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Trauma Treatment Considerations for Sexual Minoritized Veterans

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ABSTRACT

Sexual minoritized veterans face unique stressors throughout their life span and during military service. The aims of the current manuscript are to (1) define and highlight the effects of sexual minority stress, discrimination, and trauma exposure on mental health for sexual minoritized veterans, (2) provide relevant historical context of military policies addressing sexual minority servicemembers and overview the impact of these policies on mental health and access to care; and (3) provide clinical considerations for treating trauma with sexual minoritized veterans. This paper concludes with suggestions for treatment approaches to concurrently address sexual minority stress within evidence-based treatment for posttraumatic stress disorder.

KEYWORDS

Minority stress; posttraumatic stress disorder; sexual minority; trauma; veterans

Introduction

The development of posttraumatic stress disorder (PTSD) among United States military service members and veterans remains high. The data consistently show that during their lifetime the general veteran population experiences PTSD at higher rates than adult civilians (3-29% vs. 4-8%; Department of Veteran Affairs [VA], 2023). The prevalence rate of exposure to trauma and meeting diagnostic criteria for PTSD is even more elevated for sexual minoritized veterans than heterosexual veterans (Cochran et al., 2013; Department of Defense [DoD], 2016; Gurung et al., 2018; DoD, 2020). While the psychological impacts associated with veteran and sexual minority status independently are well-documented in the literature, notable gaps in understanding the significance of this intersection remain (Cochran et al., 2013; Livingston et al., 2019; VA, 2023).

Historically terminology in the DoD legislature exclusively targets servicemembers who identify as lesbian, gay, or bisexual (LGB) (RAND National

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Defense Research Institute, 2010a, 2010b). Therefore, the DoD and veteran literature does not address the full range of affectional and gender expansive individuals, but rather focuses on individuals who had same-sex sexual attraction and behaviors. As such, we will use the term sexual minority or minoritized individuals throughout this paper, focused on LGB experiences. It is important to note that sexual and/or affectional orientation is separate from one's gender identification as these individuals may also be a part of the transgender and gender-expansive community. The focus of this paper is placed specifically on sexual minoritized veterans as veterans who are transgender or gender-expansive have a unique experience regarding military policy and discrimination. These identities are often combined in literature. The authors acknowledge the heterogeneity within the LGBTQ+ community and emphasize the importance in accounting for intersectionality of all aspects of identity while discussing a person's military experience.

History of Department of Defense (DoD) legislation

To address the clinical needs of sexual minority veterans, it is beneficial for clinicians to be informed of the legislative history attending to sexual minoritized persons serving in the U.S. military. The first explicit legislative restriction placed on sexual minoritized service members was in the 1920s and specifically addressed sexual acts between gay and bisexual men (Alford & Lee, 2016; Burks, 2011; Johnson et al., 2015). By 1942 legislature also excluded lesbian civilians from military service (Goldbach & Castro, 2016) and in 1981, the U.S. DoD passed a directive that banned same-sex sexual conduct or sexual minoritized identity in its entirety (Alford & Lee, 2016). Subsequently, an individual could be excluded from service solely based on their sexual identity (Alford & Lee, 2016).

Such legislature was influenced by the belief system that sexual minoritized persons are inferior and unsuited for military service; as well as, immoral and threatening to traditional ideologies of masculinity and warrior identity (Alford & Lee, 2016; Goldbach & Castro, 2016). Legislature during this time argued sexual minority servicemembers were a threat to national security by harming unit cohesion, decreasing recruitment, and violating privacy and rights of heterosexual service members (Goldbach & Castro, 2016; RAND National Defense Research Institute, 2010a, 2010b). Then termed "homosexual conduct" was considered a serious offense in the U.S. military that resulted in the possibility of being investigated by the chain of command, court-martialed, or dishonorably discharged (Alford & Lee, 2016). This ultimately led to the separation of nearly 17,000 servicemembers between the years 1980 and 1990 (Johnson et al., 2015).

In response to a societal shift toward equal rights and research discrediting previous claims, President Clinton passed "Don't Ask, Don't Tell"

(DADT) to reverse the prohibition of sexual minoritized individuals in the military in 1993 (Alford & Lee, 2016; Johnson et al., 2015). This policy took the stance that ones' sexual orientation is a personal and private matter unless the individual explicitly expresses their identity through verbal comments or behaviors (Goldbach & Castro, 2016; Johnson et al., 2015). While inclusivity was the initial intent of DADT, research found it likely resulted in more covert discrimination, as sexual minority servicemembers were forced to serve in silence while facing threats of being "outed" (Burks, 2011; Goldbach & Castro, 2016).

