and transgender communities makes clear the need for researchers to continue to investigate the distinct experiences of subgroups of the LGBQT* community.

The mental health consequences of IPV among LGBQT* survivors must also be understood within the broader context of historical trauma. Historical trauma is a term used to describe repeated communal traumatic events that exist across time, are embedded throughout culture, and can result in an intergenerational cycle of traumatic stress (Sotero, 2007). Oppressed communities subjected to historical trauma are at heightened risk for mental and physical health consequences compared to communities not exposed to such trauma (Danieli, 1998; McMichael, 1999; Sotero, 2007). Not only have LGBQT* people endured such historical trauma as a group, but many such individuals have also experienced intergenerational trauma originating from other identities such as those based on race or religion (DeGruy, 2005; Franklin, Boyd-Franklin, & Kelly, 2006; Jaimes & Halsey, 1992). Studies have shown that cumulative historical traumatic events actually increase survivors' risk for lifetime trauma and interpersonal violence (Chae & Walters, 2009). These forces are critical to understand when considering the mental health impact of violence against various subgroups of the LGBQT* communities.

Resilience in LGBQT Communities*

Research has identified several important factors that contribute to strength and resilience among LGBQT* survivors. In particular, a positive LGBQT* identity, or *identity affirmation,* and social support from friends can profoundly influence survivors' mental health.

Regarding the first of these two factors, LGBQT* identity affirmation has been well documented as critical to positive mental health outcomes. For example, one study investigating 165 lesbian, gay, and bisexual youth found that family support and self-acceptance mediated the relationship between victimization and mental health (Hershberger & D'Augelli. 1995). Another study surveyed 613 lesbian, gay, and bisexual individuals and found that LGB individuals who have positive appraisals of their LGB identity and do not anticipate rejection from others had lower psychological distress (Balsam & Mohr, 2007). In a subsequent study, the same authors found that higher identity acceptance negatively correlated with measures of depression, guilt, fear, hostility, and sadness, and positively correlated with measures of general life satisfaction, self-assurance, and social self-esteem (Mohr & Kendra, 2011). Finally, in a study of trans people of color who were survivors of traumatic events, participants named pride in one's gender and ethnic identity as critical to resilience (Singh & McKleroy, 2011). In short, LGBQT* individuals who feel more positive about being LGBQT* or their ethnicity are able to cope more successfully with the challenges they face.

Social support from friends and family also serves a critical protective role. Moody and Smith (2013), for example, found that perceived support from friends was associated with reduced suicidality among trans individuals. For transgender youth of color, identifying other youth and adults with similar identities helped to validate their experiences of racism within the LGBQT* community (Singh, 2013).

And in one study of MTF youth of color, friends were the most frequently cited source of support, and physicians or case managers were perceived as at least somewhat helpful (Stieglitz, 2010).

Social media has become a critical conduit for accessing social support within the LGBQT* community (Singh, 2013). Online communities have become sites of community organizing, cultural empowerment, and education for LGBQT* people, enhancing both a sense of identity and a sense of social support and community (Mehra, Merkel, & Bishop, 2004). Religion and spirituality may also contribute to resilience, particularly as these become sources of social support (Potter, 2007).

In sum, there is a clear need for supportive mental health and trauma-informed approaches for LGBQT* individuals. Furthermore, these services must recognize the societal factors that contribute to individual mental health concerns. LGB individuals, and transgender individuals in particular, experience high rates of traumatic experiences that stem from social isolation, prejudice, and discrimination. These experiences can have many negative mental health outcomes, and are exacerbated by multiple forms of oppression. Nonetheless, LGBQT* individuals show remarkable resilience by developing strong social support networks, creating and engaging with online and activist LGBQT* communities, and developing a positive LGBQT* identity. Trauma-informed approaches must allow providers to understand the context in which survivors have experienced abuse, identify sources of individual and communal strength and resilience, and support healing. Unfortunately, the current reality for sexual minorities who seek help from informal and formal supports is far different.

Help-Seeking Among LGBQT* Survivors

A range of systemic, institutional, and individual-level barriers uniquely thwart LGBQT* peoples' access to informal and formal support services (Edwards, Sylaska, & Neal, 2015; Helfrich & Simpson, 2006). At the broadest level, pervasive heterosexism renders violence between same sex partners invisible. The myth that IPV occurs only between men and women contributes to the profound difficulty that service professionals have even identifying IPV among LGBQT* couples (Blasko, Winek, & Bieschke, 2007; Brown & Groscup, 2008; Helfrich & Simpson, 2006; Seelau & Seelau, 2005). Brown and Groscup (2008) studied 120 crisis center workers' perceptions of same-sex DV by presenting scenarios in which only the gender of the abuser and survivor were changed, and found that participants ranked same-sex DV as less severe and less likely to get worse than the same scenario among heterosexual pairs. Although service providers may recognize that LGBQT* survivors deserve protection from IPV just as heterosexual survivors do (Sorenson & Thomas, 2009), these kinds of biases may affect their ability even to identify IPV in this community (Basow & Thompson, 2012).

Beyond the invisibility of LGBQT* IPV, a range of factors cause well-meaning social services systems to harm members of marginalized communities, including sexual minorities. Forms of oppression such as racism, colonialism, ableism, heterosexism, sexism, and transphobia that are often implicit in our helping systems can render these systems traumatogenic, especially when these oppressive dynamics are not acknowledged (Buzawa & Buzawa, 2003; Dirks, 2004; Herman, 2003; Walters, Simoni, & Evans-Campbell, 2002). The kind of harm done by institutions designed to provide support has been termed "sanctuary harm" (Bloom 2011; Bloom 2013).

A primary example of a system that causes this kind of sanctuary harm is the healthcare system. Historically, medicine and the health sciences were central to the effort to pathologize same sex relationships and transgenderism. Being gay or lesbian was classified as a mental disorder by the American Psychological Association until 1973, and conceptions of gender dysphoria as a mental health condition did not undergo a similar revolution until 2013 (Bayer, 1987; Drescher & Merlino, 2007).

The continuing impact of this history is evident in the experiences of LGBQT* patients in healthcare settings. Lambda Legal (2010) found that more than half of all sexual minority survey participants had experienced at least one of the following types of discrimination in a healthcare setting: being refused needed care; being blamed for their health status; seeing healthcare professionals refuse to touch them or use excessive precautions; hearing healthcare professionals use harsh or abusive language; or experiencing healthcare professionals being physically rough or abusive. Similarly, Shires and Jaffee (2015) found that over 40 percent of transgender men reported verbal harassment, physical assault, or denial of equal treatment in a doctor's office or hospital. Grant et al. (2011) reported that over one-quarter of respondents in a survey for the National Center for Transgender Equality experienced verbal harassment in medical settings, and that the likelihood of discrimination, abuse, or assault of transgender patients by their provider actually increased with the provider's awareness of their patient's transgender status. Such experiences of discrimination are far more likely to affect

LGBQT* patients of color, financially-oppressed patients, and undocumented patients (Grant et al., 2011; Lambda Legal, 2010).

Other examples of sanctuary harm abound across systems. For example, between 2010 and 2011, LGBQT* survivors reported an increase of incidences in which the police arrested both the abuser and victim when called (28.4% up from 21.9%), an increase in the percentage of LGBQT* survivors seeking shelter who were denied (61.6% up from 44.6%), and a decrease in the percentage of LGBQT* survivors who received requested orders of protection (78.1% down from 83.7%; NCAVP, 2015b). The same study found that transgender IPV survivors were over six times more likely to experience physical violence while interacting with the police than other survivors, and more likely to experience hate violence in shelters than other survivors (notably, trans men were 3.5 times more likely; whereas, trans women 1.3 times more likely) (NCAVP, 2015b). In short, transgender survivors may experience even more re-traumatization and less access to formal support systems than LGB survivors.

