THE IMPACT OF HATE CRIME TRAUMA ON GAY AND LESBIAN INTERPERSONAL RELATIONSHIPS

by

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Abstract

Homophobic hate crimes against lesbians and gay men represent a significant social problem that has important psychological consequences for survivors. Because the nature of these crimes is, by definition, against someone for his or her intrapersonal traits, it has even more potential to be damaging to a victim and in turn potentially detrimental to the development and/or maintenance of close personal relationships. The impact of trauma has long been studied from the view of the trauma survivor or any secondary traumatization of those around the primary survivor. The impact of hate crime victimization has also been examined, and it, too, has also been examined from the primary survivors perspective. Only in recent years has the impact of trauma on interpersonal relationships been examined. Additionally, there is currently little to no literature on the impact of trauma or traumatic events on gay or lesbian relationships. The types of hate crime victimization experiences range from verbal abuse to severe physical assault to death. While hate crime victimization is not specifically identified in the DSM – IV – TR as a potentially traumatic event, physical assault, which is found commonly in hate crimes, is identified. Therefore, hate crime victimization could be a potentially traumatic event. However, this has not been addressed in the traumatic stress field.

This report is intended to address the gaps in the current body of literature in both the traumatic stress field and the gay and lesbian literature. This overwhelming lack of literature has the potential to be very detrimental to professionals working with this population and in turn detrimental to the population and society. Evidence suggests that there may be a difference in how or if the potentially traumatic hate crime victimization experience manifests itself internally or in other forms because of the nature and severity of the victimization in one or both partners. Evidence also suggests, similarly to heterosexual couples, the impact of trauma has repercussions throughout the couple relationship. This report provides a preliminary start to continue and expand the work with the gay and lesbian community.

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CHAPTER 1 - Introduction

The impact of trauma has long been studied from the view of the trauma survivor or any secondary traumatization of those around the primary survivor. It has only been in recent years that the impact of trauma on interpersonal relationships has been examined. However, this only seems to apply to heterosexual relationships. There is currently little to no literature on the impact of trauma or traumatic events on gay or lesbian relationships. A major area of focus in the literature with gay and lesbian populations is the impact of hate crimes on the individual victim of such a crime (D'Augelli & Grossman, 2001; Herek, 2007; Herek, Gillis, & Cogan, 1999). Thus, the impact of hate crime trauma on gay and lesbian interpersonal relationships has been a wholly unexplored territory for researchers which in turn diminish the available literature for professionals working with this population.

Traumatic events have received substantial clinical and empirical attention in recent years. Although traumatic events have been survived by people for centuries, scientific knowledge of trauma has only been increased over the last few decades. Much of the literature on trauma and/or posttraumatic stress has been focused on the individual effects of trauma on the primary victim – the person who directly experienced the traumatic event (Herman, 1997; van der Kolk, McFarlane, & Weisaeth, 1996 as cited in Nelson Goff et al., 2006). The predominant view from the literature has been on the treatment of posttraumatic stress disorder (PTSD; American Psychiatric Association [APA] 2000) which by the definition of the disorder is intrapersonal in nature. The current definition of *trauma* in the traumatic stress field is based primarily on the *Diagnostic and Statistical Manual of Mental Disorders* (DSM–IV–TR; APA, 2000) criteria for PTSD.

However, some have challenged this notion beyond the *DSM-IV-TR*, suggesting an alternative model. Shalev (2005) indicated that a stressful event becomes traumatic when it is emotionally and personally meaningful and cognitively incongruent and it affects human bonds and networks, suggesting that "trauma should not be seen as affecting individuals but as affecting humans in their context." When looking at hate crime as being traumatic and using Shalev's suggestion of cognitive incongruence, an additional factor to this type of trauma to be considered would be the concept of internalized homophobia, which is described as the

internalization of society's view of homosexuality (Russell, 2007; Sue & Sue, 2003). From this standpoint, identifying as gay or lesbian and in turn internalizing society's homophobic view after being the victim of a hate crime seems like it would result in cognitive incongruence, thus affecting humans in their context.

The overwhelming lack of literature has the potential to be very detrimental to professionals working with this population and in turn detrimental to the population. Homophobic hate crimes against lesbians and gay men represent a significant social problem that has important psychological consequences for survivors. Hate, or bias, crimes refer to violence that is motivated specifically by the assailant's prejudice against the victim because of his or her group membership (e.g., race, religion, sexual orientation) (Federal Bureau of Investigation (FBI), 2007). Because the nature of these crimes is, by definition, against someone for his or her intrapersonal traits, it has even more potential to be damaging to a victim and in turn potentially detrimental to the development and/or maintenance of close personal relationships. If clinicians and other professionals are unaware of these effects on the individual and in turn the couple relationship, then those coming to them for services are not receiving a quality of care equal to what they require.

Research shows that hate crime victimization is widespread. Estimates based on 24 studies across the nation indicate that about 17% of lesbians and gay men reported having been assaulted during incidents in which the victim's sexual orientation was identified as the specific motive for the attack (Berrill, 1992). A more recent study of lesbians, gay men, and bisexual women and men by Herek et al. (1999) found that one in four gay men and one in five lesbian women were the victim of a hate crime since age 16. Hate crimes committed against gays and lesbians seem to have seen a slow decline throughout the United States (National Coalition of Anti-Violence Programs, 2007). However, the number of hate crimes reported may be inaccurate due to factors of fear, helplessness, and others. Nevertheless, the impact of hate crime attacks is important to recognize because of the psychological and emotional consequences these crimes have on those who are victimized.

Several authors have conducted research in areas of hate crime (Boyd, Berk, & Hammer, 1996; Franklin, 2002; Martin, 1995; Nolan, Akiyama, & Berhanu, 2002), trauma (D'Augelli & Grossman, 2001; Herek et al., 1999; Herek, 2007; Nelson Goff & Smith, 2005; Nelson Goff et al., 2006; Shalev, 2005; van der Kolk et al., 1996), and gay and lesbian couples

(Bepko & Johnson, 2000; Julien, Chartrans, & Bégin, 1999; Metz, Simon Rosser, & Strapko, 1994; Pachankis & Goldfried, 2004; Spitalnick & McNair, 2005). These topics will be discussed more in-depth in the review of literature.

Gay and lesbian populations have been of interest to me for quite a while. I believe that because of the potential impact of hate crime on individuals, it should impact policy and legislation as well as garner greater clinical attention. I also believe that current policy regarding gay marriage/civil union continues to perpetrate a negative image of gay and lesbian couples thus influencing public opinion. I have also been involved for several years in trauma research with clinical and military couples. From my work with these two populations, it seemed only natural to apply that lens to gay and lesbian couples as well. In examining the research, I found that there is no real literature on trauma and gay or lesbian couples. I feel that this is a gap in the research that should be examined to add to the body of literature of trauma in couple relationships. I hold no assumptions that trauma in general is inherently different in gay and lesbian couples than in heterosexual couples; however, I do believe there may be a difference in how or if the hate crime victimization experience manifests itself internally (e.g., internalized homophobia) or in other forms because of the nature and severity of the victimization in one or both partners. While hate crime victimization is not specifically identified in the DSM – IV – TR as a potentially traumatic event, physical assault, which is found commonly in hate crimes, is identified. Therefore, hate crime victimization could be a potentially traumatic event. However, this has not been addressed in the traumatic stress field.

This report is intended to address the benefits and limitations of the current research and implications for clinical practice and future research. This report is not intended to address best practices for the treatment of trauma or the etiology of homosexuality. Also this report will only address gay and lesbian issues and not bisexuality, transsexualism, or transgender issues. It is limited in scope as there is very little research combining the areas of hate crime trauma and gay and lesbian interpersonal relationships. Much will be interpreted and combined from the current research available in these separate areas. It is hypothesized that because of the nature of hate crime victimization, survivors may manifest more psychological symptoms than their heterosexual survivor counterparts. It is also hypothesized that because of the increase in these symptoms, gay and lesbian interpersonal relationships may experience more stress than couples with nonbias crime victims or nonvictims.

CHAPTER 2 - Review of the Literature on Gay and Lesbian Interpersonal Relationships, Hate Crime Victimization and Trauma in Couples

Gay and Lesbian Interpersonal Relationships

Data from the Census of 2000 (Simons & O'Connell, 2003) indicate that of the 5.5 million couples who were living together but not married, about one in nine were same-sex couples. Of these couples, 301,026 involved male partners and 293,365 involved female partners. In these relationships, there are several topics that are relevant, and many specific, to gay and lesbian couples. The topics that are shared between gay, lesbian and heterosexual couples include: conflict, relationship satisfaction, and stability (Kurdek, 2005). Minority stress has been defined as a state resulting from "culturally sanctioned, categorically ascribed inferior status, social prejudice and discrimination, the impact of these environmental forces on psychological well-being, and consequent readjustment or adaptation" (Brooks, 1981, p. 107). Those topics that reflect this concept of minority stress for gay men and lesbians include: family reaction, perceived support for the relationship, discrimination, sexual orientation conflict and outness, and HIV/AIDS (Lewis, Derlega, Berndt, Morris, & Rose, 2001).

