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A Qualitative Analysis of the Context and Characteristics of Trauma Exposure Among Sexual Minority Survivors: Implications for Posttraumatic Stress Disorder Assessment and Clinical Practice

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Abstract

Objective: Sexual minority individuals are exposed to traumatic harms unique to the shared cultural experience of living under conditions of identity-based stigma, discrimination, and marginalization. However, the context and characteristics by which this culture shapes traumatic experiences among sexual minority people are poorly specified in the research literature, leaving even well-intentioned mental health professionals inadequately prepared to treat sexual minority trauma survivors in a culturally affirming, tailored, and evidence-based manner.

Method: To begin to address this gap, we conducted a thematic analysis of descriptions of 52 *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM–5*) Criterion A (traumatic) events described by sexual minority participants during administration of the Clinician-Administered PTSD Scale for *DSM–5*.

Results: Probing for identity relatedness of Criterion A trauma produced a rich and reliable (κ = .83–.86) coding scheme reflecting the cultural context and characteristics of these experiences.

Conclusions: Clinicians working with sexual minority and other marginalized trauma survivors should specifically assess for the role of culture in traumatic experiences to inform case conceptualization and treatment plans supporting recovery of the whole survivor.

Keywords

assessment; diagnosis; PTSD; qualitative analysis; sexual minority

Sexual minority populations experience disparate exposure to trauma in their lifetime compared to heterosexual populations (Dworkin et al., 2018; Roberts et al., 2010). These disparities extend across the life course and across a range of trauma types (e.g., childhood maltreatment, interpersonal violence, indirect trauma exposure to close friends or relatives, unexpected death of a loved one; Agorastos et al., 2014; Roberts et al., 2010). Given these disparities, it is perhaps unsurprising that sexual minority individuals also experience greater

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lifetime prevalence of posttraumatic stress disorder (PTSD) than heterosexuals; prevalence rates range from 10.3% to 26.6% for sexual minority individuals as compared to 6.8% to 7.3% in the general population (Roberts et al., 2010).

Research suggests that elevated PTSD incidence among sexual minority populations may be accounted for by the earlier onset and greater range and multitude of types of traumatic harm sexual minority individuals face (D'Augelli et al., 2006; Stein et al., 2016). Compared to heterosexual individuals, sexual minority individuals report overexposure to traumatic experiences associated with elevated risk of PTSD onset and chronicity. These experiences include childhood maltreatment, trauma perpetuated by known assailants (e.g., family members, intimate partners), identity-based trauma (e.g., hate crimes), and traumatic experiences that are chronic in nature (D'Augelli et al., 2006; Lukaschek et al., 2013; Roberts et al., 2010; Stein et al., 2016).

Sexual minority individuals may also experience high-impact stressors that do not easily fit into widely acknowledged definitions and conceptualizations of trauma and traumatic events (D'Augelli et al., 2006; Stein et al., 2016), including traumatic experiences unique to the experience of living under conditions of identity-based stigma and marginalization (Holmes et al., 2016). Despite improvement in the legal rights of sexual minorities around the world, sexual minority individuals continue to suffer high rates of discrimination and stigmatization due to heterosexism (Alessi & Martin, 2017). The *minority stress model* (Meyer, 2003) posits that the cumulative burden of exposure to chronic social stigma-related stress (i.e., "minority stress"; e.g., heterosexism) may account for population-level disparities in health observed among minoritized social groups, including disparities in PTSD. Consistent with this model, socially patterned differences in exposure to identity-based trauma and minority stress have been empirically shown to predict and/or mediate disparities in PTSD (Dworkin et al., 2018; Straub et al., 2018; Szymanski & Balsam, 2011) and a host of other adverse health outcomes that are disproportionately prevalent among sexually minoritized (relative to heterosexual; Lee et al., 2016; Liao et al., 2015) individuals.

Because incidents of discrimination and stigmatization are identity based, they may threaten an individual's core sense of self (Bryant-Davis & Ocampo, 2005), particularly when these incidents are chronic and/or associated with other high-risk trauma characteristics (e.g., trauma perpetrated against a child or by a known assailant). When discrimination, stigmatization, and heterosexism constitute the cultural context of traumatic experiences, they may complicate the etiology, course, and treatment of PTSD among sexual minority individuals (Alessi & Martin, 2017; Livingston et al., 2019). Their impact may also constitute unique clinical intervention targets (Livingston et al., 2020).