Mainstream programs may use heterosexist language in program materials, or have ambiguous or poorly defined policies regarding service provision for LGBQT* survivors (Helfrich & Simpson, 2006). LGBQT* survivors may well anticipate discrimination both from staff members and the heterosexual survivors using these services and may worry that their sexual orientation (and one could assume, gender identity) will be revealed should they actually seek help (Bornstein et al., 2006; McClennen, 2005; Helfrich & Simpson, 2006).

Low-income LGBQT* survivors of color experience another set of barriers: A community needs assessment of Black and Latin@ LGBQT* communities in the greater Boston area (Tod@s, The Hispanic Black Gay Coalition, The Violence Recovery Program at Fenway Health, The Network/La Red, & Renewal House, 2013) found that a lack of outreach to these communities limited their knowledge of IPV resources. In addition, geographic isolation, lack of transportation options, and the cost of making phone calls were major challenges to finding formal help. Similar to Black and Latin@ communities, Two-Spirit individuals identified lack of financial resources, transportation, and geographic inaccessibility as barriers to seeking support (Walters, Horwath, & Simoni, 2001). In addition, the lack of programming specifically aimed at Two-Spirit people and fear of what other Native community members might think were consistently ranked as barriers.

In the context of these institutional barriers, sexual minority survivors describe a range of personal reasons for not seeking support. Many feel that the need to educate a provider about one's identity and experiences would be overwhelming, particularly during a time of crisis (Turrell & Herrmann, 2008). Others worry about further victimization by providers who lack training on LGBQT* issues, and by other clients accessing the same services (Bornstein et al., 2006). Talking about abuse in one's intimate relationship almost always means coming out about one's sexual orientation or possibly one's gender identity. Further, gossip in insular or tight-knit communities raises concerns of confidentiality and retaliation – not just by the abuser but also by the community at large. Gay male survivors may keep silent about abuse and be more reluctant to seek help because they do not see doing so as consistent

with notions of masculinity (Seidler, 2006). According to Spiegel (2003), the abuse thrusts male survivors into "confrontation between two disparate psychosocial processes: the realities of abuse and the mythology of masculinity" (p. 133). Notably, although LGBQT* individuals may be hesitant to contact mainstream domestic violence programs, one survey reported that 86.2% of LGBQT* respondents *would* contact a domestic violence program if it was LGBQT*-specific (Holt, 2011).

Although the majority of LGBQT* survivors do not immediately seek help from the formal service system, they do rely on their informal social support systems; that is, their friends and families (Edwards et al., 2015). And yet, here too, LGBQT* survivors face a range of barriers to support. For example, LGBQT* survivors may be reluctant to seek help from friends and family given their own or their community's gendered beliefs about violence (e.g., women cannot be violent and men cannot be victimized) (Seelau & Seelau, 2005; Walters, 2011). They may be particularly hesitant to seek help from heterosexual friends or family members if they have had previous experiences of heterosexism and cissexism from their peers (Ard & Makadon, 2011). Survivors may have received messages that LGBQT* relationships themselves are "wrong" or "sick." Consequently, they may feel that admitting violence will only confirm these messages, conferring a sense of stigma on the victim, the relationship, and the LGBQT* community in general. Alternately, survivors who feel as though they are representing the LGBQT* community may feel that admitting IPV will harm the LGBQT* community at large (Balsam, 2001). Also, friends and resources may be shared between the survivor and perpetrator to an even greater degree than in heterosexual relationships, further making it difficult to access support (Bornstein et al., 2006).

In sum, a range of factors hinder LGBQT* survivors from seeking formal and informal assistance. Some survivors choose not to seek help from anyone; however, many survivors will make at least an initial attempt, and how they are treated can affect likelihood of seeking help in the future. Formal systems such as DV programs, hospitals, and law enforcement have a responsibility to ensure that they are facilitating help-seeking, not preventing it. To that end, the next section reviews the literature on a trauma-informed approach to practice, with attention to the needs of service providers who work with LGBQT* survivors, and provides examples of community-specific approaches to trauma.

Trauma-Informed Practices

A growing body of literature suggests that incorporating trauma-informed approaches into work with survivors is beneficial for the participant, staff, and overall organization. In this section we review the definition and core principles of a trauma-informed approach. Next, we discuss the need for LGBQT*-specific trauma-informed models and the role of transformative justice in developing such models.[5]

The term trauma-informed services was first used by Maxine Harris and Roger Fallot (2001a) in the context of mental health and addictions treatment programs. They noticed that many individuals seeking these services had experienced high rates of physical and sexual abuse, yet few providers were knowledgeable about trauma and the effects of such violence. As a result, services were not designed with trauma survivors in mind, increasing the possibility of retraumatization by the very services that were supposed to help them.

In response, Harris and Fallot (2001b) proposed creating trauma-informed service systems. This meant recognizing that the majority of people seeking services are likely to have experienced trauma; and that the effects of trauma impact many life domains, including people's experience of services. Thus, they argued, services had to be redesigned to incorporate an understanding of the pervasiveness of trauma and its impact on every aspect of their work. That is, programs and practices needed to be welcoming and appropriate for individuals with a history of trauma; and they needed to minimize retraumatization and promote healing and recovery. This, in turn, required an organizational commitment to trauma-informed practice, and ensuring that the necessary training for staff was in place.

In their initial work, Harris and Fallot (2001a) identified five requirements for creating trauma-informed services: (1) administrative commitment to change; (2) universal screening for trauma history among participants/clients;[6] (3) training and education on trauma for all staff; (4) hiring staff with a deep knowledge of trauma, referred to as "trauma champions;" and (5) reviewing policies and procedures to ensure they do not replicate abusive dynamics.

Although Harris and Fallot's approach was developed in the context of mental health and addictions services, its underlying principles have been adapted and applied to several different service contexts. These contexts include correctional facilities (Hodas, 2006), psychiatric and hospital settings (Jennings, 2004), homelessness services (Guarino, Soares, Konnath, Clervil, & Bassuk, 2009), addiction

[5] While the terms trauma-informed care and a trauma-informed approach are sometimes used interchangeably, the use of these terms has evolved over time. Trauma-informed care while perhaps still applicable in settings that provide health or mental health care, is actually inconsistent with the spirit/principles of a trauma-informed approach which involves service relationships that are fully collaborative rather than one person providing and the other receiving care.

[6] The requirement for universal trauma screening emerged in the context of mental health and addictions treatment services and are not necessarily applicable to other service settings such as DV programs.

services (Covington, 2008), services for children who have experienced abuse (Hodas, 2006; Ko et al., 2008), and DV organizations (Warshaw, Sullivan, & Rivera, 2013; Warshaw 2014; Wilson, Fauci, & Goodman, 2015).

These adaptations have not fundamentally altered the original principles, but have offered more expanded and nuanced interpretations of how they work in practice. In their excellent review, Hopper, Bassuk, and Olivet (2010) identified core principles that cut across different service contexts. These include: trauma awareness (e.g., staff training, consultation, supervision and self-care); safety (e.g., physical and emotional safety for all, awareness of potential triggers, clear roles and boundaries, and cultural diversity); opportunities to rebuild control (e.g., predictable environments, rebuilding efficacy, and personal control over lives); and a strengths-based approach (e.g., focus on future and skills-building).

Furthermore, Elliot, Bjelajac, Fallot, Markoff and Reed (2005) placed trauma-informed principles in the context of the entire service system and environment. For example, in a trauma-informed system, survivors engage with staff as collaborative partners rather than as passive recipients of services, and organizations actively solicit survivor input. In trauma-informed organizations, providers also strive to understand each survivor within the context of their background and life experiences and in terms of what is meaningful to them. Such contextualizing is essential. Because survivors experience trauma and seek support in a social, historical, and political context, healing must also include recognition of this context.