Conflict

Conflict is inevitable in any relationship. In heterosexual couples, conflict is often thought to occur because of systematic differences in how men and women perceive their worlds. If this view of relationship conflict is valid, then one might expect that partners from same-sex couples would resolve conflict better than partners in a heterosexual couple because they perceive their worlds more similarly. Research supports this expectation.

Gottman et al. (2003) videotaped partners from gay, lesbian, and married heterosexual couples discussing problems in their relationships and then coded the emotions expressed by the partners in the course of the discussions. The researchers found that, relative to heterosexual partners, gay and lesbian partners began their discussions more positively and were more likely to maintain a positive tone throughout the course of the discussion. Findings from survey data also indicate that partners from gay and lesbian couples resolve conflict more positively than spouses from married couples do, they argue more effectively, are less likely to use a style of

conflict resolution in which one partner demands and the other withdraws, and are more likely to suggest possible solutions and compromises (Kurdek, 2004a). Gottman et al. (2003) speculated that partners from gay and lesbian couples handle conflict more positively than spouses from heterosexual couples because they value equality more and have fewer differences in power and status between them.

It is of note that, although partners from gay and lesbian couples tend to resolve conflict more positively, partners from gay, lesbian, and heterosexual couples are likely to disagree on the same issues. In a study in which partners rated how frequently they fought over 20 specific issues (Kurdek, 2004b), differences between gay, lesbian, and heterosexual couples were largely nonexistent. Additionally, findings that partners from gay, lesbian, and heterosexual couples identified the same source areas of conflict (finances, affection, sex, being overly critical, driving style, and household tasks) were also reported. Thus, differences in conflict resolution appear to be due to how conflict is handled rather than to what the conflict is about.

Relationship Satisfaction

Nearly all available evidence indicates not only that gay men and lesbians are, on average, satisfied with their relationships, but that their level of satisfaction is at least equal to that reported by spouses from married heterosexual couples (Blumstein & Schwartz, 1983; Kurdek, 1994; Kurdek, 2001; Todosijevik, Rothblum, & Solomon, 2005). Further longitudinal data from partners from gay, lesbian, and heterosexual couples indicated that, for each type of couple, self-reported relationship quality is relatively high at the start of the relationship but decreases over time (Kurdek, 1998).

Stability

Because survey data (Kurdek, 2004b) indicate between 8% and 21% of lesbian couples and between 18% and 28% of gay couples have lived together for 10 years or more, it is clear that gay men and lesbians can and do build durable relationships. More detailed information on the stability of gay and lesbian relationships is limited because few studies have followed the same sample of couples over time.

The data are too scant to warrant any conclusions about the relative stability of gay and lesbian couples. However, it is of note that Blumstein and Schwartz's (1983) data indicated that the dissolution rate for cohabiting heterosexual couples was similar to that for both gay couples

and lesbian couples. Unlike spouses from married heterosexual couples who experience social, religious, and legal barriers to leaving their relationships, cohabiting couples – whether gay, lesbian, or heterosexual – have no such institutionalized barriers. Further, although some gay and lesbian couples raise children, the majority do not (Simon & O'Connell, 2003), thereby removing another significant barrier to dissolution. Perhaps what is most impressive about gay and lesbian couples is not that they may be less stable than heterosexual married couples, but rather that they manage to endure without the benefits of institutionalized supports.

Family reaction

Before actually being told, a family member may suspect that his or her family member is gay or lesbian and, therefore, the mental processing may begin before the actual disclosure (Crosbie-Burnett, Foster, Murray, & Bowen, 1996); in this case the family member's blueprint about his or her family begins to shift to integrate the new beliefs. For example, a parent's blueprint of her grown son's future family might shift from a household consisting of son, daughter-in-law, and children to a household of son and male partner. Alternatively, at this stage, psychological denial is still possible, in which case, the family member does not perceive behavior that is inconsistent with the blueprint of one's child or sibling. For example a parent may not perceive a gay child flirting with a peer of the same sex.

However, after the “coming out” process, there is no turning back from addressing the reality of one's new role as a parent of sibling of a gay or lesbian person. At this point, a shift in the blueprint of one's self and one's child or sibling is necessitated. For example, a self-blueprint may shift from “I am the father of a typical American family,” to “I am the father in a family with a gay son,” (Crosbie-Burnett et al., 1996). There are cases in which parents cannot make the shift. Parents may try to maintain their original blueprint by ejecting the gay or lesbian member of the family, cutting off communication, and clearly placing him or her outside the boundary of the family (Crosbie-Burnett et al., 1996; Herek, Cogan, & Gillis, 2002).

Some extremes of these family reactions include victimization of the gay or lesbian family member by his or her family. In a recollection of such an event in Herek et al. (2002), a gay man was accosted by his father and brother after they had overheard the man talking with his mother about his weekend:

> They got up, both very angry – you could see it in their face with the blood vessels sticking out of their necks and on their foreheads. And it was what they said and their

> body language, it was pretty scary: “Queer, faggot, you're going to get what you deserve, you're going to get that AIDS...” They came in here, there was some grabbing of my clothing... I was able to defuse it, and let them know I was going to stand my ground. I was going to defend myself. (p. 328)

In another account, a woman described what happened after her mother read her diary, which included details about her sexual involvement with another woman:

> She went out and got drunk and then came home and started yelling and screaming at me about sleeping with women. Actually, it was girls at the time... She was pissed off at me because I was gay or I chose to sleep with women... She said stuff like “bumping pussies” and just stuff like that... And how sick it was, unnatural... And then she just started getting really crazy and hitting me and knocking me around. And actually I was pretty scared. (p. 328)

Strommen (1989) proposed a broad model of family members' responses to disclosure by a gay or lesbian family member. This model suggests that family members' reactions are dependent on three components: (1) the intrapersonal values concerning homosexuality held by the family member to whom the disclosure is made; (2) the effect that these values have on the cognitive, emotional, and behavioral relationship between the gay member and the other family members; and (3) the conflict resolution mechanisms available to family members, with the most significant component being the ability to reconcile values that family members hold concerning homosexuality with the reality of having a gay or lesbian child or sibling. Similar conclusions have been reached by Weinberg (1972) and Jones (1978) that focused at least two facets of parental reactions: (1) negative attributions being directed toward the gay child because the child that the parent thought he or she knew well is suddenly perceived as a very different person, making th child suddenly a stranger in the family, and (2) parents may have feelings of guilt and/or failure as parents out of beliefs and emotions based on negative values about homosexuality.

Perceived support for the relationship

Based on evidence that the level of support from members of one's social network affects the health of one's relationship, current theories about relationships (Huston, 2000) recognize that relationships develop within social contexts. Another study has examined the extent to which members of gay and lesbian couples perceive support for their relationships (Kurdek, 2004a). Relative to spouses in heterosexual couples, partners from gay and lesbian couples are

less likely to name family members as support providers. These differences are notable because they are among the largest differences found in comparisons between heterosexual and gay or lesbian couples. The lack of family support for one's primary close relationship is often viewed as a unique stressor for gay men and lesbians, and perhaps represents the overall lack of legal, social, political, economic, and religious support that gay and lesbian partners experience for their relationships. On the other hand, the high level of support that gay and lesbian partners enjoy from friends has been viewed as a way in which they compensate for the absence of institutionalized support.

Discrimination

There are currently still several areas in which gay men and lesbians face discrimination because of their sexual orientation. Two of these areas include: child custody and adoption and domestic partnership benefits. These are by no means the only areas nor are they the largest issues the gay and lesbian community as a whole face. However, these are the most prominent discriminatory stressors to interpersonal relationships. The rights of lesbians and gay men to retain their legal custody to their children or to gain custody of children by means of adoption or foster case are still a volatile issue. It has been estimated that as many as one quarter of all gay men and one half of all lesbians have been married at some point in their lives and many of them have children (Gottman, 1990; Patterson, 1992, 2000; Stewart, 2003). There are three major stereotypes that perpetuate the conflict: (a) lesbians and gay men are unfit parents, (b) homosexuals molest children, and (c) homosexual parents will make their children homosexual. First, the research on children raised by lesbian mothers or gay fathers reveals that there are no significant differences between these children and children raised by heterosexual parents (Bailey, Bobrow, Wolfe, & Mikach, 1995; Flaks, Ficher, Masterpasqua, & Joseph, 1995; Golombok, Spence, & Rutter, 1983; Huggins, 1989). Children of homosexual parents also do not suffer disproportionate amounts of turmoil or depression (Stewart, 2003).