In 2010, President Obama passed the Don't Ask, Don't Tell Repeal Act which allows for cisgender sexual minority individuals to serve openly in the military and granted those discharged due to DADT the option to re-enlist. The Repeal Act also provided the opportunity for researchers to comprehensively examine the rationales for service exclusion as active servicemembers were able to disclose their sexual orientation without fear of discharge. Contrary to prior beliefs, minimal evidence was found to support the notion that sexual minority servicemembers would adversely impact military readiness (Johnson et al., 2015; RAND National Defense Research Institute, 2010a, 2010b). Disclosure was determined to be better for unit cohesion and morale than concealment (RAND National Defense Research Institute, 2010a, 2010b).

Despite significant progress over the past decade, past policies and traditional military values leave longstanding implications for sexual and gender minoritized veterans. For example, the Repeal Act does not include transgender and gender-expansive servicemembers (Stalsburg, 2011). It wasn't until President Biden signed an executive order to end the military's ban of transgender individuals and provide support for gender affirmative treatment on January 25, 2021, that such protections existed. Additionally, the overall lack of institutional level protection set the stage for continued or increased experiences of sexual assault and harassment, physical assault, hazing, and blackmail (Burks, 2011; Johnson et al., 2015). Legislature concerning sexual and gender minority individuals have proven to be unpredictable and heavily dependent upon the current political administration. Therefore, recommendations provided in this paper are tailored for veterans specifically and may not be applicable to active servicemembers as the environment may swiftly switch to no longer be safe or inclusive.

Addressing both Criterion A and non-Criterion A events when treating trauma

Experiencing Criterion A trauma is foundational to diagnosing PTSD. The Diagnostic and Statistical Manual of Mental Disorders, Text Revision (DSM-5-TR) defines a Criterion A traumatic event as directly experiencing

or witnessing a life-threatening event, learning that a such an event happened to a close family member or friend, or chronic repeated exposure to graphic details associated with a traumatic events usually related to occupational duties (American Psychiatric Association, 2022). It is relevant to differentiate Criterion A from non-Criterion A for diagnostic purposes as Criterion A events are the target during trauma focused treatments. However, it is also clinically relevant to understand non-Criterion A events as they likely impact processing and may also exacerbate symptoms overall.

Sexual minoritized individuals are more likely to initiate military service already having experienced Criterion A events; reporting childhood sexual trauma, physical abuse, maltreatment, intimate partner violence, sexual assault and hate crimes over their life span (Goldbach & Castro, 2016; Meadows et al., 2018; Ray-Sannerud et al., 2015). Sexual minoritized servicemembers are five times more likely to screen positive for PTSD than heterosexual service members (Cochran et al., 2013). Military sexual trauma (MST) contributes significantly to the elevated rate of PTSD and is defined as experiences of sexual assault, sexual harassment, offensive remarks about one's body found to be threatening, or any unwelcomed sexual advances during one's military service (VA, 2023). Sexual minority women veterans report experiencing sexual assault at nearly twice the rate of cisgender heterosexual women (6.3% vs. 3.5%); and sexual minority male veterans report sexual assault at nearly 12 times the rate of cisgender heterosexual men (3.5% vs. 0.3% of men; Cochran et al., 2013; DoD, 2016). Similarly, the rates of sexual harassment are significantly disproportionate toward sexual minority servicemembers (22.8% vs. 6.2%; DoD, 2016). Of note, the formal Veteran Affairs definition of MST now includes both Criterion A events and non-Criterion A events, such as harassing comments about one's body or sexual activities (VA, 2023).

Minoritized groups also endorse increased rates of threatening and harmful incidents that may not reach threshold of a diagnostic Criterion A but have been found to be significant and detrimental to mental health, such as bullying, hazing, stigma, prejudice, microaggressions, maltreatment, rejection from others, and discrimination (DoD, 2016; Goldbach & Castro, 2016; Gurung et al., 2018; Ray-Sannerud et al., 2015). Minority stress theory asserts that in addition to the stressors experienced by the general population, added stress from being a minority is chronic and a product of larger social processes rather than individual biological or genetic characteristics (Meyer, 2003). The chronic nature of these experiences may lessen a person's ability to tolerate stress leading to deteriorating mental and physical health over time (Meyer, 2003).