In order to do this difficult work, staff must themselves be supported. A fundamental aspect of a trauma-informed approach, therefore, involves creating an organizational environment that facilitates providers' capacity to do their work well. Clients interact with individual providers, who themselves interact with supervisors and the organization. When providers are subject to stressful organizational dynamics, those stresses interfere with their ability to be effective (Bloom, 2010). One consequence of problematic organizational dynamics is vicarious traumatization (synonymous with secondary traumatic stress or compassion fatigue) among service providers. Vicarious traumatization has been defined by Charles Figley (1995) as "the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 7), and symptoms may mimic those of PTSD. Vicarious traumatization has been linked to burnout in several studies (Bemiller & Williams, 2011; Brown & O'Brien, 1998; Ortlepp & Friedman, 2002; Ullman & Townsend, 2007).

Vicarious traumatization is widespread. Findings from a study of 148 advocates working in a range of types of DV organizations indicate that 47.3% of participants met criteria for clinical levels of PTSD symptoms (Slattery & Goodman, 2009). Organizational factors that may contribute to vicarious traumatization include a lack of involvement or influence on decision making, feeling like one's abilities are not being used, being exposed to danger at work, and too much focus on fixed regulations, procedures, and paperwork (Brown & O'Brien, 1998). Indeed, Slattery and Goodman (2009) found that lack of access to power (i.e., equality, voice, representation, shared leadership, and respect) in the

workplace significantly predicted vicarious traumatization above and beyond individual factors (e.g., personal history of trauma and exposure to traumatized clients). They recommended creating a workplace that emphasizes support, cooperation, effective communication, and conflict resolution skills and asserted that efforts to "flatten the hierarchy" and address power differences at the organization may also help minimize vicarious traumatization.

Creating a trauma-informed service system, then, occurs on three levels. The first is focused on the needs of survivors. The second is focused on changing an organization's culture to support staff and fully integrate trauma-informed practices into its service delivery; and the third level acknowledges the larger societal context in which survivors seek services and organizations operate. This level emphasizes not only engagement with the individual as part of a community, but also with community change itself in order to transform the conditions that produce abuse, violence, and trauma in the first place (Warshaw, 2014; Wilson et al., 2015).

These overarching principles have been applied across trauma-informed service systems. However, the particular language used to describe specific practices that arise from them may vary substantially depending on the service setting. The appendix provides a table of six trauma-informed models that have been identified as having some relevance for this project either because of the communities being served (LGBQT* or IPV survivors), the popularity of the model, or the credibility of the organization. See also Wilson and colleagues' (2015) recent qualitative content analysis of key documents – publications, manuals, and training guides – that describe an emerging consensus on trauma-informed practices in the domestic violence context, as well as points of difference and tension.

It is important to note that trauma-*informed* services are different from, but related to, trauma-*specific* services. Whereas trauma-informed services are designed to be implemented at all levels of an organization and focus on limiting the potential for retraumatization among participants, trauma-specific services are aimed at treating actual trauma symptoms (Harris & Fallot, 2001a). Examples of trauma-specific services include grounding techniques, psychoeducation, mind-body approaches and body-based therapies, cognitive behavioral therapy, and complex trauma treatment (Courtois & Ford, 2009; Courtois & Ford, 2015; Jennings, 2004; Resick, 2003; Warshaw & Brashler, 2009). A number of trauma-specific interventions have been tested in experimental or quasi-experimental research designs. Several studies have also attempted to document the effectiveness of trauma-specific services for female survivors of domestic violence. For a systematic review of evidence-based, trauma-specific services for survivors of domestic violence, see Warshaw et al. (2013). It is important to note, however, that none of these studies focused on LGBQT* survivors.

Trauma-informed service models are inherently more difficult to study because they focus less on specific practices and more on general principles, and they rely on change at the organizational level. Nonetheless, the Women, Co-Occurring Disorders, and Violence Study (WCDVS) attempted to evaluate the impact of this approach. As the only longitudinal study of a trauma-informed approach, the WCVDS indicated that women who received trauma-informed services showed small but significant

improvements on mental health outcomes and trauma symptoms relative to treatment as usual, but no effect for substance abuse (e.g., Morrissey et al., 2005). Since then, researchers have developed several tools to measure the presence of trauma-informed principles and practices as experienced by survivors (see, Accessing Safety and Recovery Initiative & the National Center on Domestic Violence, Trauma, & Mental Health, 2012; Goodman et al., in press;), and are testing new measures of the effects of trauma-informed practices on survivor wellbeing (National Center on Domestic Violence, Trauma, & Mental Health, in development), yielding new possibilities for exploring this important approach.

Trauma-Informed Practices with LGBQT Survivors of IPV*

Despite the high rates of IPV and trauma in LGBQT* communities, trauma-informed approaches tailored to LGBQT* communities have been slow to develop. Some non-IPV trauma-specific interventions have been designed with input from LGBQT* individuals and with concern for LGBQT* cultural competence (e.g., de Arrellano, Ko, Danielson, & Sprague, 2008; Real Life Heroes and Target-A). In addition, the Technical Assistance Partnership for Child and Family Mental Health created a webinar that discusses trauma-informed care for LGBQT* homeless youth. However, there are few well developed trauma-informed approaches for LGBQT* clients in service settings generally, and none in the field of IPV services.

Because of the barriers and difficulties faced by LGBQT* survivors, providers who work with these particular communities may face unique challenges, including lack of resources both within and outside of the service organization, exposure to homo-, bi-, and transphobia through hotline prank callers, experiences of discrimination while attempting to connect survivors with resources, and the possibility of increased vicarious trauma through shared LGBQT* identities.

At the same time, advocates may find strength and resiliency through a shared LGBQT* identity, a strong sense of LGBQT* community, and increased work satisfaction in serving marginalized community members. Advocates who identify as LGBQT* also may be able to draw upon their own experiences of discrimination as a source of resilience in the face of hardship. However, these hypotheses, which are informed by the authors' extensive practice experiences, have not been explored in the literature; considerable research is needed to determine the strengths and job stressors for providers who work with LGBQT* survivors.

Examples of Community-Specific Approaches to Trauma

Although there are no well-developed LGBQT*-specific practices, several community-specific approaches that have been developed by members of culturally-specific communities that have experienced multiple and overlapping forms of oppression may serve as guides.

One example, "Indigenist coping," which was first posited by Walters and colleagues (2002), is a Native-specific model that asks providers to abandon a focus on individual pathology, and instead center the historical trauma, ongoing discrimination, and experiences as a colonized people within a first world nation that are the norm for Native peoples in the U.S. (Walters et al., 2002). The multiple traumas experienced by Native peoples both individually and collectively are the foundation of service provision.

Walters and colleagues interpret the disproportionate rates of substance use, mental health challenges, and HIV risk behaviors among Native people, as conditions that might best be addressed and healed within the context of reconnection to the history and spiritual and healing practices of the Native community. Perhaps the most interesting aspect of the Indigenist coping model is its focus on uprooting internalized colonization and integrating identity along political, ethnic, racial, cultural, and spiritual dimensions. Although this model is not specific to Two-Spirit peoples, it is Two-Spirit-inclusive, and provides a conceptual framework that is responsive to the layered traumas experienced by too many Two-Spirit individuals (Walters, et al., 2002).

Similarly, the National Latin@ Network for Healthy Families and Communities has long used human rights and social justice frameworks to interpret trauma. Specifically, they view trauma through an understanding of multiple kinds of historical & collective trauma, the traumatogenic impact of "non-traditional" traumas such as racism, nativism, poverty, and discrimination and unjust denial of services from helping systems currently and historically experienced by Latin peoples. The National Latin@ Network correspondingly looks to identity cultural traditions and collective knowledge and wisdom, as sources of resilience and post-traumatic growth, both for individuals and for entire communities. Much like the Indigenist coping model (Walters et al., 2002), the approach of the National Latin@ Network looks to the community for both healing and leadership (Serrata, 2012).