Second, many studies have concluded that gay men are no more likely than heterosexual men to molest children (Newton, 1978; Jenny, Roesler & Poyer, 1994; Groth and Birnbaum, 1978 as cited in Stewart, 2003). One study (Jenny, Roesler, & Poyer, 1994 as cited in Stewart, 2003) reviewed charts of all sexually abused children seen in one year and revealed that only 0 – 3.1 percent had been abused by homosexual individuals. Groth and Birnbaum (1978) concluded

that children are unlikely to be molested by homosexuals in contrast to 82% of children primarily being molested by heterosexual partners of a close relative to the child.

Lastly, the sexual orientation of the parent has no influence on the gender identity or sexual orientation of the child (Green, 1978; Hoeffer, 1981; and Steckel, 1987 as cited in Stewart, 2003). Children prefer sex-typed toys or activities consistent with their biological gender or perceived gender identity regardless of their parent's sexual orientation. Many of these antigay stereotypes have been used to continually oppress lesbians and gay men. While some are slowly fading, these stereotypes are still an area of stress when working through custody or adoption cases.

The second area of discriminatory stress, domestic partnership programs, provides some of the legal and financial benefits of marriage to couples who are not married. However, these programs vary tremendously in what they provide and who qualifies. While many large businesses are implementing these programs, many others are not. Employment benefits have monetary value and granting them only to traditional married employees gives these employees financial benefits that are unavailable to employees in same-sex relationships (Stewart, 2003). For example, in 2001, the Salvation Army's Western Corporation decided to extend benefits to domestic partners. Religious conservatives claimed that homosexual relationships are not legitimate in God's eyes and asked members to contact the Salvation Army to persuade it to change the policy. The pressure worked and the Salvation Army rescinded its domestic partnership program two weeks later. The stress associated with working for a company that does not offer domestic partnership benefits can be great for couples facing financial problems (Stewart, 2003).

Sexual orientation conflict and outness

Despite evidence that sexual orientation exists on a continuum, for most people homosexuality (lesbian and gay sexual orientations) and heterosexuality have been traditionally regarded as separate and dichotomous orientations. Heterosexuality has been considered the normal, healthy outcome of psychosexual development and homosexuality the pathological deviation from that norm. Sexual orientation conflict refers to an internalized struggle regarding one's sexual orientation (Hancock, 2000; Lewis et al., 2001; Todosijevik et al., 2005). That is to say an internal conflict about whether one is gay or lesbian or heterosexual. This conflict is typically the result of societal stigmatization of being gay or lesbian and not being gay or lesbian

itself. Psychosocial and political factors are also associated with sexual orientation conflict in our society.

One of the most difficult times in the life of a gay man or lesbian is then they decided to "come out." This describes the process and events that surround a person when his or her homosexuality is disclosed (Mattison & McWhirter, 1995). People who have not yet been open about their sexual orientation are described as being "in the closet" (Mattison & McWhirter, 1995, p. 129). Lewis et al. (2001), in an empirical analysis or stressors for gay men and lesbians, looked at the relationship between gay stress and outness. Participants who were more open about their sexual orientation reported less sexual orientation conflict, less family stress, less stress about HIV/AIDS, and less stress related to discrimination.

A problem that can arise in gay and lesbian relationships is when there is a difference in the levels of outness between partners. Mattison and McWhirter (1995) characterize the coming out process as entailing the following, not necessarily in this order: (a) self-recognition as gay, (b) disclosure to others, (c) socialization with other gay people, (d) positive identification, and (e) integration and acceptance. When one partner is completely out to friends, family and society at large and the other is only out friends and/or family, and some in the gay community, this can cause friction in the relationship.

HIV/AIDS

I have left the topic of HIV/AIDS to the end of this section to be cautious about mentioning it in conjunction with gay and lesbian issues. HIV/AIDS is not a gay problem, and this should be clearly noted. However, it is naive to ignore that there has long been an association between the two in politics, media, and societal view. In a study by Todosijevik et al. (2005), gay male couples reported experiencing more stress surrounding HIV/AIDS-related issues and violence and harassment than lesbian couples. All evidence suggests that AIDS has negatively affected the cultural climate in which anti-gay violence occurs. According to the Presidential Commission on the Human Immunodeficiency Virus Epidemic (1988, as cited in Herek & Berrill, 1992):

> Increasing violence against those perceived to carry HIV, so-called 'hate crimes,' are a serious problem. The commission has heard reports in which gay men in particular have been victims of violent acts that are indicative of a society that is not reacting rationally to the epidemic. (p. 38)

While the number of anti-gay, lesbian, bisexual, transgender (LGBT) incidents reported has been on the decline in recent years (National Coalition of Anti-Violence Programs, 2007), there remains an issue of the number of incidents that go unreported each year. Survey data confirm the conclusion that AIDS has contributed to the problem of anti-gay violence. In Gross, Aurand, and Adessa's (1988) study of anti-gay violence in Pennsylvania, 13% of the gay men and 1% of the lesbian women reported that they had experienced violence or harassment that was AIDS-related (such as being called a "plague-carrying faggot" during an attack). In the Morgen and Grossman (1988, as cited in Herek & Berrill, 1992) study of anti-gay violence in Baltimore, 7% of the males and 6% of the females had encountered AIDS-related harassment or violence in a single year. According to a mail-in survey by Platt (1990, as cited in Herek & Berrill, 1992), of gay men and lesbians in 36 states, the District of Columbia, and Canada, 15% of those who had been verbally or physically assaulted reported that the perpetrator(s) had made reference to AIDS.

Asked whether fear and hatred associated with AIDS had fostered anti-gay harassment and violence in their communities, approximately 2/3 of the groups reporting incidents to the National Gay and Lesbian Task Force (NGLTF) for the year 1989 answered affirmatively (NGLTF, 1990). Of the 7,031 anti-gay episodes reported to the NGLTF in 1989, 15% were classified by local groups as "AIDS related" (i.e., incidents that involved verbal reference to AIDS by perpetrators or were directed against persons with AIDS). The proportion of AIDS-related incidents in previous years was 17% in 1988, 15% in 1987, 14% in 1986, and 8% in 1985 (NGLTF, 1986, 1987, 1988, 1989). The actual extent of AIDS-related episodes is probably underestimated because most organizations reporting to the NGLTF did not routinely note weather AIDS was a factor in incidents documented.

Although newspaper headlines have asserted that attacks on gay men and lesbians have been provoked by the fear of AIDS ("AIDS Epidemic Fuels Attacks on Gays," 1988; Johnson, 1987), AIDS is probably less a cause of anti-gay sentiment than it is a focus and justification for expressions of anti-gay prejudice (Herek & Glunt, 1988). Such prejudice is hardly a new phenomenon. What is new, however, is the visibility of gay men and lesbians in American society as a result of AIDS. Since the onset of the epidemic, there has been a dramatic and unprecedented increase in media attention to gay and lesbian issues. Such coverage, along with growing political activism within the gay community as a result of AIDS, may have

simultaneously increased public acceptance and exposed gay men and lesbians to greater risk of violence.

Hate Crime

Hate crime based on sexual orientation is a widely recognized social problem. So much so that in 1994, a federal law was passed that increased penalties for those crimes found to be hate crimes (Federal Bureau of Investigation, 2007). Researchers have suggested that limitations in police reporting, law enforcement practices, and politics cast doubt on the accuracy of anti-gay and lesbian victimization data (Boyd, Berk, & Hammer, 1996; Franklin, 2002; Martin, 1995; Nolan, Akiyama, & Berhanu, 2002). Of hate crimes that were reported, 50% of all victims were injured, 25% received serious injuries, and 2% were killed. The majority of these crimes (95%) were directed at the individuals (Anti-lesbian, gay, bisexual, and transgendered violence in 1996, 1996). Therefore, it is possible that the number of incidents occurring each year is higher than what is reported, leaving many victims possibly too afraid to report because of disclosure of their sexual orientation or too distrustful of law enforcement. A study by Herek et al. (2002) reported that victims' concerns of police bias and public disclosure of their sexual orientation were important factors in deciding whether to report antigay crimes, as were beliefs about the crime's severity and the likelihood that perpetrators would be punished.

Prior to the passage of the Hate Crime Statistics Act passed in 1990 (Federal Bureau of Investigation, 2007), no federal statute addressed the problem of antigay violence. Similarly, very few laws at the state and local level specifically addressed these types of crimes. The Hate Crime Statistics Act mandates collection of “accurate” hate crime information nationwide. This data would then be included in the Uniform Crime Report (UCR). From 1996, hate crime data collection became a permanent feature of the UCR. Despite this, conducting empirical research into anti- gay and lesbian hate crimes is complicated as the data quality is rather poor (Green, McFalls, & Smith, 2001; Nolan et al., 2002). It has been argued that hate crimes represent reporting characteristics, as opposed to criminal incidents, meaning that it is more representative of the types of victimization being reported versus the actual number occurring. Despite the limitations of using UCR data, it remains one of the only national databases containing information about anti- gay and lesbian hate victimization. A study by the NGLTF (1990 as cited in Herek & Berrill, 1992) reported the following:

- 19% reported having been punched, hit, kicked, or beaten at least once in their lives because of their sexual orientation.
- 44% have been threatened with physical violence.
- 92% of the individuals who were targets of antigay verbal abuse has experienced such harassment "more than once or many times."