Understanding your patient: expanding the use of assessment of trauma and minority stress

Diagnostic assessment and rapport building

Societal and institutional marginalization of identity increases the risk of exposure to repeated adverse events impacting feelings of safety and utilization of healthcare. Sexual minoritized veterans report delaying or missing appointments due to fear of stigma, previous bad experiences with healthcare providers, experiences of harassment, and feeling unwelcome at facilities (Shipherd, Darling, et al., 2018; Simpson et al., 2013) resulting in physical and mental disorders going untreated (Livingston et al., 2019; Mattocks et al., 2013; Shipherd, Darling, et al., 2018). Given the level of distrust sexual minoritized veterans report within the military and healthcare institutions, strong rapport is crucial to establish a safe and inclusive environment (Simpson et al., 2013). Since military treatment facilities have not routinely integrated questions about sexual orientation in medical records, a clinician may be the first healthcare provider to inquire and validate experiences of sexual minority stress (Shipherd, Darling, et al., 2018).

Assessment can be viewed as a clinically time consuming and impersonal tool. However, when working with minoritized individuals we have found it to be most effective to utilize assessment as an opportunity to build rapport by creating a safe and inclusive space with the client while assessing for symptom presence, severity, and degree of interference in functioning. This may require clinicians to adapt their approach to conducting assessment by making parts of the process more interactive, flexible, and personal to the client. From clinical experience we found that prioritizing questions about sexual and gender identity, identity related trauma, and minority stressors have assisted in establishing rapport with clients. This can involve a semi-structured conversation that is followed by more structured symptom assessment tools once a safe inclusive environment has been initiated. Incorporating qualitative and quantitative assessment measures can inform treatment planning to determine if sexual minority stressors and non-criterion A events should be incorporated as a focal point of trauma-treatment.

The most thorough, yet time intensive, assessment tools include structured clinical interviews. The Clinician Administered PTSD Scale DSM-5 (CAPS-5; Weathers et al., 2018) is the gold standard in assessing the presence and severity of trauma-related symptoms with the purpose of diagnosing PTSD. A clinician may consider the administration of structured interviews assessing a wider range of diagnoses such as the Structured Clinical Interview for DSM-5, Clinician Version ([SCID-5-CV]; First et al., 2016) and the Mini International Neuropsychiatric Interview ([MINI]; Sheehan et al., 1998). Clinicians can determine if additional assessment

is warranted using self-report screeners to capture presenting concerns. To capture a complete picture of the various experienced Criterion-A events, the clinician may consider administering the Life Event Checklist for DSM-5 (LEC-5; Weathers et al., 2013); which is commonly administered in conjunction with the CAPS-5. The PTSD Checklist for DSM-5 is commonly used as a self-report trauma measure ([PCL-5], Weathers et al., 2013). It is a 20-item measure covering the four clusters of PTSD. The PCL-5 has both monthly and weekly versions, is face-valid and easy to administer and score. Clinicians are encouraged to use other relevant self-report measures to capture a wider range of symptoms such as anxiety, depression, suicidal ideation, and psychosocial functioning.

Based on the authors clinical observation, it has been useful to inquire about non-Criterion A events that are impacting the veteran. Non-Criterion A experiences may exacerbate symptoms associated with Criterion A trauma, as identity-related non-Criterion A events may reinforce trauma-related cognitions, mood states, and physiological reactivity (Livingston et al., 2019). Not acknowledging the functional impacts of these events may be invalidating or stigmatizing to the individual's experience. To date, there is not a standardized questionnaire as a part of a clinical interview to capture sexual minority stressors and non-Criterion A impactful life events. We have been using a semi-structured set of open-ended questions to capture these events; most often utilized during an evaluation or treatment planning (for more information about specific sample questions see Appendix).

Clinicians are encouraged to inquire about the coming-out process or how one's sexual orientation was revealed (American Psychological Association [APA], 2021). Additionally, we recommend asking about the level of acceptance or rejection expressed by their family of origin and what implicit and explicit messages they received about sexual minoritized individuals or gender role expectations during childhood. Clinicians may facilitate conversation around the individual's own relationship with their sexual orientation and/or gender expression throughout their life. This could consist of identifying any examples of behavioral attempts to hide, explore, or embrace their identity or potentially any efforts to present stereotypically more masculine or feminine to manage others perception of them. Clinicians are also encouraged if and when the veteran opted to engage in lack of disclosure, and their reasoning for this (e.g., such as during military service, religious affiliations).

It may be useful to elicit examples of when the individual felt the safest and the most endangered both prior and post revealing sexual orientation. Exploratory questions about familial reactions and current support system could bring to surface concrete examples of experienced stigma or acceptance, use of safety behaviors and coping strategies (adaptive and maladaptive), and one's cognitive, behavioral, and interpersonal patterns as it

relates to sexual minority stressors throughout their life. Other life experiences likely to garner helpful information include, relationship history, their level of connectedness to the LGBTQIA+ community and how connection may have shifted over time, examples of feeling safe or unsafe within the community itself (LGBTQIA+ and/or military), any influence of military culture on identity and gender expression and asking about any current distress associated with their affectional, sexual, or gender identity or expression.