Transformative Justice as a Trauma-Informed Practice

Transformative justice analyses recognize systemic oppression as contributing to and exacerbating the impact of interpersonal and community violence and seeks justice at every level (Hairston & Oliver, 2006; Generation Five, 2007). Whereas trauma-informed practice was conceptualized in clinical and academic contexts, transformative justice grew out of a community-based intervention model. It moves away from criminalizing and pathologizing those who use violence and toward transforming organizations, conditions, and systems that perpetuate violence. It is critical that trauma-informed practices include transformative justice as an additional lens in service delivery and system reform.

Generation Five (2007), an advocacy-based project working to end childhood sexual abuse, has helped shape a practice-oriented understanding of transformative justice by offering several goals and principles needed to build greater capacity of communities to challenge traumatogenic systems. According to Generation Five, there are four specific goals of transformative justice: safety, healing, and agency for survivors; accountability and transformation for people who use violence; community action,

healing, and accountability among those in positions of power; and, transformation of the social conditions that perpetuate violence. Notably, these goals build on a set of core principles: 1) liberation, 2) shifting power, 3) safety, 4) accountability, 5) collective action, 6) honoring diversity and 7) sustainability. Here, we explain these principles by providing possible ways in which they could be applied to work with LGBQT* survivors.

Liberation refers to ending long-standing intergenerational cycles of systemic and family violence, which can be partly achieved by shifting power away from those whose power has been achieved through domination, oppression, and violence. In the case of LGBQT* survivors, shifting power includes listening and responding to survivors' articulation of their stories and needs in order to promote self-determination. Liberation and shifting power also applies to LGBQT* individuals who use violence: To end intergenerational cycles of violence, it is important to understand their violent behaviors within the context of institutions and norms that perpetuate violence against them. For example, DV organizations can adopt more fluid and nuanced definitions of "victim" and "perpetrator"; that is, definitions that allow for someone to be (or have been) both a victim of violence and someone who used violence. Doing so invites people's full trauma history into the conversation for consideration and healing.

Safety is conceptualized on three intersecting levels. First, on an individual level, LGBQT* survivors must be protected from immediate and future acts of violence via intervention and prevention efforts. Second, within individual communities, action must be taken to foster norms and practices that condemn violence and support conditions for healing. Finally, at the macro level, communities must be accountable to one other in order to challenge institutional power. Part of that accountability includes acknowledging the prevalence and impact of interpersonal and historical trauma on individuals and communities as well as committing to survivor empowerment and healing. For example, mainstream DV programs can develop relationships with LGBQT* community members and programs to work toward long-term accountability of culturally sensitive service provision. They also can engage in ongoing program evaluation, including open discussion of policies, procedures, and staff profiles, in an effort to transform trauma-inducing organizational norms. Futures Without Violence (n.d.) has developed a series of "Program Personnel Policy Questions" for DV organizations to assess their readiness to work with children and teens; many of these questions can be amended to assess readiness to work with LGBQT* survivors. The National Center on Domestic Violence, Trauma & Mental Health's Accessible, Culturally Relevant, DV & Trauma-Informed (ACDVTI) Agency Self-Assessment Tool also provides guidance on organizational readiness and LGBTQ* inclusiveness.

Collective action highlights the need to address cycles of isolation and shame resulting from traumatic experiences by building alliances with communities to transform structures that perpetuate abuse. Additionally, honoring diversity includes creating and implementing interventions that respond to the unique needs of each community. Finally, sustainability refers to building internal capacity of intimate and community networks to support and maintain survivor-centered safety and healing. These last three principles highlight how social service organizations must incorporate advocacy efforts into

their work and cannot operate in isolation. Instead, they must learn from and collaborate with other organizations, specifically culturally specific organizations. Such collaboration includes not only LGBQT* organizations but also organizations that reflect the range of identities that LGBQT* survivors possess. Incorporating a diversity of expertise and perspective into programs and policies is critical for providing a more trauma-informed approach.

Conclusion

This literature review documents the need for LGBQT*-specific trauma-informed practices with survivors of IPV. IPV is at least as common among LGBQT* individuals as heterosexuals, and may be highest in bisexual and transgender communities. Furthermore, although LGBQT* IPV shares many underlying dynamics with IPV in heterosexual couples, it also has unique characteristics, including the types of abusive tactics used and the context of discrimination and social stigma faced by LGBQT* individuals. Moreover, there are additional complexities within LGBQT* subgroups.

LGBQT* survivors also face unique barriers to help-seeking. Overall, LGBQT* individuals are less likely to seek services from law enforcement and mainstream providers and more likely to rely on informal social support and LGBQT*-focused programs. There are also differences in help-seeking *within* LGBQT* subgroups. For instance, trans individuals may have an especially difficult time accessing culturally competent and non-traumatizing services. For LGBQT* people of color, stigma, economic constraints, and the absence of community outreach are barriers to accessing services.

Trauma and mental health are major concerns in LGBQT* communities in general, and for LGBQT* survivors specifically. LGBQT* individuals experience higher rates of traumatic events, and may be more susceptible to developing symptoms of PTSD, depression, isolation, suicidality, and anxiety. These concerns, which must be viewed in the context of historical trauma, are amplified for LGBQT* people of color and transgender individuals. Nonetheless, LGBQT* individuals find strength and resilience through identity affirmation and social support. More research focused on the strengths and sources of resilience of LGBQT* people is needed to complement and inform existing research on pathology and barriers.

Despite the high rates of IPV and trauma that LGBQT* communities experience, trauma-informed approaches tailored to LGBQT* survivors have been slow to develop. We hope that this document will facilitate thinking about how the core principles of trauma-informed practice can be applied to working with this community and to ameliorating vicarious traumatization among service-providers who do their best in difficult circumstances. The practice-based observations in the Appendix provide further framing for this important endeavor.

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Appendix A: Existing Trauma-Informed Approaches

Trauma-informed Approach	Trauma-informed Care with LGBQT* Homeless Youth
Community	LGBQT* Homeless Youth

Principles	Examples of Practices
• Recovery is possible • Healing happens in relationships • Sharing power and governance • Understanding trauma and its impact • Promoting safety • Supporting client control, choice, autonomy • Focus on strengths • Integrating cultural awareness	• Organizational commitment to nondiscrimination and cultural competence • Involve LGBQT* youth in decisions about services • Provide positive LGBQT* role models • Coordinate with LGBQT* service and advocacy organizations • Collaborate with other organizations • Outreach to change public awareness • Include LGBQT* youth in outreach • Assess staff for knowledge, attitudes, skills

Poirier, J., Murphy, C., Shelton, J., & Costello, S. (2013). Ending LGBT youth homelessness: A call to action. Retrieved from http://tapartnership.org/events/webinars/webinarArchives/presentationSlides/20130710_LGBThomelessness_FINAL.pdf

Trauma-informed Approach	Trauma-Informed or Trauma-Denied
Community	Female Survivors of Trauma

Principles	Examples of Practices
• Recognize the impact of violence and victimization on development and coping • Identify recovery from trauma as primary goal • Employ an empowerment model • Strive to maximize women's choice and control over recovery • Services are based in relational collaboration • Create an atmosphere respectful of survivors' need for safety, respect and acceptance • Emphasize women's strengths, adaptations and resiliency • Minimize retraumatization • Services are culturally competent and understand each woman in context • Solicit participant input and involve participants in designing and evaluating services	• Outreach and Engagement: prioritize safety, ask permission, follow client's lead • Screening and Assessment: screen all clients for trauma history, understand survivor's unwillingness to answer certain questions, only ask for necessary information, balance usefulness of information against client needs, clearly communicate reason for asking questions • Resource Coordination and Advocacy: focus on empowering clients, identify strengths, emphasize skill-building • Crisis Intervention: plan for crises in advance, avoid using restraints or forced hospitalizations, make sure clients know their options • Trauma-Specific Services: offered in trauma-informed environment by individuals trained in trauma and its treatment • Parenting Services: build on parents' strengths • Mental Health and Substance Abuse: treat trauma and substance abuse in integrated way, emphasize physical and emotional safety, collaborate on treatment • Healthcare: prepare clients for medical appointments that might be triggering, debrief and review information provided during exam

Elliot, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology, 33*(4), 461-477.