The NGLTF reported "[Hate crime] figures released... by the FBI demonstrate that local law enforcement entities across the United States are massively underreporting hate crimes based on sexual orientation, and show the necessity for more effective legislation mandating that hate crimes be reported to the federal government" (NGLTF, 2001). The NGLTF survey also highlighted the difference between reports issued by gay rights activists and law enforcement authorities. It is important to note that private organizations have been monitoring hate crimes for a longer period of time than the government. The actual number of hate crimes based on sexual orientation reported by the UCR in 2006 is included in Table 2.1.

Table 2.1 2006 Hate Crime Statistics for Sexual Orientation Bias Offenses

	Incidents[1]	*Offenses*[2]	*Victims*[3]	*Known offenders*[4]
Totals:	**1,195**	**1,415**	**1,472**	**1,380**
Anti-Male Homosexual	747	881	913	914
Anti-Female Homosexual	163	192	202	154
Anti-Homosexual	238	293	307	268
Anti-Heterosexual	26	28	29	26
Anti-Bisexual	21	21	21	18

[1] The term *incident* refers to the number of single- or multiple-bias events.

[2] The term *offense* refers to the type(s) of crime committed in a incident. These include, but are not limited to, destruction/damage/vandalism, intimidation, simple assault, & aggravated assault.

[3] The term *victim* may refer to a person, business, institution, or society as a whole.

[4] The term *known offender* does not imply that the identity of the suspect is known, but only that an attribute of the suspect has been identified, which distinguishes him/her from an unknown offender.

Source: Federal Bureau of Investigation, *Incidents, Offenses, Victims, and Known Offenders by Bias Motivation***,** 2006

The scope and nature of antigay violence is severe throughout the nation. Violent hate crimes committed against gays and lesbians are notable in another respect: these incidents are especially brutal. According to one study:

> an intense rage is present in nearly all homicide cases involving gay male victims. A striking feature... is their gruesome, often vicious nature. Seldom is the homosexual victim simply shot. He is more apt to be stabbed a dozen or more times, mutilated, and strangled. (Winer, 1993 as cited in Altschiller, 1999, p. 10)

A hospital official in New York City also remarked, "Attacks against gay men were the most heinous and brutal I encountered... They frequently involved torture, cutting, mutilations... showing the absolute intent to rub out the human being because of his (sexual) preference" (Winer, 1993 as cited in Altschiller, 1999, p. 10). Murders of gay and lesbian individuals in recent history include: a lesbian couple, Rebecca Wright and Claudia Brenner; two gay men in Dallas, TX, Tom Trible and Lloyd Griffen; Vietnam veteran James Zappalorti; Seaman Allen Schindler; and, perhaps the one that has drawn the most public attention, Matthew Shepard.

The brutality of hate crimes has consequences for the entire community, not just the victim. It is not an exaggeration to say that "bias-motivated attacks function as a form of terrorism" (Herek et al., 2002, p. 336), sending a message to all lesbians and gay men that they are not safe if they are visible. Thus, even when one does not personally know the victim, hate crimes can threaten the illusion of invulnerability that is so important in one's daily life (Janoff-Bulman, 1992). A gay or lesbian person who encounters an expression of hostility because of his or her sexual orientation does not know in advance how the incident will end. He or she may be attacked with words or a deadly weapon. Consequently, an incident that appears minor in retrospect might nevertheless have considerable psychological consequences on the victim.

Research has found that gay men and lesbians as a group are not more psychologically disturbed because they are gay or lesbian (Gonsiorek, 1982). However, exposure to society discrimination may be responsible for findings that gay and lesbian individuals report elevated rates of major depression, generalized anxiety disorder, and substance abuse (DeAngelis, 2002). Gay men reported higher rates of major depression than lesbian women. Lesbian women appear to fare better and reported mental health equal to that of their heterosexual counterparts as well as higher self-esteem (DeAngelis, 2002).

Much of the literature on hate crime victimization is targeted at the impact on the individual survivors. A pilot study (Herek, Cogan, Gillis, & Glunt, 1997) reported that compared

to other respondents, those who were hate crime survivors manifested higher levels of depression, anger, anxiety, and symptoms of posttraumatic stress. These results were supported by an additional study by the authors (Herek et al., 1999). Additionally, the authors found that hate crime survivors displayed more crime-related fears and beliefs, lower sense of mastery, and attributions of their personal setbacks to sexual prejudice than did nonbias crime victims and nonvictims.

In a study of older (age 60+) lesbian, gay, and bisexual (LGB) individuals, those who had been physically attacked reported lower self-esteem, more loneliness, and poorer mental health than other types of victimization (D'Augelli & Grossman, 2001). Additionally, more suicide attempts were reported by those older adults who were physically attacked. Nearly three quarters reported some kind of sexual orientation victimization with men reporting more overall victimization than women (D'Augelli & Grossman, 2001). The authors associated physical victimization with earlier achievement of sexual orientation milestones (e.g., first time same-sex sexual feelings and first considered themselves LGB, how they first self-identified, and when they first told someone about their orientation) and more time being open about their orientation.

A model for examining why hate crime against LGBT individuals occurs was posed by Alden and Parker (2005). The authors assert that in order to understand anti- gay and lesbian hate, one must first understand the concept of *heterosexism*. Heterosexism refers to an "ideological system that denies, denigrates, and stigmatizes any non-heterosexual form of behavior, identity, relationship or community... heterosexism is manifested both in societal customs and institutions" (Herek & Berrill, 1992, p. 89). In understanding this concept, it suggests how cultural belief systems that consistently denigrate gay and lesbian individuals, and describe them as not being "real" men or "real" women, perpetuate and encourages hate crimes. In areas with liberal attitudes toward gender roles, it did not significantly reduce the incidents of hate crimes. However, those areas with less gender equality have less hate crime victimization. Therefore, homophobia and gender stratification seems to directly influence incidents of hate crime victimization.

As reviewed in Alden and Parker (2005), previous research in this area also found that the intensity of homophobia at the individual level is impacted by gender (Connell, 1995; Kimmel, 1994), age (Kite & Whitely, 1998; Kurdek, 1988; Morrison, McLead, Morrison, Anderson, & O'Connor, 1997; Whitley, 1987), education (Kurdek, 1988; Strand, 1998), religious

ideology (Birken, 1997; Edwards, 1989; Henley & Pincus, 1978; Herek, 1984; Larsen, Reed, & Hoffman, 1980; Newman, 1989; Peplau, Hill, & Rubin, 1993), and adherence to traditional gender role ideology (Cotten-Huston & Waite, 2000; Ficarrotto, 1990; Stark, 1991). The authors found that beliefs around morality were significant predictors of hate crime victimization. Additionally, urban areas with more gender equity have significantly higher counts of gay and lesbian victimization. Alden and Parker assert that gay bashing provides proof of manhood and serves as a resource for accomplishing masculinity. Lastly, the authors found that areas of high concentrations of gay and lesbian households showed increased incident rates of hate crime victimization.

Trauma in Couples

The area of trauma has been studied substantially in the past few decades. However, much of the literature in this area is focused on the individual effects of trauma on the primary victim – the one who directly experienced the traumatic event (Herman, 1997; Nelson, Wangsgaard, Yorgason, Higgins Kessler, & Carter-Vassol, 2002; Nelson Goff et al., 2006; van der Kolk et al., 1996). There has also been a move to study the effect of possible secondary traumatization in those close to the primary trauma survivor. Being in close contact with and emotionally connected to a trauma survivor becomes a stressor and those close to the survivor experience his/her own symptoms of traumatization (Arzi, Solomon, & Dekel, 2000; Nelson Goff & Smith, 2005). Several terms have been used to describe these effects, like “compassion fatigue” (Figley, 1995, 2002), “vicarious traumatization” (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), and “burnout” (Figley, 1998). However, much of this literature is focused on heterosexual relationships.

Because of the nature and prevalence of hate crimes discussed earlier, it seems that they have great potential to be very traumatic experiences. The impact of trauma on individual survivors has been well documented; however, there is limited information regarding its impact on couples. One such study by Nelson Goff et al. (2006) addressed the effects of trauma on intimate relationships. In this study, clinical couples in which at least one partner had reported exposure to a traumatic event were interviewed regarding the long-term, interpersonal impact of trauma on the couple relationship. Several salient themes were found, including themes that were dichotomous to each other. These themes included: increased communication, decreased

communication, increased cohesion/connection, decreased cohesion/connection, increased understanding, decreased understanding, increased relationship distress, support from partner, and relationship resources.