However, traumatic events that meet *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM–5*) criteria (direct experience, witness of, learning about, or repeated or extreme exposure to aversive details of death, threatened death, or actual/threatened serious injury or sexual violence; American Psychiatric Association [APA], 2013) are not routinely or systematically assessed to probe for linkage to bias. They also are not routinely or systematically differentiated by qualitative distinctions in trauma type, despite research demonstrating that PTSD onset, severity, and duration are impacted by qualities of the

precipitating traumatic event including pattern of exposure (e.g., discrete vs. chronic: Ehring & Quack, 2010; Salazar et al., 2013; Stein et al., 2016), type of trauma (e.g., interpersonal violation vs. natural disaster; Salazar et al., 2013), identity of assailant (e.g., known vs. unknown; Lukaschek et al., 2013), and relation of trauma to identity (Berman, 2016; Roberts et al., 2010).

Descriptive characterization of this diversity of experience among trauma-exposed sexual minority populations is essential to guide evidence-based clinical assessment of the role of cultural context and sexual minority stigma in Criterion A trauma exposure and recovery. The APA (2017) Clinical Practice Guideline for the Treatment of PTSD in Adults identifies attention to cultural context as a required component of trauma-informed mental health care provision but does not specify the role of culture in trauma or in recommendations for assessment and intervention. As such, they fall short of providing clinicians with the knowledge necessary to adhere to its dictates. We echo the critique of Bryant-Davis (2019), who noted that lack of acknowledgment of oppression, discrimination, and violence due to cultural group membership in the APA's clinical guideline is unethical—not only in its erasure of parts of clients' lives and recovery centered in their cultural identity but also in the resulting failure to engage clinical providers in adequate assessment and treatment of traumatic stress sequalae in line with current empirical evidence.

Greater attention to the unique experiential and identity-related factors linked to the traumatic experiences of sexually minoritized individuals is needed to inform culturally affirming and attuned conceptualization and treatment in service of trauma recovery. The current study aimed to characterize the cultural context and characteristics of Criterion A traumatic experiences described by participants during administration of the Clinician-Administered PTSD Scale for *DSM–5* (CAPS-5; Weathers et al., 2013a). By systematically describing the heterogeneity of Criterion A traumatic experiences among sexual minority individuals and identifying emergent themes characterizing identity-related traumatic events, we aimed to inform culturally attuned clinical case conceptualization and trauma-informed treatment of this high-need population.

Method

Participants

Fifty-three sexual minority individuals participated in the current study. Participants were recruited from undergraduate introductory psychology courses offered at a large, urban university in the Northeastern United States ($N = 9$) and from flyers posted throughout the surrounding community ($N = 43$). Individuals interested in participating in the study were directed to take an online screener survey to determine eligibility. Inclusion criteria were as follows: endorsement of lesbian, gay, bisexual, pansexual, queer, or other sexual minority identity; age between 18 and 65; and exposure to a potentially traumatic event as assessed by the Life Events Checklist (LEC; Weathers et al., 2013b).

One participant was excluded from analysis because their index event was determined not to meet the definition of a Criterion A traumatic event (i.e., did not involve death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence);

thus, the final analytic sample consisted of 52 participants. The mean age of participants was 23 years (*SD* = 10.02; range = 18–62). Participants identified as 48.1% bisexual, 17.3% pansexual, 15.4% lesbian, 7.7% gay, 3.8% asexual, 3.8% queer, and 3.8% other nonexclusively heterosexual identity. The racial makeup of the sample was 40.1% White, 25.0% Asian/Pacific Islander, 9.6% Black, 3.8% Middle Eastern, and 1.9% mixed race. About a third of participants were Hispanic/Latinx (32.7%). Most participants reported they were single (46.2%), had an annual household income of between $10,000 and $50,000 (46.2%), and completed some college (50.0%).

Procedures

All procedures were approved by the Institutional Review Board of Hunter College, City University of New York. Eligible participants were instructed to contact the study team to schedule an interview session. Informed consent was obtained for all enrolled participants. Participants recruited from the broader community were compensated $20 for the study procedures described herein; those recruited from the undergraduate research pool could choose to accept either course credit or monetary compensation for participation. Study sessions took place in person at Hunter College between June 2019 and March 2020.