Trauma-informed Approach	The Sanctuary Model
Community	Originally for adults who experienced abuse as children, adapted to domestic violence settings

Principles	Examples of Practices
• Core Concepts: nonviolence, viewing organization as whole entity, parallel processes • 7 Commitments: • Nonviolence: physical and psychological nonviolence at all organizational levels • Emotional Intelligence: staff must cultivate awareness of emotional responses and be able to manage and talk about them • Social Learning: organization must be dynamic and constantly identify and respond to changing needs of communities being served • Open Communication: organization should espouse transparency, nonviolent language, and effectively manage conflicts • Democracy: everyone at the agency, clients and staff, should have a voice that is heard • Social Responsibility: create a just and safe organization • Growth and Change: focus should be on the future, with goal of changing and growing over time	

The Sanctuary Model. Accessed 7/2014, from http://www.sanctuaryweb.com/

Trauma-informed Approach	National Center for Domestic Violence, Trauma & Mental Health's Accessible, Culturally Relevant, Domestic Violence-and Trauma-Informed (ACDVTI) Agency Self-Assessment Tool
Community	Domestic violence survivors and programs

Principles	Examples of Practices
• ACDVTI Approach • Be sensitive to the pervasiveness of trauma and its impact on survivors, staff and organizations including historical trauma and ongoing experiences of discrimination and oppression • Recognize the role of coercive control and DV-related safety and confidentiality concerns • Ensure services are welcoming, inclusive, accessible and culturally responsive • Work to minimize retraumatization • Support resilience, healing and well-being • Employ a collaborative strength-based approach • Attend to the quality of interactions for people using services and staff • Involve people using services and communities being served in shaping and evaluating services • Maintain a commitment to changing the conditions that contribute to abuse, violence, discrimination & oppression • Key tenets include recognizing the importance of • Physical and emotional safety • Relationship & connection • Respect, empowerment, transparency, collaboration & choice • Hope & resilience • A survivor-defined approach	The ACDVTI tool provides guidance on engaging in a reflective organization-wide self-assessment process. It is structured to walk agencies through a process of considering what an ACDVTI approach would look like in each of the following 7 domains. • Organizational Commitment and Infrastructure • Staff Support • Physical, Sensory and Relational Environment • Intake Process • Programs and Services • Community Partnership • Evaluation and Feedback It also includes a section on organizational readiness.

National Center on Domestic Violence, Trauma & Mental Health. *Becoming Accessible, Culturally Relevant, Domestic Violence- and Trauma-Informed Organizations: An Organizational Reflection Tool*. National Center on Domestic Violence, Trauma & Mental Health. Chicago, IL. 2015 in press. National Coalition of Anti-Violence Programs.(2012). Hate Violence Against Lesbian, Gay, Bisexual, Transgender, Queer, and HIV- affected Communities In the United States in 2011: A Report from the National Coalition of Anti-Violence Programs. New York City: NCAVP. Retrieved 8/22/2015 from: http://www.cuav.org/wp-content/uploads/2012/08/4379_NCAVPHVReport2011Final_Updated.pdf.

Trauma-informed Approach	SAMHSA TIC in Behavioral Health Services Guide	
Community	Behavioral health service organizations	
Principles		**Examples of Practices**
6 Initial Chapters: • Trauma-informed care: A sociocultural perspective • Trauma awareness • Understanding the impact of trauma • Screening and assessment • Clinical issues across services • Trauma-specific services		• Show organizational and administrative commitment to TIC • Use trauma-informed principles in strategic planning • Review and update vision, mission and value statements • Assign a key staff member to facilitate change • Create a TIC oversight committee • Conduct and organizational self-assessment • Develop an implementation plan • Develop policies and procedures to ensure trauma-informed practices and prevent retraumatization • Develop a disaster plan • Incorporate universal routine screenings • Apply culturally responsive principles • Use science-based knowledge • Create a peer-support environment • Obtain ongoing feedback and evaluations • Change the environment to increase safety • Develop trauma-informed collaborations
Substance Abuse and Mental Health Services Administration. (2014). *Trauma-informed care in behavioral health services*. Rockville, MD: Substance Abuse and Mental Health Services Administration.		

Trauma-informed Approach	Developing Trauma-Informed Organizations Toolkit	
Community	Women with co-occurring disorders and histories of violence	
Principles		**Examples of Practices**
• A comprehensive, continuous, integrated service system • Person-centered services • Trauma • Safety • Family-focused • Diversity		• Establish open dialogue among providers, recipients, and systems • Increase capacity through cross-training, modification and addition of services as necessary • Increase access to peer support • Use respectful, gender-neutral, non-violent language • Recognize and understand cultural differences and how they impact the healing process • Provide co-ed and gender specific services • Staff should be knowledgeable about trauma • Provide access to trauma-specific services • Work with participants to develop calming skills • Validate participant experiences • Allow participant to define their family and support them in their role as parent • Cultural differences should be viewed as community resources and incorporated into service planning
Institute for Health and Recovery. (2012). *Developing Trauma-Informed Organizations: A Tool Kit* (Second ed.). Cambridge, MA: Institute for Health and Recovery.		

Appendix B: A Set of Practice-Based Observations for Trauma-Informed Practice with LGBQT* Survivors of Intimate Partner Violence

GLBTQDVP

GLBTQ Domestic Violence Project

TRAUMA-INFORMED APPROACHES FOR LGBQT* SURVIVORS OF INTIMATE PARTNER VIOLENCE

A Set of Practice Observations
June 2016

The production of this publication was supported by Grant Number 90EV0421 from the Administration on Children, Youth and Families, Family and Youth Services Bureau, US Department of Health and Human Services. The opinions, findings, conclusions and recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the Administration on Children, Youth and Families, Family and Youth Services Bureau, US Department of Health and Human Services.

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Acknowledgements:

The authors wish to give special thanks to members of our Advisory Board, including the NorthEast Two-Spirit Society, Queer Muslims of Boston, Fenway Community Health, the Hispanic Black Gay Coalition, the Massachusetts Alliance of Portuguese Speakers, HarborCOV, and Massachusetts Asian & Pacific Islanders for Health. This literature review would not have been half of what it is without their considerable and thoughtful contributions.

Produced by
The GLBTQ Domestic Violence Project

GLBTQDVP

For more information on supporting LGBQT* survivors of intimate partner violence, contact one of the organizations below:

The LGBTQ DV Capacity Building Learning Center
c/o The Northwest Network
A program focused on improving research, practice and policy regarding domestic violence in LGBTQ communities.
1-206-568-777 | info@nwnetwork.org | www.nwnetwork.org

FORGE
A transgender anti-violence organization, specializing in technical assistance for victim service agencies, with a focus on domestic violence, sexual assault, dating violence, stalking, and hate crimes.
1-414-559-2123 | AskFORGE@forge-forward.org | www.forge-forward.org

If you would like more information about accessible, culturally relevant trauma-informed approaches for survivors, contact:

The National Center on Domestic Violence, Trauma & Mental Health
A program providing training, support, and consultation to advocates, clinicians, attorneys and policymakers as they work to improve agency and systems-level responses to survivors and their children.
1-312-726-7020 | info@nationalcenterdvtraumamh.org | www.nationalcenterdvtraumamh.org

Introduction and Project Overview

This document contains a set of preliminary practice observations from the field, which are intended to inform the development of a trauma-informed transformative justice approach specific to lesbian, gay, bisexual, queer, and transgender (LGBQT*) survivors of intimate partner violence (IPV). These observations are the result of a research project that was led by the GLBTQ Domestic Violence Project (GLBTQ-DVP) and funded by the Administration for Children, Youth and Families, Family and Youth Services Bureau, US Department of Health and Human Services.