With several of the themes seemingly opposite of one another, it shows that relationship responses to trauma history may fall along a continuum. This indicates probable areas of strengths and weaknesses within the relationship. Even participants who reported relationship distress also described positive aspects as well as participants who described being satisfied with their relationship reported a range of problems. These findings fit with the Couple Adaptation to Traumatic Stress (CATS) Model (Nelson Goff & Smith, 2005). This model addresses areas of attachment, satisfaction, stability, adaptability, support and nurturance, power, intimacy, communication, conflict, and roles as key factors in systemic functioning of couples with trauma history. While not all the CATS themes were present in the Nelson Goff et al. (2006) study, it was able to provide additional information to the body of research on trauma in couples.

Another study of interest was Nelson et al.(2002) that investigated the relationship characteristics of single- and dual-trauma couples. There are still very few articles available that describe dual-trauma couples from a clinical perspective (Balcom, 1996; Compton & Follette, 1998). Dual-trauma refers to couples who report different trauma experiences (e.g., one was robbed at gunpoint and the other was physically assaulted resulting in serious injury), as opposed to a couple with a shared trauma experience (e.g., both being involved in a car crash that resulted in the death of their child). This study identified eight characteristics: issues of power and control, competition between partners, external boundary ambiguity, trauma-related symptoms, survivor guilt, preoccupied-dismissing couples, and current behavior and past experiences. Issues of power and control seemed to reflect one partner having control over important aspects of the relationship whereas the other partner had limited or no control. Competition between partners manifested as which partner had the “worst” traumatic experience, a tendency towards the “victim role,” or competition for being the “healthy survivor.” External boundary ambiguity refers to either extremely fluid or extremely rigid external boundaries with respect to attempts by others to enter the system (e.g., in therapy) and can be inconsistent. Trauma-related symptoms pertain to symptoms related to their trauma histories. Anxiety seemed to be a common symptom because of what they describe as “feeling the presence of the perpetrator(s) in their relationship,” (p. 64). Survivor guilt manifests as one or both partners having witnessed a traumatic event but

were not the direct victims. Goodwin (1980 as cited in Nelson et al., 2002), defines this as a feeling of "self-blame for witnessing the abuse or for not being abused" (p. 64). Preoccupied-dismissing couples appear to take complementary positions regarding their reaction to the traumatic event. One partner may become overly preoccupied with the effect of the event whereas the other may deny or dismiss the effects. Finally, current behavior and past experiences may manifest as one or both partners minimizing the effects of past traumatic experiences on their current behaviors and relationship patterns.

Application of trauma research to hate crime-specific effects in gay and lesbian interpersonal relationships is absent in the current literature. Traumatic events such as assault or possibility of death have been documented far too well to include here. However, crimes that take on a decidedly more personal tone because of bias do not seem to be on the research radar for impact on gay and lesbian interpersonal relationships. It seems that there is a potentially detrimental gap in the research to address a still common problem and one that may be of clinical importance. Because of the number of incidents, both reported and unreported, and the potentially traumatic nature of hate crime victimization, this gap in the literature may have serious clinical implications, which will be discussed next.

CHAPTER 3 - Clinical Implications

Approximately 1.2 million people are part of gay and lesbian couples in the United States, representing a 300% increase since 1990 (Cohn, 2001 as cited in Sue & Sue, 2003). Gay men and lesbians are utilizing therapy at rates higher than the general population (Bell & Weinberg, 1978; Liddle, 1996; Morgan, 1992; National Lesbian and Gay Health Foundation, 1988; Pachankis & Goldfried, 2004). Because of the large number of gay and lesbian couples and families, mental health professionals are likely to encounter them as clients. Most therapists have seen gay or lesbian clients in their practices. In a survey of 2,544 American Psychological Association member psychotherapists, 99% had reported seeing a minimum of one gay or lesbian client during their careers (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991), and, on average, therapists reported that 13% of their caseloads are gay and lesbian clients (Green & Bobele, 1994).

As noted before, a hate crime incident that appears minor in retrospect might have considerable psychological consequences on the victim. In turn, This means that therapists must be properly prepared not only to face the issues their clients are presenting but also their own perceptions and feelings regarding homosexuality. Anti-gay and -lesbian bias can operate in obvious as well as subtle ways in society. These biases may not only influence the therapist's conceptualization of clients but can also influence the gay or lesbian client's conceptualization of themselves.

There are several issues, in general, that mental health professionals must be ready to face when working with gay/lesbian clients and their families. Gay and lesbian individuals must face prejudice and discrimination from society. In relationships, each individual may differ in internalized homophobia or the extent to which they are “out” to others in their social, work, or family networks (Blando, 2001). Identity issues, coming out, child custody and adoption, and aging are all areas that professionals must be aware of when working with gay/lesbian client systems as well as being aware of the implications that these issues bring with them.

The impact of traumatic stress on survivors and their families is of particular interest to couple and family therapy. The similarity between the symptoms reported in the literature and

the presenting problems many couples bring to therapy is striking. The potential for the development of disruptive interpersonal processes suggests that individual trauma may have extensive consequences for the couple system. Treating trauma in isolation may overlook the consequences for couples, as well as the potential for interaction patterns to exacerbate symptoms of primary trauma. Understanding how trauma effects manifest within the couple system will improve clinicians' ability to intervene successfully with these client systems.

There have been several studies (Godfrey, Haddock, Fisher, & Lund, 2006; Malley, 2002; Pachankis & Goldfried, 2004; Spitalnick & McNair, 2005) that have addressed the issue of working ethically with the gay and lesbian population. Many others have been used in compiling the APA's Guidelines for Psychotherapy with Lesbian, Gay, & Bisexual Clients. Under those guidelines, guidelines 14 – 16 specifically address the area of education for professionals working with this population. A full, abridged version of these guidelines is included in Appendix A.

Homophobia and Heterocentrism

Homophobia is a term typically used to describe hostility and prejudice toward homosexual individuals and their behavior (Bepko & Johnson, 2000; Herek, 1996; Sue & Sue, 2003). It refers to an extreme, negative reaction on the part of both heterosexual and homosexual persons to homosexual individuals and homosexual behavior. However, the term *homophobia* has been criticized by some as inaccurate or misleading because of the fact that it is not a phobia in a clinical sense (Kitzinger, 1987; Shields & Harriman, 1984) and suggests a pathology in the person who displays it versus an internalization of cultural values (Herek, 1991).

Heterocentrism can be used to describe the implicit – or sometimes explicit – bias against gay and lesbian individuals. The term *heterosexism* is typically used in the literature to describe such bias. However, the term heterocentrism better captures the notion that this bias is often not intentional but rather is due to oversights on the part of mainstream society in considering the existence of diverse sexual orientations. Heterocentrism manifests itself in more subtle ways than does homophobia. Heterocentrism is conveyed by the systemic attitudes and assumptions that operate in a society that understands itself, by default, as purely heterosexual. These beliefs can be manifested at the cultural and individual levels (Herek, 1996).

Potential Therapeutic Biases

Societal and individual heterocentrism can affect the ways that therapists conceptualize and treat clients. Approximately 46% of gay and lesbian clients have experienced a homophobic therapist, and 34% have experienced a therapist who refused to acknowledge their sexual orientation or viewing their sexual orientation as a temporary situation (Nystrom, 1997) Countering such bias is central to establishing ethical practices with gay and lesbian clients (Brown, 1996). There are many obvious and subtle biases that can permeate the treatment of a gay or lesbian individual. One of the most blatant injustices reported by the APA Task Force on Bias in Psychotherapy With Lesbians and Gays (Garnets et al., 1991) was the attempts by a therapist to change the client's sexual orientation or to make continuation in therapy contingent on “dealing with” one's gay/lesbian identity (this may also be referred to as conversion or reparative therapy). Further abuses have included attributing a client's problems to his or her sexual orientation without taking into account the damage that societal heterocentrism and internalized homophobia can inflict on gay and lesbian individuals. Less than appropriate treatment of gay and lesbian clients may also occur when either: a therapist assumes that the client is heterosexual, or when a gay or lesbian orientation is revealed, the therapist then focuses on the sexual orientation of the client, despite the fact that it is not the issue at hand. Other mistreatment occurs when the therapist is unaware of the unique aspects inherent in gay and lesbian identity development; how gay and lesbian individuals deal with family of origin issues; the parameters associated with gay and lesbian romantic relationships and gay/lesbian individuals as parents; and the unique issues experienced by older, religious, and/or ethnic minority gay and lesbian individuals. Such inadvertent biased practices may cause more distress for a gay or lesbian individual at a time when they are vulnerable and in need of empathetic care.

Given these very real risks of biased treatment, it is essential to investigate the possibility that therapists' original training and continued education fail to facilitate competence in working with gay and lesbian clients. The APA has taken steps by introducing a set of guidelines for psychotherapy with gay and lesbian clients. The APA, American Association of Marriage and Family Therapy (AAMFT), National Association of Social Workers (NASW), and American Counseling Association (ACA) have all taken steps by including LGBT affirmative continuing education courses. However, given the previous notion of heterocentrism, some therapists may not elect to take these continuing educational courses either because they feel that their current training is sufficient for dealing with gay and lesbian issues or they may decline working with

gay and lesbian individuals for personal/moral/religious/or other reasons. In either event, not only is it the gay and lesbian population's loss, but the therapist's as well. It is my belief that all therapists, regardless of their personal beliefs, must be able to deliver ethical services to all clients because they may not be aware of all the aspects of a particular client's life.