Considerations for applying evidence-based practice for PTSD: inclusion of minority stress factors in treatment

Trauma-focused, time limited, manualized interventions have been proven to be highly efficacious in the treatment of PTSD; and are consistently the front-line recommended interventions (Department of VA/DoD, 2023). These treatments are largely driven from cognitive-behavioral theory, and utilize either cognitive or exposure-based interventions. Cognitive Processing Therapy ([CPT]; Resick et al., 2016) and Prolonged Exposure ([PE]; Foa et al., 2019) are the most utilized interventions with the most empirical research. Given their high levels of utilization and empirical support with the veteran population this paper will focus specifically on these two protocols. To date there is no research informing specific modifications to these protocols, however there is consistency in addressing both Criterion A and non-Criterion A events with sexual minoritized individuals (Livingston et al., 2019). As such, the considerations provided are based on the author's clinical observations that integrate insights from existing literature on sexual minoritized veterans engaging in trauma-focused treatment.

Consistent with other cognitive-behavioral therapy interventions, the initial sessions of both CPT and PE are largely focused on information gathering, understanding the impact of the trauma on functioning, and the delivery of psychoeducation. During these sessions, providers can tailor the interventions by exploring common reactions to both trauma and minority stressors, and provide definitions as relevant, when eliciting examples from the client. Additionally, we suggest exploring the ways in which trauma-related symptoms may be adaptive in the context of legitimate safety concerns. Labels such as "hypervigilance" or "symptoms" to categorize these reactions may be unintentionally pathologizing for a population that is experiencing ongoing threat (Livingston et al., 2019).

Cognitive Processing Therapy (CPT)

Cognitive Processing Therapy (CPT) is traditionally delivered in a once-to-twice weekly 60-minute individual format over the course of 9 to 15

sessions. The underlying premise of CPT is to catch, assess, and challenge thoughts related to the trauma that are preventing individuals with PTSD from living their lives. CPT posits PTSD is a result of unhelpful or inaccurate thought patterns ("stuck points") that develop in effort to gain control over the trauma or predict future occurrences. Over the course of the protocol, the patient is introduced to a series of worksheets that teach how to identify maladaptive cognitions and learn how to successfully challenge these thoughts to promote change over time. Five schematic themes are a focus within the protocol: safety, trust, power and control, esteem, and intimacy. It is important to validate and understand when beliefs may be adaptive related to trust and safety. Rather than challenging the belief to generate a more "accurate" belief clinicians can use Socratic dialogue to assist with a more "helpful" belief by exploring what the individual does have control over, harm reduction strategies, and how they plan to cope with stressors in the future.

The format of the CPT protocol allows space to process non-Criterion A events and sexual minority stressors is it relates to beliefs about oneself, others, and the world. Within CPT, one is asked to write out the impact the trauma has had on their life; and how this impact has changed belief systems. The clinician can explore minority stress events such as asking additional questions at the end of the impact statement based upon information the veteran disclosed during assessment (ex: How has your experience with discrimination and harassment impacted your beliefs about yourself? Others? The world? Do you feel like this impacted your view of the traumatic event? If yes, how so?).

Within the CPT protocol, patients are encouraged to "catch" *Stuck Points* related to their traumatic experience (ex: If I wasn't drinking, I would have never been raped"). These thoughts are captured on a *Stuck Point Log* and through CPT, the therapist helps then to develop more balanced beliefs. Balanced beliefs are adjusted through the practice of daily worksheets to teach new skills in thought challenging. An additional adjustment that can be made in CPT, is encouraging sexual minority veterans to add cognitions related to non-Criterion A events to their log. While the intervention should initially focus on the Criterion-A index event associated with their PTSD, over the course of treatment as PTSD symptoms start to decrease, the clinician may assist in challenging cognitions related to minority stress experiences (non-Criterion A events that are causing distress). Additional sessions can be added if needed, at the end of the protocol to expand on processing global accumulative experiences of minority stressors or traumas.

CPT length is variable, and additional sessions may be warranted to address cognitions impairing functioning. One theme that may commonly be both a trauma-related experience as well as a sexual minority stress

experience is the struggle of both guilt and shame. Within the CPT protocol, time is spent understanding the nuanced differences of responsibility, blame, and intentionality to address trauma-related guilt and shame. Sexual minority veterans may be more likely to engage in self-blame or take responsibility for acts against them (i.e., sexual assault, physical assault) as they may have received messages throughout their life that they "chose" their sexual orientation reinforcing negative cognitions (Dworkin et al., 2018). Examples of cognitions include believing they deserved the trauma as a punishment for their sexual orientation such as "I deserved this because I am gay" or "God is punishing me because I am gay." Following trauma sexual minorities endorsed higher rates of negative esteem and trust belief resulting in stuck points including "I am a weak person," and "I can't rely on myself" (Dworkin et al., 2018). Other common maladaptive cognitions may be related to internalized self-stigma for example, "I don't deserve to feel better because I am gay" or "I deserve to be punished because I am gay." Self-stigma cognitions have been found to be associated with more severe depression and PTSD symptoms (Dworkin et al., 2018; Gold et al., 2007).