Measures

Demographics—As part of a larger study examining PTSD, discrimination, and physiological stress in sexual minority populations, participants completed a self report demographic questionnaire. Demographic characteristics assessed include: age, gender identity, race/ethnicity, sexual orientation, and level of education.

Life Events Checklist—Study interviewers administered a pencil-and-paper version of the LEC (Weathers et al., 2013b) to measure lifetime history of trauma exposure and to facilitate the identification of the index event to which to anchor administration of the CAPS-5 (Weathers et al., 2013a).

Clinician-Administered PTSD Scale for DSM–5—Participants were administered a gold-standard, clinical assessment of PTSD, the CAPS-5 (Weathers et al., 2013a). Audio recordings of the CAPS-5 interview were generated for all participants consenting to audio recording (*N* = 24) to ensure fidelity of interview administration. The interviewer team consisted of a clinical psychologist and doctoral- and master's-level students. All interviewers were trained to fidelity in reliable administration of the CAPS-5 and were supported by weekly group supervision by a licensed clinical psychologist (first author), which included review of audio recordings.

The current study focuses on administration of the Criterion A item of the CAPS-5 interview, a brief description of the index traumatic event (Weathers et al., 2013a). The interviewer asked the participant to briefly describe the event, prompting as needed for clarifying information about the age the event occurred, the level of the exposure (directly experienced, witnessed, learned about, exposed to aversive detail), actual or threat of injury or death, sexual violence, and acuity of the event (single instance vs. chronic exposure). The CAPS-5 was modified to include a question probing for anti-sexual-minority bias (i.e.,

"Was this event related to your sexual identity?"). The study interviewer transcribed written description of participant responses to all Criterion A prompts into a study database; audio recordings of these responses were uploaded to a password-protected server.

Data Analysis

Focused qualitative analysis was guided by Braun and Clarke's (2006) method of thematic analysis. An initial codebook was developed inductively by consensus between the first and second authors after review of a subset of Criterion A event written summaries. In line with the study aims, themes focused on characterizing the index event described by the participant. The codebook was iteratively adapted until theoretical saturation. If a new or revised theme definition was deemed necessary, all previously coded event summaries were recoded.

A random selection (21.2%) of the event description summaries were double coded by a bachelor's-level team member (fourth author), demonstrating excellent interrater reliability (86.84% agreement; $\kappa = .86$). A random selection of audio recordings, 20.8% of the total sample, were also coded and compared to written summary coding, demonstrating excellent cross-method reliability (83.58% agreement; $\kappa = .83$). After all event summaries and audio descriptions were coded, we conducted a phase of axial coding, in which codes and themes were reviewed to ensure that codes accurately reflected the theme identified and organized to increase our ability to interpret themes.

Results

Over one third ($n = 19$; 36.5%) of the Criterion A trauma-exposed sample met criteria for PTSD. Exposure to a single potentially traumatic event was rare, with the average participant endorsing 7.79 items on the LEC ($SD = 3.08$; minimum = 0, maximum = 15). Table 1 provides a summary of the frequency of Criterion A trauma type codes indexed to the event identified by participants as currently most distressing or haunting. Twenty-five percent ($n = 13$) of the sample identified an index event that entailed direct exposure to life threat. The vast majority of index events were interpersonal in nature (e.g., physical assault: $n = 14$, 26.9%; sexual violence: $n = 26$, 50.0%), compared to noninterpersonal traumatic events (e.g., motor vehicle accidents: $n = 3$, 5.8%; serious illness: $n = 1$, 1.9%; other accidents: $n = 1$, 1.9%). Rates of sexual violence were particularly high, including experiences of molestation/groping ($n = 10$; 19.2%), rape ($n = 9$; 17.3%), and sexual coercion ($n = 7$; 13.5%). Five participants (9.6%) reported potentially traumatic experiences entailing exposure to suicide and/or self-harm behaviors as their currently most haunting/distressing index trauma.

Table 2 lists codes emerging from our characterization of contextual factors associated with Criterion A index event data. The majority of participants identified index events occurring in childhood ($n = 13$; 25%) or adolescence ($n = 22$; 42.3%) relative to events occurring after 18 years of age. Although a sizable percentage of index events were perpetrated by strangers ($n = 12$; 23.1%), the majority were perpetrated by individuals known to the victim including family members ($n = 11$; 21.2%), intimate partners ($n = 8$; 15.4%), and friends ($n = 2$; 3.8%).