Some therapists have developed models of therapy that affirm gay and lesbian identities and seek to foster the development of all aspects of a gay/lesbian client's identity and the enhancement of a gay/lesbian individual's experiences. However, many clinicians still believe that gay and lesbian clients can and ought to be treated in the same manner as their heterosexual counterparts. Despite these good intentions, it is essential to recognize that gay and lesbian clients present unique issues in the therapeutic context. Gay- and lesbian-affirmative therapists utilize the body of knowledge that addresses issues specific to gay and lesbian individuals with the purpose of bridging the gaps left by heterocentric assumptions of the prevailing therapy models (Davies & Neal, 1996). Some of these issues include: identity development, couple relationships and parenting, and families of origin and families of choice to name a few. I would pose that hate crime based on sexual orientation is also a specific issue to gay and lesbian individuals.

As there is no literature to my knowledge that addresses the specific area of hate crime victimization in regards to interpersonal relationships as a clinical concern, it seems that that very issue is a clinical concern. Much has been researched about individual presentation of victimization effects. However, applying a systemic lens to gay and lesbian couples presenting with a history of hate crime victimization seems lacking. Given the severe and cruel nature of many anti-gay and -lesbian hate crimes, it seems as though looking at it through a trauma lens has also been lacking.

Hate crime victimization goes as far as murder of gay and lesbian individuals. While this is a small percentage, hate crime survivors manifested higher levels of depression, anger, anxiety, and symptoms of posttraumatic stress (DeAngelis, 2002). As noted in the review of literature, several authors have found that hate crime survivors displayed more crime-related fears and beliefs, a lower sense of mastery, and attributions of their personal setbacks to sexual prejudice than did nonbias crime victims and nonvictims (Herek et al., 1997; Herek et al, 1999). Exposure to societal discrimination may be responsible for findings that gay and lesbian individuals report elevated rates of major depression, generalized anxiety disorder, and substance

abuse. Gay men also reported higher rates of major depression (Anti-lesbian, gay, bisexual, and transgendered violence, 1996). Of hate crimes that were reported, 50% of all victims were injured, 25% received serious injuries, and 2% were killed. The majority of these crimes (95%) were directed at the individuals (Anti-lesbian, gay, bisexual, and transgendered violence, 1996). To ignore this information when working with gay and lesbian victims of hate crime assault is to ignore crucial components therapists need to be aware of.

Recommendations

In order for marriage and family therapists (MFTs, as well as therapists in general) to work competently with gay and lesbian clients, they must have the appropriate training and appropriate mindset to work ethically with them. For new MFTs, this training begins in their masters programs. In recent years, national organizations for therapists have begun to call attention to the importance of training therapists to work with gay and lesbian clients. The Commission on Accreditation of Marriage and Family Therapy Education (COAMFTE) requires accredited training programs to integrate treatment issues pertaining to sexual orientation into curricula (Godfrey et al., 2006).

Despite these efforts, many therapists report feeling inadequately trained to work with these clients and their families. About one-half of a national random sample of American Association for Marriage and Family Therapy (AAMFT) clinical members felt incompetent to treat gay and lesbian clients (Doherty & Simmons, 1996). Many training programs offer little in the way of training or coursework on gay and lesbian topics. Doctoral students in counseling and clinical psychology reported that gay and lesbian topics were integrated into some of their coursework, but that they seldom were required to read materials on gay and lesbian topics (Phillips & Fischer, 1998). Fewer that 25% of MFTs had spent more than 2 hours in their entire training on gay and lesbian topics (Malley & Tasker, 1999). In addition, nearly 75% of students reported that gay and lesbian topics were not included on comprehensive exams. One-half of respondents reported that they were not encouraged to explore their heterosexist biases during their training programs (Murphy, Rawlings, & Howe, 2002). The majority of students took advantage of opportunities to learn more about working with gay and lesbians clients; however, only 22% reported that their graduate training programs offered seminars or similar trainings, and only 14% reported internship or postdoctoral training opportunities related to gay and

lesbian issues (Murphy et al., 2002). With these statistics, it is not surprising that gay and lesbian clients are concerned with therapists who may try to change their orientation, lack understanding of and experience with gay and lesbian issues, and view them as being untrustworthy (Alexander, 1998).

In a Delphi study by Godfrey et al. (2006), the authors obtained a consensus from a panel of experts concerning the components that training programs should include to prepare therapists to provide high-quality services to gay and lesbian clients. These components included: important values and qualities for a therapist to possess (e.g., awareness of one's one comfort level, values, biases, and prejudice about sex, gender, and sexual orientation and how these can affect interactions with clients); key components of the assessment phase of therapy (e.g., the degree of integration into the gay and lesbian community and awareness of resources that can empower clients and challenge bias, misinformation, and oppressions); important interventions (e.g., normalizing, advocacy that includes assisting client and family to identify sources of social support and resources in the community); important in-classroom experiences (e.g., listening to a gay and lesbian panel and guest speakers, including gay and lesbian people of color) and having important materials and counterproductive items (e.g., books, journal articles, websites, and authors). Other areas of importance that the authors addressed were self-of-the-therapist issues, systemic perspective, the role of sexuality, and diversity.

Several implications regarding training therapists to work with gay and lesbian clients and their support systems (Alexander, 1998; Doherty & Simmons, 1996; Godfrey et al., 2006; Malley & Tasker, 1999). First and foremost, therapists need to pay attention to self-of-the-therapist issues. My recommendation (as well as the recommendation of the aforementioned authors) would be for trainees, with the encouragement of their professors and supervisors, need to examine their own comfort levels, values, biases, and prejudices about sex, gender, and sexual orientation and how these can have an effect on the interactions with clients. Second, trainees need to learn about working with gay and lesbian clients from a systemic perspective, which can be interwoven through classroom discussion, self-of-the-therapist work, and clinical supervision. Third, trainees need experience getting to know gay and lesbian people. Allowing students to have personal contact with people from the gay and lesbian community is helpful in challenging students' biases about gay and lesbian people and orienting them to common struggles of this population. Trainees also need to be provided the opportunities to work with gay and lesbian

clients with appropriate supervision. Fourth, supervisors need to have knowledge and experience around supervising gay and lesbian cases. This education can be through formal education, such as continuing education classes, workshops, and interacting with the gay and lesbian community.

Once the basics of working with this larger population are established, it becomes an issue, then, of working with a population within a population of those gay and lesbian individuals who may have experienced hate crime victimization. As mentioned previously, gay and lesbian individuals are hesitant enough to seek therapy because of fears of bias. Adding an event, such as a brutal attack because of their sexual orientation, may make that step even harder. Therefore, I believe it is imperative that, as therapists, we have to set our biases aside and focus entirely on, what I call "damage control." That is to say, once a client reveals that he or she has been the victim of a potentially traumatic hate crime (e.g., a brutal, physical assault), all the therapist's energy should be focused on assessing the impact that event has had on the individual, and, if in the context of couples therapy, the impact that that event has had on their relationship.

If an individual (or both people in a relationship) reveals that the event may have been particularly traumatic and may be experiencing symptoms such as PTSD, depression, nightmares, triggers, or avoidance of situations, it becomes a matter of working through trauma, both individually and as part of the couple relationship. As some of the dynamics within gay and lesbian couples differ slightly from heterosexual couples, this trauma may manifest itself in different ways. One obvious difference would be the manifestation of internalized homophobia. Another possible manifestation could be a change in conflict patterns. If the research is accurate and gay and lesbian couples do argue more effectively and resolve conflict more positively (Kurdek, 2004a), if after the traumatic event, this pattern shifted, one could assume this change occurred possibly as the result of the trauma of the event. If the event occurred before the couple relationship formed, one might miss that a less effective and more negative conflict resolution style may not have otherwise occurred without the event. In either case, the appropriate intervention should be used to help the individual and the couple relationship thrive in the aftermath of the trauma.

As there is no one theoretical perspective that is *the* way to treat trauma, it is generally accepted in the traumatic stress field that some type of cognitive or emotionally focused approach seems to work well with those who have experienced trauma. The International Society for Traumatic Stress Studies (ISTSS) offers some treatment recommendations for traumatic

stress. This information can be found at the organizational website: http://www.istss.org (ISTSS, 2008a).

One such cognitive treatment was documented in a case study by Kaysen, Lostutter, and Goines (2005). A 30-year old gay male with symptoms of acute stress disorder (ASD) following a recent homophobic assault underwent 12 weeks of Cognitive Processing Therapy (CPT) Treatment of this individual addressed assault-related posttraumatic stress disorder symptoms and depressive symptoms. Additional areas addressed were low self-esteem, helplessness, and high degrees of internalized homophobia. The authors reported that symptoms were significantly reduced by the end of 12 weeks of therapy and were maintained at 3-month follow-up. This case highlights the utility of this therapy in targeting both ASD symptoms and internalized homophobia relating to experiencing a hate crime-related assault. For additional information about this treatment, the reader is referred to the ISTSS website on CPT (ISTSS, 2008b).