Clinicians may consider integrating a stigma-informed approach into their CPT practice when incorporating sexual-minority stress events into treatment (Ellis, 2020). A stigma-informed approach works toward shifting thoughts of self-blame and internalized stigma to external sources such as the sociopolitical structures in society while also promoting healthy coping and support systems (Ellis, 2020; Russell & Hawkey, 2017). Examples of more balanced, externalized, and helpful thoughts may include: "It is not my fault I experienced this trauma and because of institutional or societal stigmatization I am at increased risk in some environments," "I experienced this trauma because the perpetrator chose to use violence and act on their own prejudicial thoughts not because my identity deserves to be targeted," "In certain circumstances I may be at increased risk for victimization and I can implement strategies and support to increase safety," "I am proud of who I am and I can recognize and feel anger/fear/sadness about minority stressors that I carry," and "There are people/institutions who do not accept me and I can find community because I deserve to feel safe in my relationships." Addressing these stuck points may assist in reducing negative self-talk, self-blame, and self-stigma secondary to sexual or gender identity by shifting responsibility to appropriate external sources that contribute to minority stressors. It is important to validate and understand when beliefs may be accurate and adaptive related to trust and safety. Rather than challenging the belief to generate a more "accurate" belief providers can use Socratic dialogue to assist with a more "helpful" belief by exploring what the individual does have control over, harm reduction strategies, and how they plan to cope.

Prolonged Exposure (PE)

Prolonged Exposure (PE), an exposure-based intervention, is traditionally delivered once weekly for 90 minutes over 8-to-15-sessions. PE posits PTSD develops in response to avoidance of external and internal stimuli associated with the trauma. Through *in-vivo exposures* (purposefully approaching "real life" anxiety-provoking situations that are likely safe) and *imaginal* exposure (repeated re-telling of the trauma event); PE assists in confronting trauma-related memories, feelings, and situations in a systematic and gradual manner. All sessions are recorded, and the patient is assigned to listen to their sessions daily to habituate to the trauma memory. In addition, the daily practice of in vivo exposure exercises is assigned to decrease anxiety, promote self-efficacy, and increase life living through behavioral activation.

During the *trauma interview* and processing of the *imaginal exposure*, Veterans may express overlapping emotional reactions and themes related to both the index Criterion A trauma and minority stress events that can be further explored. In the initial stages of the protocol, an *in vivo hierarchy* is also developed. This is a list of experiences the patient would like to be engaging in (behavioral activation) or that they are avoiding because it reminds them of the trauma. Over the course of the protocol the *in vivo exposures* (experiences) are assigned to practice approaching the avoided stimuli in a systematic way to increase mastery and improve quality of life.

Clinicians can include situations that trigger minority stress experiences eliciting avoidance (tangible and emotional) on the hierarchy. The inclusion of minority stress themes within the in vivo hierarchy is especially relevant when the events reinforce or exacerbate trauma-related symptoms. It may also be the case that it is reversed, experiential avoidance increases the likelihood of developing internalized self-stigma due to the stigma in society (Dworkin et al., 2018). In addition, if an individual is fulfilling societal gender expression stereotypes in response to self-stigma that are not aligned with their identity or personal values it may be therapeutic to identify safe and incremental steps to take toward reducing safety behaviors. This would increase insight into potential unhelpful thinking patterns and ideally build confidence in assessing safety and in self-esteem. It may be useful to encourage consideration of others within the community and whether behavior is consistent with someone of a similar intersectional background in this case.

Vigilance may be adaptive for sexual minoritized individuals if they are experiencing ongoing victimization. While the goal may be to reduce avoidance and use of safety behaviors, dismantling protective safeguards may not be in the veteran's best interest. For example, after experiencing

or learning about identity related trauma in the community, avoidance behaviors may include not engaging in public displays of affection with a significant other, not going to sexual and gender minority affiliated locations or events, and increased efforts to manage other's perceptions of their sexuality or gender identity or expression. This can include clothing style, walk, pitch of voice, and bodily posture all to appear either more masculine or feminine to fulfill gender expression stereotypes. Identity-related exposures may be beneficial in the event it would allow for new learning.