Participants' descriptions of contextual factors facilitating the predatory behavior of assailants emerged as a coded theme. The modal code in this category was age-differential facilitated trauma (i.e., events described by participants included mention of perpetrators who were significantly older and/or at a different development stage than the victims; *n* = 11, 21.2%), followed by predation facilitated by alcohol (*n* = 3; 5.8%). In terms of occurrence or duration of index events, most were discrete in nature (*n* = 34; 65.4%), However chronic and/or ongoing index events were not uncommon (*n* = 18; 36.5%), despite the Criterion A indexing constraints of the CAPS-5.

Nine (17.3%) participants described events that entailed acts of resistance to violence, including active verbal and physical self-defensive actions and/or bystander intervention behavior. On the other hand, the same number (*n* = 9; 17.3%) included descriptions of the harmful absence of needed responsiveness from putative social supports (e.g., adults, police, school representatives). These data are contrasted with the fact that over a fourth of the index events reported occurred in public spaces (*n* = 14).

Just under half of the sample (*n* = 24; 43.4%) described Criterion A events coded as related to sexual minority identity. We generated cross-tabulations of the frequency of co-occurring high-risk Criterion A event elements and sexual minority relatedness to account for synergistic risk experiences. Approximately one third of the sample reported identity-related sexual violence (*n* = 17; 32.7%), and nearly 20% reported occurrence of chronic identity-related Criterion A events (*n* = 10; 19.2%). Nearly 30% of the sample reported sexual-minority-identity-related Criterion A events occurring in childhood or adolescence. It was not uncommon for sexual-minority-identity-related Criterion A events to be perpetrated by a family member (*n* = 5; 9.6%).

Table 3 lists sexual-minority-identity-related trauma themes and associated emergent contextual codes. Participants often (*n* = 8; 32.0%) described the identity relatedness of the event in terms of the perpetrator's behavior (e.g., perpetrators used anti-sexual-minority stereotypes and slurs while perpetrating physical and/or sexual violence). In some instances, perpetrators explicitly communicated to the victim that their violent behavior was enacted in an attempt to punish or control the participant's sexual and or gender expression. In other instances (*n* = 6; 24.0%), the association between the Criterion A trauma and the participant's sexual minority identity was established through the proximal association between the participant's resistance to or rejection of heterosexist norms and perpetrator behavior. For example, one participant was stalked and assaulted at knifepoint by a group of men after she rejected their sexual advances by asserting her sexual minority identity. Two participants (8.0%) described Criterion A events that were coded as identity related because they occurred in a queer space (e.g., gay/lesbian bar).

When prompted as to the sexual minority identity relatedness of the traumatic experience, 12 (48.0%) participants made causal attributions, including self-directed identity-related causal attributions for the event (*n* = 7, 25.0%; e.g., "This happened because I am bisexual"), attributions of perpetrator beliefs about a marginalized aspect of their identity ("This happened because the perpetrator thinks women are easy to control"), and attributions of the social roles and norms of dominant groups (e.g., "Boys and men cannot be trusted").

Five participants (2.0%) responded to the identity relatedness prompt by reporting that they altered their identity expression (either gender expression or sexual orientation) as a result of the event.

Discussion

We generated and applied a reliable coding scheme to characterize the heterogeneity of Criterion A traumatic experiences reported by a diverse sample of sexual minority trauma survivors. We also identified emergent themes characterizing the role of sexual minority cultural and contextual factors of these traumatic events generated by probing for linkage to anti-sexual-minority bias. Findings have significant implications to inform clinical case conceptualization of the role of culture and identity in the traumatic experiences and recovery of sexual minority survivors.

Consistent with prior research, findings reflect high incidences of exposure to trauma types that confer higher risk for PTSD development, severity, and chronicity, including interpersonal traumatic events that occurred during childhood, sexual violence, and trauma perpetuated by known assailants (often their family). Our analysis also revealed high levels of synergistic risk among these high-risk trauma types and events that were experienced by survivors as related to marginalization of their sexual minority identity. These findings align with core theoretical assumptions of recent work by researchers seeking to integrate conceptual models of trauma and discrimination (e.g., Bryant-Davis, 2019; Livingston et al., 2019); that is, experiences of trauma and minority stressors are overlapping and, for some, inextricably linked.