Another treatment for trauma in couples is Emotionally Focused Therapy (EFT; Johnson, 2002). Johnson maintains that an individual's emotional difficulties can often be most productively addressed by considering the relational aspects. Negative interactional cycles are maintained because the individuals involved are trying to fulfill their emotional needs. Trauma survivors who are seeking couple's therapy may not have made the connection between their traumatic experiences and current difficulties in their interpersonal relationships. However, the somewhat erratic and mystifying responses of a partner to uncertainty and change in the couple's life can sometimes be understood in the context of the past trauma. Johnson details the ways that an insecure attachment can increase and sustain the negative effects of trauma, and argues that a secure attachment provides an antidote to the negative effects of traumatic experience. As of right now, it seems that this model has only been applied in the context of heterosexual couples. However, because this model relies primarily on emotional responses and attachment, it may easily lend itself to application to hate crime trauma as well.

These are only two examples of trauma therapy in context. Typically when a clinician wants to learn more about a particular subject or has a particular type of client situation they have not encountered before, they turn to the research or perhaps their colleagues. Regrettably, as of now, there is no research for therapists to turn to on the issue of hate crime-related trauma which is a detriment to both the therapist and the client(s). The following chapter will describe areas for future research.

CHAPTER 4 - Research Implications

As previously mentioned, research in the field of the impact of hate crime trauma on couple relationships is severely lacking. As such, clinician's have no specific resources to pull from should they encounter such clients. It has also been stated that using the same lens one applies to heterosexual couples does not encompass the true nature of working with gay and lesbian clients. Therapists have to be aware of the specific issues that this population has to deal with and the societal scrutiny they face. The generalist training model that so many therapists and clinicians are subjected to in graduate school is insufficient to prepare them for providing high-quality and therefore ethical services to this population. As many graduate programs rely on empirically sound modalities and theories, it seems to reason that in order to prepare upcoming therapists for working ethically with this population, training programs must have the research to support proper training. It seems that this is currently not the case.

Research is available on the impact of hate crimes on the individual and the impact of trauma on heterosexual couples. It is my belief that more education is needed to understand the dynamics of gay and lesbian relationships when the issue of hate crime trauma is involved. This education is only possible through investigative research into this area. As there is currently no available literature in this area, it means that education on this topic is nonexistent.

One model for beginning to address the impact of trauma on interpersonal relationships in general, is the Couple Adaptation to Traumatic Stress (CATS) Model (Nelson Goff & Smith, 2005). This model includes the primary and secondary effect of trauma in individuals, as well as the interpersonal effects within the couple system . There are four components to the model: individual level of functioning of the primary survivor, individual level of functioning of the primary survivor's partner, predisposing factors and resources, and relational functioning and dynamics within the couple system (Nelson Goff & Smith, 2005). In the CATS Model, there are five mechanisms the authors identify as possibly providing understanding of the systemic traumatic stress and trauma transmission in couples. These include chronic stress, attachment, identification and empathy, projective identification, and conflict and physiological responses. If this model is accepted to be a useful model in examining trauma in heterosexual couple

relationships, which I believe it is, then it makes sense to determine if the CATS model also is applicable for gay and lesbian couple relationships.

As I have said before, I do not believe that the nature of trauma itself is inherently different between heterosexual and homosexual individuals. However, also as has been stated before, the nature and severity of some incidents of hate crime is quite severe, severe enough, in fact, for research to examine exactly how the resulting aftermath is potentially more damaging than the impact of nonbias crime. Add this to the already existing body of knowledge regarding gay and lesbian specific stressors and their impact on individuals and the result is a field of psychological land mines this population has to navigate. When a hate crime occurs resulting in a traumatic event and thus tripping those land mines, the resulting impact on that person is devastating and in turn devastating to how that person acts inside relationships. How devastating, we do not know, because the literature does not exist.

Perhaps one reason the research in this areas is nonexistent is because of the difficulty that may be inherent in doing this type of research with this population. There is a certain element of secrecy in both trauma and the gay and lesbian community. Some trauma may be seen as shameful and therefore kept to oneself. The concept of “coming out” also involves an element of secrecy as one's sexual orientation was kept unknown to those around the person prior to this process. To target research at these individuals and being able to find those that are willing to break through the secrets they've been keeping is a daunting task for any researcher, gay or straight. That is why it is important for future research in this area to be done carefully and with respect.

Future Research Recommendations

There are several different paths that future research needs to take in this area. First, continued research into the impact of trauma, and specifically hate crime trauma, at the individual level is necessary to move other gay and lesbian traumatic stress work forward. Several studies have already been conducted on the impact of hate crime at the individual level (Alden & Parker, 2005; Birken, 1997; Connell, 1995; Cotten-Huston & Waite, 2000; DeAngelis, 2002; Edwards, 1989; Ficarrotto, 1990; Kaysen, Lostutter, & Goines, 2005; Henley & Pincus, 1978; Herek, 1984; Herek et al., 1996, 1999, 2002; Kimmel, 1994; Kite & Whitely, 1998; Kurdek, 1988; Larsen et al., 1980; Morrison et al., 1997; Newman, 1989; Peplau et al., 1993;

Stark, 1991; Strand, 1998; Whitley, 1987); however, the majority of this work is pre-21st century. Additionally, none specifically addressed hate crime in the context of trauma. Some have alluded to PTSD symptoms (DeAngelis, 2002; Herek et al., 1997, 1999; Kaysen, Lostutter, &Goines, 2005), but did not examine the phenomenon through a traumatic stress lens. With the increasing spotlight on the gay and lesbian population in media, politics, and society as a whole, hate crimes could potentially have a different impact since the early works of Edwards (1989), Herek (1984) and Peplau (1993). Simply because the work has "already been done" does not mean that it should not be re-done and that new areas need to be studied.

Second, at the individual level, it is unclear how trauma in general manifests itself in the gay and lesbian population. Again, I do not believe the nature of trauma is inherently different between homosexual and heterosexual individuals; however, it is unclear if the gay/lesbian lens shades the impact of trauma in a different way. For example, would a gay or lesbian victim of a physical assault be impacted differently than a heterosexual individual if the motive for such assault was unclear? Could pre-existing internalized homophobia alter the victim's perception of such an attack? Could another pre-existing mental health issue (e.g., schizophrenia, PTSD, obsessive-compulsive disorder) increase paranoia related to motive? The answers to these questions and many others are unclear because the research is not currently available.

Third, given that approximately 1.2 million people are part of gay and lesbian couples in the United States (Cohn, 2001 as cited in Sue & Sue, 2003), there is no research that investigates the impact of trauma on the couple relationship. The research on trauma in couples in general is limited with little or no attention paid to the gay and lesbian community. Lesbian and gay couples have to walk in a world that is inherently stacked against them by its heterocentric nature, whether implicitly or explicitly. It is no wonder that the gay and lesbian community has fallen through the cracks because even research into this subject is susceptible to heterocentric bias. That is why it is so important for training programs to address these issues with clinicians and researchers of the future. Allowing students to examine their own biases and become more aware of their impact in turn allows for them to become less heterocentric and more objective when examining these issue. The end result would be better research as seen through a clearer traumatic stress lens.

Through this clearer traumatic stress lens, it would be important to examine the difference between single-trauma and dual-trauma couples. Did the trauma(s) occur before of

after the formation of the couple? If in a dual-trauma couple, is the trauma a shared traumatic event (e.g., a hate crime act that involved both partners)? What is the combined trauma history of both partners and how does that impact current relationship functioning? Does one partner have a greater history of trauma, and, if so, how does that impact individual as well as relationship functioning and satisfaction?

Additionally, a more comprehensive view into gay and lesbian family functioning needs to be free of this bias. The common, heterocentric view of a family is mother, father, and child(ren). This allows no room for less "traditional" families. A family with two mothers with a biological child to one mother may not be on the radar. A family with two fathers with an adopted, non-biological child may be seen as toxic. A blended family that is the result of a heterosexual marriage and divorce with children involved is still seen as an aberration and abnormal. An individual who is cut off from his/her family-of-origin, because of sexual orientation, who has created a tight-knit family-of-choice, may not necessarily be considered a family. I believe the definition of "family" in this culture needs to be expanded to include any configuration that *considers themselves* to be a family. As such, under this new definition, research must follow suit and adopt an encompassing lens to accurately reflect the functioning of these families on this proposed new definition. It seems that politics is trying to push a definition of family and marriage that only includes heterosexual couples and families by banning gay marriage and trying to ban adoption by gay and lesbian couples. As such, the rights of these "non-traditional" families are being stripped. This, too, poses a detriment to accurately reporting on "family functioning." It is up to research to inform clinicians, politicians, and society alike about what makes a *healthy* family as opposed to a "traditional" family.