The goal of the project was to help develop a culturally-specific, trauma-informed approach to working with LGBQT* survivors with support and input from a range of stakeholders. To meet this goal, the following activities[1] were conducted over the course of two years (2013-2015):

- A substantive literature review on intimate partner violence in the LGBQT* communities (page 1), which is intended to be read in tandem with the observations
- Input from an advisory committee that included Queer Muslims of Boston, the Hispanic Black Gay Coalition, the Northeast Two Spirit Society, the Massachusetts Alliance of Portuguese Speakers, HarborCOV, Massachusetts Asian & Pacific Islanders for Health, and Fenway Health
- Two focus groups with survivors participating in one GLBTQ DVP program, the goal of which was to explore their experiences seeking help
- Three separate focus groups and multiple individual conversations with staff of one GLBTQ DVP program to assess their perceptions, experiences, and ideas about trauma-informed organizations and providing trauma-informed services
- Surveys of the program's staff as well as LGBQT* practitioners nationally to assess knowledge and experience of trauma-informed practices
- Informal conversations with staff and leadership of LGBQT* culturally-specific organizations across the country
- The authors' own collective experience working with LGBQT* organizations and communities over the past 30 years
- Considerable guidance from the National Center on Domestic Violence, Trauma, & Mental Health

From these multiple sources of data, a set of six observations emerged, which then were simplified and distilled in the hopes that they will be broadly applicable. They are listed here and explained in detail in the subsequent pages.

- Observation 1: The majority of LGBQT* survivors have experienced multiple forms of violence and abuse in their lives. Experiences of historical trauma and ongoing discrimination can compound these multiple experiences of victimization.

[1] The Simmons College Institutional Review Board approved the research activities involving human subjects (i.e., interviews and focus groups with practitioners and program participants).

- Observation 2: Organizations that work with LGBQT* survivors must operate from a place of understanding that perceived "challenges" may actually be creative strengths.

- Observation 3: Organizations that work with LGBQT* survivors must operate from the premise that if LGBQT* communities, staff, board members, organizations, and individual survivors lend you their trust, they are often accepting you as a community member, and possibly even as their family of choice, not merely as a service provider or colleague.

- Observation 4: If practitioners are to truly be of service, a social justice and anti-oppression framework must become the cornerstone of their individual work, their organization's work, and their organization's interactions with the community.

- Observation 5: Staff self-care (and organizational support for self-care) is critical.

- Observation 6: There is a profound need for transformative justice[2] approaches to working with LGBQT* and other multiply oppressed communities.

It is important to note that the authors view these observations as dynamic and evolving, and we are hopeful that LGBQT*organizations, practitioners, activists, and researchers will expand upon them as part of their own trauma-informed, anti-oppression, transformative justice work. Some sections of this addendum tie directly to the literature review (e.g., observations 1 and 5), and others do not. Also, although these observations grew in tandem with the literature review – and should be read together – some of the ideas are not yet supported by a body of literature. Rather, they reflect the practice wisdom and lived experience of LGBQT* practitioners and LGBQT* survivors who contributed to this project.

The practice observations and companion literature review are intended primarily for staff in domestic and sexual violence organizations; however, they are applicable to practitioners in other anti-abuse disciplines, homelessness services, mental health and healthcare circles, criminal legal systems, youth services, and an array of other human services disciplines and social change endeavors that seek to serve and ensure the inclusion of LGBQT* communities.

[2] The authors wish to thank Hales Burton at the Fenway Violence Recovery Program for first suggesting this conceptual shift.

A Note on Language[3]

Before describing the observations, the authors wish to acknowledge the deep complexities of language. In this document, IPV refers to the physical and/or emotional abuse of an individual by a current or former intimate partner. It includes the full range of tactics used to create and maintain power and control over another person, including financial abuse, verbal abuse and intimidation, and cultural abuse. In this document, the phrases *intimate partner violence* and *domestic violence* are used interchangeably to denote partner violence. However, it is important to note that domestic violence (DV) is sometimes defined more broadly to include violence and abuse perpetrated by relatives. Although many LGBQT* individuals experience abuse and/or rejection from family and relatives, the dynamics of partner violence versus family violence may differ dramatically. When we discuss the latter, we use the phrase *family violence* to distinguish it from violence by an intimate partner.

LGBQT* stands for lesbian, gay, bisexual, queer, and transgender. It is often used interchangeably with GLBTQ, LGBQT-TS, and similar acronyms to broadly refer to sexual and gender minorities. This document honors the current practice of including an asterisk after the "T" to signify the broad diversity of trans communities, including trans women – transgender individuals who identify as women, though assigned male at birth; trans men – transgender individuals who identify as men, though assigned female at birth; those transitioning from female to male (FTM); those transitioning from male to female (MTF); cross dressers; gender non-conforming individuals; and others who might self-identify as being members of trans communities. In this paper, transgender and trans are used interchangeably.

These definitions belie the complexity of the terms, however. The words *lesbian*, *gay*, *bisexual*, *transgender*, and *queer* all carry particular historical, political and cultural meanings. To a great extent, these words have been shaped in white, Western contexts. Words such as lesbian, gay, and bisexual, for example, are uniquely English. There are seldom translations into other languages that carry the same understanding of LGBQT* identity as being an identity rather than a set of behaviors. Literal translations, into Spanish or Haitian Creole as but two examples, carry few if any of the presumptions that are inherent in English. In many parts of the Latin and Spanish-speaking world, men who engage in sex with same sex partners are only considered "gay" in the English sense of the word if they are the receptive partner. It is not engaging in the acts that is the determinant of identity, so much as the role that an individual plays (traditionally read as *masculine* or *feminine*) in the conduct of that act. Similarly, men who marry women, but engage in same sex acts with other men, are frequently identified as heterosexual. In short, they are defined by their social role, rather than by their private, intimate acts. Hence the conception of *gay*, as defined in U.S. contexts, frequently fails to apply.

Precisely because identifiers such as LGBQT* were defined in white middle class and academic contexts, the limitations of LGBQT* labels and identifiers may be particularly acute in communities of

[3] For those of you who are reading the literature and practice observations in tandem, please note that this "note on language" section is identical to the "note on language" section in the literature review.

color, Indigenous communities, and immigrant communities, among others. During the course of crafting this literature review, members of our Advisory Board taught us a tremendous amount. The Hispanic Black Gay Coalition (HBGC) suggested use of the term *same gender loving*, a community-specific phrase coined by Cleo Manago to distinguish African Americans, and in particular African American men, who do not self-identify as being part of the predominantly white gay movement in the U.S., but who nonetheless wish to affirm their same sex intimate relationships. Corey Yarbrough, one of the founding Executive Directors of HBGC, suggested that for some same gender loving people this language may be a form of racialized resistance to the racism of the mainstream LGBQT* movement in the U.S. In the alternative, Corey stated, some members of African American communities may be on the *down low*, engaging in same sex sexual activity, but rejecting LGBQT* identifiers as a result of internalized homo and biphobia.

The NorthEast Two-Spirit Society (NETSS) in part echoed Corey's thoughts about the racism of the mainstream LGBQT* movement. In addition, Harlan Pruden, one of co-founders of NETSS, spoke about an "internal muddiness" that some Native peoples may experience when seeking to find language for their experience. Speaking of his own Cree inheritance as a registered member of the Saddle Indian Reservation, Harlan said that when he asked something of an elder, he knew to offer them tobacco, but never understood the spiritual dimension of the ceremony. Having been separated from too much of their own history by colonialism, genocide and forced assimilation, Harlan stated, many Native people may use the words *Two-Spirit* when what they really mean is gay Indian.[4]

Harlan also spoke at length about the contextual nature of Native Two-Spirit identities. As Harlan put it, "When I am out on a Friday night in a gay club, I am a gay man. Yet when I am in rural Oklahoma at a Two-Spirit gathering, I am a proud Two-Spirit man." Alluding to the unique role and cultural responsibilities that Two-Spirit people often held (and may still hold) in the life of Native communities, Harlan pointed out the obvious differences in the spiritual role of Two-Spirit peoples, and the political and social function of people claiming LGBQT* identities in mainstream communities. Several members of the project's advisory board echoed this point,
speaking about the complex layering of cultural and spiritual value systems that accompanied their choice to self-identify in, with, and outside of their own communities.