Results also highlight resistance to interpersonal violence as an underrecognized theme in the context of the traumatic victimization experiences of sexual minority survivors. Sexual minority trauma survivors described acts of active verbal and physical self-defensive actions and/or bystander intervention behavior when describing acts of resistance to Criterion A trauma. Despite empirical support for the psychological benefits of assertive and physical forms of resistance to interpersonal violence (for a recent review, see Dardis et al., 2018), its presence is not a routine component of PTSD assessment, conceptualization, or treatment guidelines. This omission ignores that fact that marginalized people often do take effective action to thwart or interrupt interpersonal trauma—asserting competence, bodily integrity, and self-integrity in the face of traumatic victimization. Failure to probe for this possibility in PTSD assessment is a missed opportunity for clinicians to highlight and leverage the strength and resiliency of sexual minority individuals. We recommend that clinicians routinely assess for the presence of resistance to traumatic victimization in PTSD assessment. Clinicians may also integrate violence resistance frameworks as a healing resource to empower sexual minority clients in trauma recovery work. For example, empowerment self-defense training, a time-limited, group-based intervention that teaches a range of verbal and physical self-defense skills for resistance violence (Hollander, 2018), has been shown to reliably reduce risk of sexual victimization (Hollander, 2014; Senn et al., 2015) and may be strategically implemented as a clinical intervention for sexual minority trauma survivors (Rosenblum & Taska, 2014).

The harmful absence of needed responsiveness from putative social supports (e.g., adults, police, school representatives) also emerged as an important theme in participants' descriptions of Criterion A trauma. Findings suggest that the social environment proximal to sexual minority trauma survivors may often be characterized by inaction, passivity, denial, and victim blaming. Absence or withdrawal of social support resources following trauma exposure is one of the most robust predictors of chronic PTSD (e.g., Campbell et al., 2001; Janoff-Bulman, 1992; Ullman & Filipas, 2001). Our findings extend this literature by contextualizing this uniquely pathogenic component of traumatic experiences among sexually minoritized survivors. The harm of social neglect in the context of traumatic experiences is of particular concern to sexual minority survivors as inadequate social support in the immediate social environment in which trauma occurs reflects, and is refracted by, the structural-level oppression and tolerance of violence that reinforces the power differentials responsible for the oppression of sexual minority individuals at outer levels of the social ecology (e.g., media, laws, religious institutions). As such, insufficient social support in the context of trauma may exacerbate the psychological, spiritual, and emotional harms of interpersonal trauma to sexual minority survivors.

These findings have clear implications for trauma assessment and clinical intervention for sexual minority survivors. In terms of their assessment implications, they speak to the importance of assessing for what is missing in the context of traumatic experiences (e.g., social support) along with more traditional assessment of the presence of pathogenic elements (e.g., sexual violence, life threat, serious injury). Further, given the breakdown in social support experienced by many sexual minority trauma survivors, social withdrawal and mistrust may be reasonable survival responses that unfortunately block the survivor's access to the healing power of community and intimate connection. As such, sexual minority survivors may benefit from clinical interventions that balance an acknowledgment of the real safety risks and limited support that sexual minority individuals face in a heterosexist society, with encouragement and skills training (e.g., interpersonal effectiveness module of dialectical behavior therapy; Linehan, 2014) to support development and maintenance of healthy and healing interpersonal relationships and social networks.

Study findings regarding the bias relatedness of the traumatic experiences of sexual minority individuals were particularly striking as nearly half of the participants described sexual-minority-identity-related Criterion A events. Emergent themes among these events (i.e., perpetrator's behavior, outness related, proximal occurrence with outness/resistance to heterosexism) exemplify how these types of traumatic experiences reinforce the systems of power and privilege that position particular sexual identities as "other," inferior, and deserving of punishment. These findings align with theory suggesting that perpetrators may use violence as a way to disseminate distorted beliefs about the cultural group of those they victimize (i.e., normalizing assault as punishment for rejection of heterosexist norms; Bryant-Davis & Ocampo, 2005). When perpetrators of identity-based trauma receive explicit or tacit social approval (e.g., lack of punishment) for their behavior, violence-justifying logic is reinforced—to the detriment of the psychological health of the victim, perpetrator, and society (Bandura, 2002; Bryant-Davis, 2007; Sanchez-Hucles, 1999).