Lastly, additional overall research on the gay and lesbian community needs to be updated to reflect the impact of current political and social movements in this country and across the globe. One possible area would be to examine the impact of being a gay or lesbian couple in a country or a state that does not condone same-sex marriages or civil unions on relationship satisfaction. Perhaps, then, it might be useful to take that data and compare it to the relationship satisfaction of gay and lesbian couples in other areas that are allowed to be married or in a civil union. It would be interesting for research to compare divorce and dissolution rates between lesbian and gay marriages and heterosexual ones. Another area might be what other factors contribute to gay and lesbian relationship satisfaction in general. Others areas should include the

application of other theories and models primarily examined on heterosexuals to gay and lesbian individuals, for example, like applying the CATS model (Nelson Goff & Smith, 2005) to lesbian and gay couples. Does the same model for examining heterosexual systemic processes that occur with trauma apply in the same way to a lesbian or gay couple? These and many other questions remain unanswered (or answered so long ago that time and social climate may have changed the results). These are not topics of interest to only researchers and clinicians but should be topics that society needs to be aware of in order to make informed choices and stances.

Mental health professionals have to have the research to support their work. Researchers have to have the curiosity to examine the impact certain events have on certain populations. Mental health professionals have to have the results of the investigation of this curiosity. Society needs the results of both clinical and investigative work to be a better informed society. It is a cycle that has to be continuous. It is my hope that readers, clinicians and researchers alike, will take away from this a message that their work with this population is not over and really is still only just beginning. With the current political and social climate surrounding gay marriage versus civil unions, gay and lesbian adoption, and many others, it is important to continue to the work started only a few decades ago and continue to expand it.

CHAPTER 5 - Conclusion

As long as there are natural disasters, war, violence, and death, trauma will always occur. As long as there is trauma, its impact will continually be assessed. However, when we lose sight of how that trauma effects *people*, we lose sight of ourselves. The potentially traumatic impact of hate crime on gay and lesbian couples has gone unnoticed for far too long. All the while the gay and lesbian numbers continue to grow. The traumatic stress field has left these individuals, couples, and families wholly ignored and with that, has done them a great disservice.

Current evidence is available to support that trauma impacts couple relationships (Arzi et al., 2000; Balcom, 1996; Compton & Follette, 1998; Nelson et al., 2002; Nelson Goff & Smith, 2005). There is more evidence to support that hate crime victimization has a negative impact on gay and lesbian individuals (Altschiller, 1999; Boyd et al., 1996; DeAngelis, 2002; D'Augelli & Grossman, 2001; Franklin, 2002; Herek et al.,1997; Herek et al., 1999; Herek et al. 2002; Martin, 1995; Nolan et al., 2002; Winer, 1993). There is more evidence still to support that gay and lesbian interpersonal relationships are similar to heterosexual relationships, but that they face unique stressors as a result of their sexual orientation (Blumstein & Schwartz, 1983; Brooks, 1981; Gottman et al., 2003; Herek & Berrill, 1992; Herek & Glunt, 1988; Kurdek, 1994, 2001, 2005; Lewis et al., 2001; Todosijevik et al., 2005). However, there is still no evidence of the impact of the combination of these areas, which I believe is a substantial loss to researchers, clinicians, and society.

This overwhelming lack of literature has the potential to be very detrimental to professionals working with this population and in turn detrimental to the population and society. Homophobic hate crimes against lesbians and gay men represent a significant social problem that has important psychological consequences for survivors. Because the nature of these crimes is, by definition, against someone for his or her intrapersonal traits, it has even more potential to be damaging to a victim and in turn potentially detrimental to the development and/or maintenance of close personal relationships. If clinicians and other professionals are unaware of these effects on the individual and in turn the couple relationship, then those coming to them for services are not receiving a quality of care equal to what they require. With the number of gay and lesbian

population growing (whether recorded in censuses or not), more will be utilizing counseling services. Some will be utilizing them for many of the same reasons that all people who utilize therapy are seeking guidance on (e.g., phobias, trauma, couple's issues, personal reflection and insight). However, some gay and lesbian individuals may present with a combination of factors that leaves them in a unique and overwhelming position: a gay male or lesbian in a relationship where one or both partners have been the victim of a brutal hate crime assault. Without the knowledge available, how will one know what is common and uncommon in this situation?

It is important to note that trauma in general is not inherently different in gay and lesbian couples than in heterosexual couples; however, evidence suggests that there may be a difference in how or if the potentially traumatic hate crime victimization experience manifests itself internally (e.g., internalized homophobia) or in other forms because of the nature and severity of the victimization in one or both partners. Evidence also suggests, similarly to heterosexual couples, the impact of trauma has repercussions throughout the couple relationship. While hate crime victimization is not specifically identified in the DSM – IV – TR (APA, 2000) as a potentially traumatic event, physical assault, which is found commonly in hate crimes, is identified. Therefore, hate crime victimization could be a potentially traumatic event. Though it has not been studied, the inherently violent nature of many hate crimes indicates a great potential to have a more severe impact on the relationship because of its motive, severity, brutality and consequences (e.g., internalized homophobia) that could never be reflected in heterosexual relationships.

The research process is a cycle that has to be continuous. Without continued efforts in this area, researchers, clinicians and society may all suffer from ignorance. It is my sincerest hope that readers will take away from this a message that great work with this population is not over and really is still only just beginning. Current policy regarding gay marriage/civil union continues to perpetrate a negative image of gay and lesbian couples because of the lack of knowledge, thus influencing public opinion. The current political and social climate surrounding gay marriage versus civil unions, gay and lesbian adoption, and many others show no sign of improving in the near future. It is important to continue the work started only a few decades ago and continue to expand it. When researchers and clinicians become complacent, it is society as a whole that can suffer.

Many questions have been raised in this report, and many others remain unasked. This report is by no means an entirely exhaustive view. There would be far too much information to include in a report and would be better captured as the result of empirical study. However, this report provides a preliminary start to continue and expand the work with the gay and lesbian community. With new research comes new horizons and with new horizons comes greater understanding. Understanding not just for researchers and clinicians, but understanding and knowledge about the impact of hate crime trauma for all of us.

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Appendix -A Guidelines for Psychotherapy with Lesbian, Gay, & Bisexual Clients

Attitudes Toward Homosexuality and Bisexuality

Guideline 1. Psychologists understand that homosexuality and bisexuality are not indicative of mental illness.

Guideline 2. Psychologists are encouraged to recognize how their attitudes and knowledge about lesbian, gay, and bisexual issues may be relevant to assessment and treatment and seek consultation or make appropriate referrals when indicated.

Guideline 3. Psychologists strive to understand the ways in which social stigmatization (i.e., prejudice, discrimination, and violence) poses risks to the mental health and well-being of lesbian, gay, and bisexual clients.

Guideline 4. Psychologists strive to understand how inaccurate or prejudicial views of homosexuality or bisexuality may affect the client's presentation in treatment and the therapeutic process.

Relationships and Families

Guideline 5. Psychologists strive to be knowledgeable about and respect the importance of lesbian, gay, and bisexual relationships.

Guideline 6. Psychologists strive to understand the particular circumstances and challenges facing lesbian, gay, and bisexual parents.

Guideline 7. Psychologists recognize that the families of lesbian, gay, and bisexual people may include people who are not legally or biologically related.

Guideline 8. Psychologists strive to understand how a person's homosexual or bisexual orientation may have an impact on his or her family of origin and the relationship to that family of origin.

Issues of Diversity

Guideline 9. Psychologists are encouraged to recognize the particular life issues or challenges experienced by lesbian, gay, and bisexual members of racial and ethnic minorities that are related to multiple and often conflicting cultural norms, values, and beliefs.

Guideline 10. Psychologists are encouraged to recognize the particular challenges experienced by bisexual individuals.

Guideline 11. Psychologists strive to understand the special problems and risks that exist for lesbian, gay, and bisexual youth.

Guideline 12. Psychologists consider generational differences within lesbian, gay, and bisexual populations, and the particular challenges that may be experienced by lesbian, gay, and bisexual older adults.

Guideline 13. Psychologists are encouraged to recognize the particular challenges experienced by lesbian, gay, and bisexual individuals with physical, sensory, and/or cognitive/emotional disabilities.

Education

Guideline 14. Psychologists support the provision of professional education and training on lesbian, gay, and bisexual issues.

Guideline 15. Psychologists are encouraged to increase their knowledge and understanding of homosexuality and bisexuality through continuing education, training, supervision, and consultation.

Guideline 16. Psychologists make reasonable efforts to familiarize themselves with relevant mental health, educational, and community resources for lesbian, gay, and bisexual people.

Source: American Psychiatric Association. (2008). *Guidelines for psychotherapy with lesbian, gay, & bisexual clients*. Retrieved May 4, 2008 from http://www.apa.org/pi/lgbc/guidelines.html