These same Advisory Board members also acknowledged the landscape in which such decisions are made, and stated that individuals in their communities may shift how they self identify as a means of preserving their safety. As the rest of this literature review discusses, LGB, transgender, same gender loving, Two-Spirit, and queer-identified peoples make choices about how, when, and if to "out" themselves in a complex social and political landscape that is too often unsafe, if not violent. Hence how

[4] Two-Spirit is a contemporary term, adopted from the Northern Algonquin, and meant to signify the embodiment of both masculine and feminine within one person. Now embraced by many Native peoples as a pan-Indigenous umbrella term connoting both diverse gender expressions and sexual orientations, Two-Spirit generally speaks to the respect that Native peoples held for diversity, and the unique sacred and ceremonial roles that Two-Spirit people held (and may still hold) within their own communities. Herein the phrase Two Spirit speaks not simply to a third gender, or to same gender attraction, but more broadly to the history of compulsory Christianization that sought to erase Two-Spirit peoples within their own nations. Notably, there is no single consensus definition of Two-Spirit, and the term means different things to different Native peoples.

any individual self-identifies may shift depending on who is asking, why, and in what context. As one Advisory Board member stated, "identities have to be fluid in order to be protective."

Finally, the leadership of HarborCOV, an LGBQT*-affirming DV organization in Boston that specializes in serving communities facing cultural or linguistic barriers, has noted that some cultures may not have the variety or depth of language that words such as LGB, transgender, same gender loving, and Two-Spirit convey. Indeed, Kourou Pich, Co-Executive Director of HarborCOV has observed that people from some cultures and communities may have difficulty finding language for themselves in their own communities, and that that invisibility is intentional – a function both of denial of the existence of sexual minorities in those communities, but also perhaps protectiveness of gender queer and same gender attracted people.

Language is power. We authors, therefore, have put a great deal of thought into the words we use to name peoples' experiences. At the same time, we know that we can never be as inclusive or sensitive as we want to be. We have done our best to honor the range of experiences we are writing about in this document.

Notes from the Field: A Set of Practice-Base Observations

Observation 1: The majority of LGBQT survivors have experienced multiple forms of violence and abuse in their lives. Experiences of historical trauma and ongoing discrimination can compound these multiple experiences of victimization.*

A trauma-informed approach, at its core, asks that practitioners assume that everyone they serve has experienced some form of violence, abuse, or other trauma in their lives and to see these experiences as the norm, rather than the exception (Felitti et al., 1998; Harris & Fallot, 2001).

Given the prevalence and overlapping nature of violence and abuse in the lives of LGBQT* peoples, it might be more prudent to suggest that practitioners build practices and systems that presume *multiple* forms of victimization among the people they serve. It is not unusual for LGBQT* peoples to be targets of many different forms of violence and abuse at the hands of multiple individuals, at numerous points throughout the lifespan (Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010; Grant, Mottet, & Tanis, 2011; Stotzer, 2009).[5] Indeed, traumatic experiences such as intimate partner

[5] To date, the fragmented nature of the research into violence and abuse in the lives of LGBQT* individuals means that, although there is a broad practice consensus about the prevalence of "polyvictimization" in the lives of LGBQT* peoples, there is little peer-reviewed research examining the phenomenon. However, there is abundant evidence that LGBQT* people, and in particular LGBQT* people of color, are more likely to be targeted for multiple forms of violence and abuse, in multiple contexts (family, partnerships, community) over the course of their lifetime. For example, LGBQT* peoples are disproportionately subject to childhood sexual abuse, bullying by peers, sexual violence in adolescence and adulthood, intimate partner violence, hate crimes, and police brutality (Roberts et al., 2010; Grant et al., 2011; Stotzer, 2009). Again, the authors wish to encourage individuals to read these observations in tandem with the literature review to learn more about these siloed areas of research.

violence, family violence, and other types of trauma that occur over the course of the lifespan, including childhood sexual assault, bullying, hate crimes, or police brutality, may intersect and compound each other in the lives of LGBQT* survivors in ways that create unique challenges for survivors themselves, and unique opportunities for control by future perpetrators.

These interpersonal traumas are often further compounded by experiences of oppression and historical trauma in LGBQT* communities. LGBQT* peoples have historically experienced discrimination at the hands of helping professionals in a range of systems (e.g., healthcare, mental health, criminal-legal, child protection, public assistance, and sexual and domestic violence organizations) – if LGBQT* peoples have been visible in those systems at all.[6] In addition, many of these systems (in particular mental health and criminal-legal systems) have not only pathologized, labeled, isolated, and detained LGBQT* individuals, but also intentionally fractured LGBQT* partnerships, families, and communities. Such treatment is especially the case for multiply marginalized LGBQT* communities, such as communities of color, immigrants and refugees, Two Spirit communities, and people with disabilities.

It is important to understand, however, that these forms of oppression are not merely historical artifact in the lives of LGBQT* survivors, but ongoing and continuing realities, especially for those who are multiply marginalized. This ongoing oppression then exacerbates experiences of current and historical trauma.

A trauma-informed approach encourages practitioners, and indeed entire systems, to minimize the possibilities for retraumatization by creating an atmosphere that prioritizes survivor's need for safety, respect, and acceptance (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005; Guarino, Soares, Konnath, Clervil, & Bassuk, 2009; Jennings, 2004; Substance Abuse and Mental Health Services Administration, 2014; Warshaw, 2014; Wilson, Fauci & Goodman, 2015). In short, a trauma-informed approach asks first and foremost that practitioners – as well as the systems in which they work – do no harm.

However, for LGBQT* survivors in particular, the mandate to do no harm requires that practitioners understand the concept of *sanctuary harm* – the idea that institutions and institutional gatekeepers can inflict enormous damage on the very people whose healing, empowerment, and safety they are supposed to nurture and protect (Bloom & Farragher, 2011; Smith & Freyd, 2014). Survivors who participated in the focus groups for this project spoke of blatant discrimination, noting, for example, institutions and practitioners who had at times openly refused services to male and LGBQT* survivors. And, in the staff focus groups, participants spoke about the challenges of advocating with organizations that had a funder mandate to be LGBQT* inclusive, but who were still actively resistant to accepting some members of this diverse community.

[6] The authors are mindful that historical trauma means different things in different communities. Many members of First Nation communities frame historical trauma in terms of colonization, genocide, and boarding-school trauma. Members of Jewish communities may frame historical trauma in terms of the intergenerational impact of the Holocaust. And members of the African Diaspora may think of the Middle Passage and the enslavement of African peoples when referencing historical traumas. The specific nature of the historical influences the way it continues to affect the lives of individuals and entire communities.

Conversations with LGBQT* practitioners across the country, especially those from mainstream organizations, surfaced deep ethical tensions over their own roles as institutional actors in organizations and agencies that they believed too often inflicted sanctuary harm. Consciousness of the harm they were doing – and the good they were prevented from doing – was a significant source of mental, emotional, and ethical distress for many practitioners, especially when contrasted with their larger awareness of the needs of the communities and people they were serving.