Sexual-minority-identity-related themes also have direct applications to case conceptualization and treatment of these traumatic harms, specifically as they relate to the importance of meaning making and challenging casual association in trauma recovery work with sexual minority clients. Because many of the traumatic incidents described by participants occurred in temporal proximity to outness/expression of sexual minority identity, our findings suggest that these experiences may function to punish behavioral expressions of minoritized sexual and/or cultural identities. In pairing expression of self with traumatic harm, these experiences may threaten a victim's core sense of self (Bryant-Davis & Ocampo, 2005) and generate or reinforce internalized heterosexism and related patterns of logic (e.g., "If I am myself, I will be traumatized. So maybe I am not me?") likely to result in painful estrangement from the self, numbing, and dissociation. Internalization of self-blaming cognitive patterns learned from traumatic events (e.g., "I was assaulted because I am gay") may be a key target for intervention among survivors of identity-related traumatic events. Clients who describe identity-related self-blame when thinking about traumatic experiences may benefit from cognitive therapy interventions to challenge such cognitions and to interrupt internalized heterosexism by acknowledging the impact of the larger stigmatizing contexts in which trauma against sexual minority individuals occurs.

The traumatic harm of sexual-minority-identity-related events also accrues to society. When researchers, clinicians, and educators do not assess or acknowledge the identity relatedness of traumatic experiences, we become complicit in social neglect and institutional betrayal (Freyd, 1996; Herman, 1992). As such, we strongly encourage routine inclusion of questions probing for linkage to bias in PTSD assessment. Our findings suggest that characterization of the context of pervasive discrimination experienced by sexual minority individuals is likely to result in more accurate, complete, and effective conceptualization and treatment of traumatic harm. Importantly, all data used to generate reliable themes and codes richly characterizing the context of trauma in this sample were generated through administration of a single item of the CAPS-5 (Weathers et al., 2013a), highlighting the feasibility of this practice in clinical contexts. We believe this is not only an ethical imperative but also one that can be readily implemented into research and clinical protocols. It is only by assessing the harms of bias-related trauma and discrimination that we can address them (Bryant-Davis, 2007).

Limitations

There are several limitations of note in the current study. Reliance on retrospective reporting of traumatic experiences may limit the breadth of information participants disclosed about their experiences. Moreover, when investigating the identity relatedness of the event, it is impossible to determine perpetrator motivations separate from participant perceptions. However, arguably, an individual's perception of identity relatedness will impact their response to trauma whether or not the perpetrator intended to target the individual based on their identity. The current study sample overrepresents undergraduate students and individuals who feel comfortable enough in their identity to self-select participation in a study for sexual minority trauma survivors. Additionally, the sample represents sexual minority communities in urban settings; it is likely that those in rural or suburban settings may describe unique experiences with distinct thematic content.

A strength of the study is its diversity in terms of gender identity and race/ethnicity of the sample; however, distinct thematic content could be found in a sample with a higher percentage of sexual minority men and transgender individuals, and intersectional themes could arise if the identity-related prompt explicitly mentions racial or ethnic identity and their intersections with other identity dimensions. Future research should prioritize communities that experience violence and trauma at the nexus of heterosexism, racism, classism, transphobia, and xenophobia and on characterizing the experiences of individuals in multiple interlocking stigmatized social positions. Work that centers on intersectional social positionality in PTSD assessment and treatment would facilitate better understanding of heterosexism's impact on trauma as it functions with the complex contexts and realities experienced by diverse sexual minority individuals and communities. Future research should also prioritize assessment of the impact that identity relatedness may have on trauma recovery. Our findings suggest that assessing the identity relatedness, causal associations, and societal responses when discussing trauma with clients and integration of these themes into current evidence-based treatment for trauma may increase the relevance of trauma interventions to sexual minority communities.