Discussion of clinical considerations and next steps

Although sexual minoritized and gender-expansive veterans have been serving in our military for decades there continues to be a gap in our understanding of how to best meet this population's needs when presenting for trauma-focused treatment. In recent years, a spotlight has been placed on how mental health providers can increase diversity and inclusion efforts within their practice. As a result, the American Psychological Association (APA, 2021) established guidelines for working with sexual minority persons and the Department of Veteran's Affairs provided guidelines for working with sexual minority veterans (Department of Veteran Affairs & Veterans Health Administration Directive 1340, 2022). Despite these advancements, there continues to be notable gaps in the literature addressing population specific needs; especially when addressing both Criterion A and minority stressors (Alford & Lee, 2016; Goldbach & Castro, 2016). To address this need, a clinician may elect to integrate aspects of transdiagnostic identity-related interventions such as Effective Skills to Empower Effective Men (ESTEEM; Pachankis et al., 2019) and Acceptance and Commitment Therapy (ACT) for Self-Stigma Around Sexual Orientation (Yadavaia & Hayes, 2012) into a veteran's care plan.

Due to a continuously changing environment, providers working with sexual minority individuals are recommended to seek out training providing culturally competent and informed care. Affirmative sexual/affectional minority psychotherapy trainings have been found to increase therapist's knowledge of culturally specific clinical issues, self-efficacy in being able to advocate for clients, and ability to establish a strong therapeutic relationship with clients (Ellis, 2020). Providers are also encouraged to be cognizant of their own potential biases and assumptions; and consultation may be crucial in assisting with identifying biases.

Research focused on capturing a comprehensive understanding of the impacts and treatment of trauma with sexual minority veterans is limited. Not only is there minimal research, but sexual orientation has also been excluded from large, randomized trials due to not being asked about in

demographic data (Hamblen et al., 2019). There is currently no literature exploring the efficacy of manualized trauma-focused treatments with sexual minorities (civilian or veteran) presenting with the complexity trauma and high impact life stressors. There is also no guidance for structured questions to be incorporated into trauma work with sexual minority veterans; or if modifications of a protocol would be warranted. Specific to sexual minority veterans, there is ample room for future research to explore the ways military culture and potential intuitional betrayal may impact trauma processing. Future research assessing the appropriateness of fit of traditional trauma focused treatment is needed for sexual minority veterans. Future research should investigate adaptations for these protocols to incorporate the impact of minority stress into evidence-based practice.

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Appendix

Sample Discussion Questions Assessing for Sexual Minority Stressors

1. What messages about LGBTQ+ individuals did you receive growing up from your family? Religion? Culture? Race? From other sources? Inquire about potential intersectional identity impacts.
2. Did you ever feel pressured to act in a particular way to hide or conceal your identity/self from others? What did that look like? How did you feel when you were doing those things?
3. When did you disclose your identity to others? What motivated the decision at that time? What reaction from others did you receive? What do you wish you received?
4. How was your experience in the military as it relates to being LGBTQ+?
5. Did your military service have any influence on your relationship with yourself and/or your identity?
6. Did you ever experience any events where you felt unsafe related to your identity while in the military? Would you be willing to share examples?
7. Did you ever experience any sort of assault, violence, or threat of violence related to your identity while in the service? Since being out of the service?
8. Did you ever experience any discrimination, hateful comments, or rejection from others related to your identity while in the service? Since being out of the service? During health care appointments?
9. What has been your level of involvement with the LGBTQ+ community as a civilian and/or affiliated with the service? Have you experienced any feelings of unsafety or rejection from individuals within the LGBTQ+ community?
10. What has been the most helpful for you while navigating your identity and overcoming minority stressors throughout your life?

PTSD: National Center for PTSD

Assessment and Treatment Considerations for Working With LGBTQ+ Clients With PTSD

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LGBTQ+ is an acronym that stands for those who identify as lesbian, gay, bisexual, transgender or queer. The "+" indicates any other minoritized identities such as intersex, asexual, pansexual or nonbinary.

LGBTQ+ individuals are at greater risk for experiencing traumatic events such as assault and violence and therefore have higher rates of PTSD than those in the general population. They are also more likely to experience additional burdens related to discrimination, social exclusion, and other minority stressors. Despite an increased need for support, LGBTQ+ individuals may be hesitant to seek treatment due to expectations of discrimination in health care settings. These additional burdens, and poorer quality of care, place LGBTQ+ people at higher risk of developing mental health problems.

This article orients clinicians to central concepts of creating a safe, welcoming and affirming care environment for PTSD treatment. Next, considerations for assessment, case conceptualization, and treatment approaches for PTSD that are relevant to LGBTQ+ clients are reviewed. See Trauma, Discrimination and PTSD Among LGBTQ+ People for more background information.