Observation 2: Organizations that work with LGBQT survivors must operate from a place of understanding that perceived "challenges" may actually be creative strengths.*

Recognizing the potentially significant impact of violence and abuse on development and coping strategies, a trauma-informed approach aims to contextualize coping strategies such as substance use, cutting, eating disorders, "promiscuous" sex, and dissociation as adaptive responses to otherwise intolerable situations (Elliot et al, 2005; Guarino et al., 2009; Jennings, 2004; SAMHSA, 2014, Warshaw 2014). Because it is rooted in clinical frameworks, trauma-informed practice approaches often frame such strategies as necessary within the context of abuse, but no longer adaptive once relative safety had been achieved. Following the examples of Kate Bornstein and Sylvia Rivera, the LGBQT*-specific practitioners who participated in the survey and informal conversations spoke about celebrating survivors' coping strategies as not merely adaptive, but indeed creative, even when such strategies are not on the surface immediately conducive to health or perceived well-being. Given the multiple forms of victimization, ongoing discrimination, and historical trauma that shape the LGBQT* experience, it may be that there is no safety anywhere. In that context, any strategy that allows people to survive – internally or externally – is to be celebrated. As one practitioner put it, "It isn't about coping, it is about surviving. We celebrate survival, because it is so uncertain." Such a response should not preclude practitioners from expressing concern or helping survivors to develop alternative survival strategies in parallel; however, it does require that practitioners fully embrace survivors and honor and respect their own strategies.

Observation 3: Organizations that work with LGBQT survivors must operate from the premise that if LGBQT* communities, staff, board members, organizations, and individual survivors lend you their trust, they are often accepting you as a community member, and possibly even as their family of choice, not merely as a service provider or colleague.*

A trauma-informed approach asks that practitioners base everything they do in relational collaboration. In fact, one of the core principles of a trauma-informed approach is to ensure that goals and strategies are collaboratively defined, and that the partnership between survivor and practitioner is itself a place of healing (Elliot, et al, 2005; SAMHSA, 2014; Warshaw, 2014; Davies & Lyon, 2014; Wilson et al., 2015).

Just as with other historically oppressed communities, the complexities of the LGBQT* experience may be such that a traditional relationship between service provider and client is not sufficient to fully support the person's healing. Instead, a different and more porous set of boundaries may be required – or at least expected. As several LGBQT* practitioners put it, when LGBQT* communities, staff, co-workers, and individual survivors lend you their trust, they are often accepting you as a community member, and possibly even as their "family of choice," not merely as a service provider. Program participants supported this sentiment, describing how one of the most important and helpful aspects of the services they received was the staff's willingness to go "above and beyond their job descriptions." Providing the sort of attention that a friend might provide (e.g., calling to check in or going along to doctor's appointments) was important because, as one survivor expressed, "I had never been treated that way in my life, not even by my family." Although this can raise complex ethical issues for both survivors and practitioners in navigating this important but complicated terrain, recognizing it is critical in working with LGBQT* survivors and working within LGBQT* communities.

Observation 4: If practitioners are to truly be of service, a social justice and anti-oppression framework must become the cornerstone of their individual work, their organization's work, and their organization's interactions with the community.

Another principle of trauma-informed practice is to respond to all people in ways that are sensitive to their individual social locations and contexts (Wilson et al., 2015; see also Elliot, et al, 2005; Jennings, 2004; Guarino et al., 2009; SAMHSA, 2014; National Center on Domestic Violence, Trauma & Mental Health, in press). At a minimum, this principle sets forth an expectation of cultural sensitivity across multiple aspects of identity. Given the chronic and cascading traumas, ongoing oppression and historical trauma referenced above, cultural sensitivity is essential but not sufficient for responding to the experiences of LGBQT* survivors. Instead, attention to individual social locations and contexts must be situated within a broader anti-oppression framework.

LGBQT* practitioners from across the country observed that the broader movements against sexual and domestic violence sometimes minimized the ways in which violence and abuse intersect with other forms of oppression. They took note not simply of the ways in which this lack of proactive attention shaped direct services, but also how it shaped their organization's hiring practices, the tokenization of staff members from historically marginalized communities, the narrow makeup of their organization's governing board, the focus on quantity over holistic quality of services, and the lack of input particularly from transgender community members and community members of color in strategic planning and other organizational activities.

By contrast, they called on practitioners to build organizations that are integrated into and learn from the historically marginalized communities they serve (or should be serving) and that center the knowledge and experiences of those communities. Historically oppressed communities, including LGBQT* communities, are at the leading edge of anti-violence work, not a set of "minority communities" requiring special logistics or uniquely special care. What organizations learn from historically oppressed communities should serve as the foundation of their organizational philosophy, practices, and policies.

Observation 5: Staff self-care (and organizational support for self-care) is critical.

Empathic engagement and bearing witness to other people's pain can affect us deeply. To be effective, it is important for service providers and activists serving people in pain and crisis to be mindful of how they have been affected by their own experiences of trauma *and* how they are affected when they open themselves up to other people's experiences (Saakvitne, Gamble, Pearlman, & Lev, 2000; Hopper, Bassuk, & Olivet, 2010; Bloom & Farragher, 2013; SAMHSA, 2014). Hence, an understanding of vicarious trauma and encouragement to develop strong habits of self-care have become foundational principles in trauma-informed practice (Bloom & Farragher, 2011; Bloom & Farragher, 2013). Thus, to be truly trauma-informed, organizations need to institute programmatic supports for self-care at all levels of the organization (Bloom & Farragher, 2011; Bloom & Farragher, 2013, Warshaw 2014).

Conversations with LGBQT* practitioners across the country led to an additional observation: There is a particular weight that accompanies serving LGBQT* people experiencing violence, abuse, and discrimination while simultaneously identifying with those same communities. Trauma, vicarious trauma, organizational trauma, and historical trauma compounded one another in the lives of the LGBQT* practitioners who contributed to this project, just as they do for the survivors who participate in their programs. Moreover, the impact of compounding trauma was one each group articulated virtually unanimously. Their experiences underscore the need for self-care at the individual level. They also point to need for organizational policies that enable self-care, provide LGBQT*-affirming workspaces, and facilitate connection with the larger community of providers and activists that support and depend upon the work and health of that organization. Essentially, caring for each other individually and as a collective is a critical element of any trauma-informed approach.

Observation 6: There is a profound need for transformative justice[7] approaches to working with LGBQT and other multiply oppressed communities.*

Because the companion literature review focused largely on peer-reviewed, published literature, it did not consider the enormous array of activist literature and art that historically oppressed communities have often used to express their communal strategies for survival and resistance. The work of Incite!, Creative Interventions, Black & Pink, and Break Out, along with broader bodies of art, music, dance, autobiography, fiction, and oral history attest to this creative communal drive.

One innovation that has emerged from this kind of activist energy is the concept of *transformative justice* (Generation Five, 2007; Creative Interventions, 2012). Transformative justice recognizes the profound harm and trauma that mainstream approaches have inflicted on LGBQT* peoples, particularly those who face multiple forms of oppression. Its practitioners argue for an approach that understands these historical harms and seeks to create new and innovative responses that avoid replicating them. Rather than work within the framework of social services, it aims for the liberation of oppressed people as communities not just as individuals, under the fundamental

[7] The authors wish to thank Hales Burton at the Fenway Violence Recovery Program for first suggesting this conceptual shift.

assumption that “individual justice and collective liberation are equally important, mutually supportive, and fundamentally intertwined” (Generation Five, 2007, p.1). In other words, transformative justice seeks to transform the political and cultural conditions that allow violence, abuse and oppression to exist in the first place. It is critical that trauma-informed practices include transformative justice as an additional lens in service delivery and system reform.

Conclusion

In summary, these six observations underscore the ways in which individual, interpersonal, and structural factors coalesce in the lives of LGBQT* survivors of domestic violence, creating a unique context, that affects their experiences and needs. Future trauma-informed approaches for LGBQT* survivors of domestic violence should consider the multi-layered context that surrounds LGBQT* survivors and use that knowledge to inform not only client-level practices, but also organizational-level policies.

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