Conclusions

The current study fills a gap in the literature regarding the unique characteristics and contexts of trauma exposure for sexual minority populations. Findings emphasize the frequency of identity-related trauma exposure among sexual minorities. Additionally, contextual characteristics of trauma in sexual minority survivors highlight core themes by which culture influences the meaning and impact of traumatic harm among sexual minority individuals. We hope these findings encourage and support clinicians in integrating questions about identity relatedness into PTSD assessment and to develop culturally tailored conceptualizations and treatments that center on the full lives and identities of trauma survivors.

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Clinical Impact Statement

We describe specific and reliable patterns of overlap between experiences of trauma and discrimination among sexual minority trauma survivors, assessed with a brief and widely accessible clinical tool. Results serve as concrete guidance for clinicians to consider when assessing and addressing the role of culture in posttraumatic stress disorder with patients marginalized based on their sexual identity.

Table 1

Frequency of Criterion A Trauma Type Codes

Theme	*n*	%
Life threat/serious injury/death	33	63.5
Interpersonal violence (i.e., physical assault)	14	26.9
Direct exposure	10	19.2
Witnessed	4	7.7
Noninterpersonal trauma	5	9.6
Motor vehicle accident	3	5.8
Fire	1	1.9
Serious illness	1	1.9
Exposure to self-directed violence/suicide	5	9.6
Sexual violence	26	50.0
Molestation/groping	10	19.2
Rape	9	17.3
Coercion	7	13.5
Sexual harassment	2	3.8
Incest	2	3.8
Attempted rape	2	3.8
Stalking	2	3.8

Note. Codes are not mutually exclusive. As such, the % column totals to greater than 100.

Table 2

Frequency of Criterion A Trauma Type Contextual Characteristics Codes

Theme	*n*	%
Age when occurred		
During adolescence	22	42.3
During childhood	13	25.0
Identity of the perpetrator		
Stranger	12	23.1
Family member	11	21.2
Intimate partner	8	15.4
Multiple assailants	5	9.6
Friend	2	3.8
Sex work relationship	1	1.9
Facilitating factors		
Age differential	11	21.2
Alcohol	3	5.8
Social status differential	1	1.9
Occurrence or duration of event		
Discrete	34	65.4
Chronic	17	32.7
Ongoing	1	1.9
Setting		
Public space	14	26.9
Resistance to violence		
Active physical resistance to assault	5	9.6
Verbal resistance to assault	3	5.8
Bystander intervention	1	1.9
Insufficient response from the social system		
Insufficient response from adults	4	7.7
Insufficient response from police	2	3.8
Insufficient response from school	2	3.8
Insufficient response from peers	1	2.9

Note. Codes are not mutually exclusive. As such, the % column totals to greater than 100.

Table 3

Frequency of Identity-Related Trauma Themes and Associated Codes

Theme/subtheme	% (*n*)	Codes
Perpetrators' behavior	32.0 (8)	Perpetrator used biphobic stereotypes to justify violence Perpetrator justified attack as an attempt to alter (by punishment) victim's sexuality Perpetrator used anti-SM slurs during the event Perpetrator conflated gender identity with sexual orientation (i.e., used anti-SM slurs during the event; victim identifies trans) Perpetrator prescribed lesbian identity onto victim to control sexuality Perpetrator expressed homophobic beliefs during assault
Setting	8.0 (2)	Event occurred in "queer" space
Outness related	32.0 (8)	Event entailed threats to "out" sexual orientation Event reaction to coming out Event coincided with coming out Experienced same-sex romantic connection to fellow victim (i.e., came out to self)
Event prompted by survivor's violation/resistance to heterosexist norms	24.0 (6)	Event prompted by woman's rejection of men's sexual advances Event prompted by assertion of SM identity Event prompted by resistance to homophobia
Altered identity expression as a result of event	20.0 (5)	Altered gender expression as a result of event Altered sexual expression as a result of event
Survivor's causal attribution	48.0 (12)	
Self-directed	28.0 (7)	Attributes cause of event to gender expression Attributes cause of event to gender role nonconformity Attributes cause of event to bisexuality Attributes cause of event to gender
Perpetrator directed		Attributes cause of event to misogynistic attitudes of perpetrator Attributes cause of event to perpetrator attempt to alter victim's sexual orientation
Directed toward social systems structures		Attributes cause of event to boys' and men's socialized gender role behavior
Suicidality	4.00 (1)	Suicide threat made in context of SGM stressors

Note. *n* = 25. SM = sexual minority; SGM = sexual and gender minority.