Setting the Stage: Central Concepts for Providing Safe, Welcoming and Affirming Care

Due to historical and ongoing maltreatment in health care, LGBTQ+ clients may express mistrust of medical and mental health providers. Concerns about trust and safety may be heightened for LGBTQ+ who have also experienced interpersonal trauma.

Clinicians and their practice settings can take steps to create an environment of safety and inclusion by:

- Establishing clear non-discrimination policies that are posted publicly
- Providing training on health of LGBTQ+ people
- Establishing a formal process to allow LGBTQ+ clients to raise issues or complaints

Other system- or clinic-level approaches might include:

- Reviewing intake forms and paperwork to ensure inclusive language for assessing sexual orientation and gender identity and removing language that assumes cisgender (i.e., gender identity that is the same as sex assigned at birth) or heterosexual experience
- Ensuring the use of inclusive images on educational materials or posters and offering LGBTQ+ health-specific information for clients (e.g. VHA Fact Sheets)

- Improving gender-inclusiveness of bathroom signage

At the individual clinician level, this may entail:

- Starting sessions with a provider stating the name they go by and their pronouns
- Asking all patients the name and pronouns they use
- Asking about relationships in an inclusive fashion (i.e., not assuming heterosexual or cisgender identity), for example, "Who are the important people in your life?"
- Displaying LGBTQ+ safety cues (e.g., symbols, flags, signage)

Comprehensive Assessment of Trauma, Minority Stress and Common Comorbidities

Case conceptualization for LGBTQ+ clients starts with careful consideration of the contribution of various stressor exposures on clinical presentation. This should include assessment of trauma **and** minority stressors, as well as common mental health consequences of both, including PTSD, depression, anxiety, substance use and suicidality. For example, clinicians may better understand causes of symptoms by directly asking clients' perceptions of whether presenting concerns are related or not related to their LGBTQ+ identity (e.g., hate crime, bias assault).

Case Conceptualization and Treatment Planning

Based on minority stress theory, clinicians may conceptualize mental health symptoms as being driven by exposure to a range of high-stress experiences combined with inadequate support structures to prevent harm and foster resilience. Individual-level interventions are appropriate for symptom reduction and for improving coping skills to buffer the effects of trauma and discrimination. Ideally, interventions also foster resilience by addressing social support and community building needs that aim to enhance coping and resistance to minority stressors. System-level interventions may also involve clinicians engaging directly in advocacy work or policy reform to reduce institutional harms to LGBTQ+ people (1).

Treatments Focusing on PTSD Symptom Reduction

The most effective treatment for PTSD is trauma-focused psychotherapy. The most well studied trauma-focused treatments are Prolonged Exposure (PE) , Cognitive Processing Therapy (CPT) , and Eye Movement Desensitization and Reprocessing (EMDR) . These treatments have been shown to be effective across numerous trauma types such as combat, sexual assault, motor vehicle accidents, natural disasters and terrorism. Research consistently supports that these treatments are effective across various populations, including those that are more complex or with comorbidities such as suicidality, borderline personality, psychosis or substance abuse. There is reason to believe that LGBTQ+ individuals with PTSD would respond similarly to efficacious treatments; however, no studies have tested the effectiveness of these treatments in LGBTQ+ samples. There are a few helpful book chapters on application of PE and CPT with LGBTQ+ clients that we recommend (e.g., 2-4). Some modifications might be needed to provide care in a way that is culturally responsive—yet even this remains an empirical question.

General guidance for PTSD-focused treatments

LGBTQ+ clients may be more prone to experience shame-based trauma, adding some treatment complexity relative to fear-based trauma clients (5,6). Although not tested in LGBTQ+ populations specifically, research supports the effectiveness of existing PTSD treatment for shame-based traumas.

Other considerations to support LGBTQ+ clients include:

- Validating clients' experiences by using the labels they use for events (e.g., "trauma") even when the experience is perceived by the clinician as not meeting Criterion A.

- Providing psychoeducation on how minority stress experiences can further complicate the clinical presentation of PTSD (e.g., discrimination events may be trauma reminders; 7).

- Assessing threat responses to LGBTQ+ clients' interpretations of the environment as hostile (5). An accurate view of a hostile situation may benefit from understanding whether a threat response is adaptive or not adaptive, given the context.

Considerations for cognitive restructuring

Cognitive restructuring is a core component of Cognitive Processing Therapy (CPT), one of the most effective treatments for PTSD. The basis of CPT is that thoughts and beliefs that were learned (or strengthened) by trauma experiences inhibit complete processing of the trauma event, stalling recovery. There is some evidence that experiences of discrimination can lead to similar cognitions as trauma (e.g., "I cannot trust anyone," "People will harm me."). It is therefore strongly encouraged that clinicians carefully perform contextual and functional assessment of cognitions prior to using cognitive restructuring. For example, some cognitions may be accurate, and therefore, should not be a focus of cognitive restructuring (e.g., safety beliefs that reflect actual or realistic appraisals of threat). In contrast, other post-trauma cognitions related to identity should be integrated into treatment (e.g., extreme esteem beliefs that reflect internalized stigma such as, "Abuse made me gay,"; identity-linked self-blame beliefs such as, "It's my fault this happened because I shouldn't have left the house expressing as a woman.").

Considerations for exposures

Exposures are a core component of efficacious treatments for PTSD, including Prolonged Exposure (PE).

Imaginal exposures include repeated recounting of the trauma memory to process emotions and gain context and control over the memory. When selecting events for imaginal exposure work, it is important for the clinician to assess the context and the function of a client's cognitive, emotional and behavioral responding. In cases where the index Criterion A event is bias-related, the exposure procedure is the same; however, in processing, the clinician may assist the client in teasing apart which ways of responding were adaptive (protective) and which ways of responding were not adaptive. In these cases, imaginal exposure activates the bias-related trauma memory so that habituation can occur, while also attending to contextual identity-related factors relevant to how the client responded to the event such as realistic appraisals of safety based on sexual orientation or gender identity. Similar to cognitive restructuring guidance, this type of contextual processing allows for new learning and reductions in cognitively-loaded emotions that maybe related to identity (e.g., shame).

In vivo exposures involve engaging with trauma reminders (triggers) and emotions by doing activities that the client has been avoiding since the trauma. The goal is to facilitate habituation and new learning and improve functioning. Because LGBTQ+ clients may regularly encounter unsafe environments, when creating an *in vivo* hierarchy, we recommend collecting an additional rating representing actual safety risk (beyond just anticipated subjective units of distress). These ratings will help the clinician and client rank and prioritize in *vivo exposures* that elicit affect but pose little objective risk to safety (e.g., spending more time with affirming peers / engaging with avoided social supports).

Treatments Focusing on Coping Skills Building and Bolstering Social and Community Supports

The application of coping skills and social support / community building interventions may be helpful in addressing distress related to discrimination, internalized stigma (shame), and identity concealment. The state of the evidence of these approaches is preliminary, although this is an area of rapid growth in recent years. Some examples of preliminary research studies in this area include:

- **Dialectical Behavior Therapy (DBT) Skills Training:** We highly recommend that clinicians aiming to apply the DBT skills training framework to work with transgender and gender diverse clients review work by Sloan and Berke (2018). This approach focuses on addressing chronic invalidation as a driver of emotional and behavioral dysregulation and interpersonal difficulties (conceptualizing both discrimination **and** trauma on the same continuum of invalidating experiences) and promotes skills development, to replace ineffective coping with effective coping strategies (8). Although DBT skills were originally designed for the treatment of borderline personality disorder (BPD), the skills in this case are being used with LGBTQ+ people to target distress related to chronic invalidation (discrimination/exclusion).

- **Transdiagnostic Cognitive Behavioral Therapy Approaches:** A study of a transdiagnostic cognitive behavioral therapy (CBT) intervention ESTEEM (Effective Skills to Empower Effective Men) demonstrated efficacy in reducing minority stress processes that underlie sexual orientation-based HIV disparities (9). ESTEEM is an adaptation of the Unified Protocol (10) for gay and bisexual men at risk of acquiring HIV. The intervention includes education on the minority stress model and related cognitive and emotional processes, and CBT techniques such as cognitive restructuring and behavioral exposures. The ESTEEM model has not been tested for other LGBTQ+ groups, nor has it been used to address trauma-related distress.

- **Empowerment and Peer-Supported Approaches:** Empowerment interventions and peer-based supports that focus solely on the consequences of minority stress may be complementary to PTSD treatment and often are provided in group format. One example is Empowerment Self-Defense programs that have been tailored for LGBTQ+ people (11). Although varied, these programs focus on bolstering self-efficacy, agency and social supports needed to buffer the effects of chronic invalidation, rejection and victimization in the lives of LGBTQ+ people.

Conclusion

This article has provided an overview of assessment, case conceptualization and treatment recommendations for LGBTQ+ people with PTSD. The goal was to note some of the complexities and nuance that are essential to providing care that is both effective and affirming. This includes respectfully asking about a range of stressor exposures—including trauma, discrimination, and other minority stress experiences—as well as asking about linkages between identity, exposures, recovery processes and common co-occurring disorders. Appropriate interventions include existing evidence-based treatments for PTSD, as well as additional supports in preventing and reducing harms caused by discrimination and social exclusion.

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