

LGBTQ Survivors of Identity Abuse: Heterosexist and Gender Oppressive Abuse Tactics and Their Relationship to Mental Health Among LGBTQ Survivors

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LGBTQ SURVIVORS OF IDENTITY ABUSE: HETEROSEXIST AND GENDER
OPPRESSIVE ABUSE TACTICS AND THEIR RELATIONSHIP TO MENTAL
HEALTH AMONG LGBTQ SURVIVORS

Dissertation by
JULIE M WOULFE
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LGBTQ Survivors of Identity Abuse: Heterosexist and Gender Oppressive Abuse Tactics and Their Relationship to Mental Health Among LGBTQ Survivors

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Intimate partner violence (IPV) and its substantial consequences remain widespread for LGBTQ (lesbian, gay, bisexual, transgender, queer) individuals (Balsam, Rothblum, & Beauchaine, 2005; Walters, Chen, & Breidig, 2013). LGBTQ IPV survivors are particularly vulnerable to identity abuse: tactics leveraging heterosexism and cissexism (FORGE, 2014; NCDSV, 2014). Past research has documented the existence of LGBTQ-specific identity abuse as a unique dimension of victimization (Balsam & Szymanski, 2005; FORGE, 2014; NCDSV, 2014), with limited attention to those at greatest risk despite the diversity of the LGBTQ community.

Participants who identified as LGBTQ ($n = 734$; 53% cisgender women; 39% queer or pansexual; 84% White; $M_{\text{age}} = 33.48$) completed surveys that assessed their exposure to identity abuse (7-items; $\alpha = .79$), physical and sexual abuse (20-items; $\alpha = .89$) and psychological abuse (14-items; $\alpha = .87$), and other demographics. The data were analyzed to determine 1) whether there were demographic differences in exposure to identity abuse, 2) whether identity abuse contributed to variance in PTSD or depression scores; and, 3) whether the relationships between identity abuse and PTSD and depression scores were moderated by affirmative LGBTQ identity.

Findings indicated that there were significant differences in identity abuse exposure by gender and sexual orientation. With regard to gender, ANOVA analyses

revealed transgender or nonbinary-identified individuals reported higher rates of past year identity abuse exposure than cisgender males and cisgender females. Also, cisgender females were most likely to report adult exposure to identity abuse compared to transgender or nonbinary-identified individuals and cisgender males. Queer-identified individuals were most likely to report adult exposure to identity abuse compared to lesbian, bisexual, and gay-identified individuals.

Identity abuse contributed to the variance in symptoms of PTSD and depression. This relationship remained significant even after accounting for exposure to other forms of violence (e.g., psychological abuse and physical abuse). Further, an affirmative LGBTQ identity indeed weakened the relationship between exposure to past year and adult identity abuse, respectively, and depressive symptoms. However, there was no moderating effect found for symptoms of PTSD.

These results add to existing IPV literature by identifying particular subgroups within the LGBTQ community who are at greater risk of identity abuse exposure within intimate partner relationships, suggesting that exposure to identity abuse contributes to poorer mental health outcomes, and indicating that affirmative LGBTQ identity is a protective factor that could be utilized in intervention and prevention efforts. As a whole, these results highlight the need for increased awareness of identity abuse within the LGBTQ community, as well as routine and comprehensive assessment for identity abuse exposure by service providers.

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Chapter I: Introduction

Despite decades of activism, intimate partner violence (IPV) remains a pervasive public health concern with serious personal and societal costs. Emerging research indicates that lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) communities experience rates of IPV that are similar to, if not higher than, heterosexual and cisgender communities (Blosnich & Bossarte, 2009; Edwards, Sylaska & Neal, 2015; Greenwood et al., 2002; Messinger, 2011). Further, this population faces unique barriers accessing social support and formal services needed to recover from abuse (Basow & Thompson, 2012; Edwards et al., 2015; Turell & Herrmann, 2008). High rates of violence and lack of access to resources occur in the context of ongoing heterosexism and gender oppression, which already place LGBTQ individuals at a disproportionate risk for psychological distress (Lehavot & Simoni, 2011; Meyer, 2003). Consequently, LGBTQ survivors of IPV may be particularly vulnerable to mental health disparities.

One type of IPV that has received little attention in the literature despite its apparent salience in the LGBTQ community is *identity abuse*, a set of abusive tactics within an intimate partnership that leverage systemic discrimination (i.e., ableism, sexism, and racism) to harm the individual (Gay Men’s Domestic Violence Project, 2014). This paper examines LGBTQ-specific identity abuse; that is, those abusive tactics that leverage heterosexism and cissexism against the survivor¹ (Ard & Makadon, 2011; Balsam, 2008; FORGE, 2014; National Center on Domestic & Sexual Violence, 2014). Examples of such abuse include threatening to “out” a survivor to family or an employer

¹ The term ‘survivor’ will be used in place of ‘victim’ throughout this study

or restricting access to a supportive LGBTQ community (NCDSV, 2014). Despite emerging evidence documenting the existence of identity abuse (Balsam & Szymanski, 2005; FORGE, 2014; NCDSV, 2014), little is known about its prevalence across specific subgroups of the LGBTQ population, its relationship to psychological distress, or the factors that may moderate its relationship to mental health outcomes.

Given that identity abuse leverages cultural and systemic discrimination, it may have effects that are different in type or degree from other forms of psychological abuse that are not bias-based. Theoretical models such as the minority stress framework developed by Meyer (2003) that aim to explain and predict the effects of marginalization and discrimination on mental health may provide an important framework to explore identity abuse.

The minority stress framework holds that the higher rate of psychological distress in LGBTQ communities is the direct result of chronic and pervasive exposure to, and subsequent internalization of, discrimination (Meyer, 2003). Minority stress theory helps to illuminate potential outcomes of identity abuse as well as moderators of the relationship between identity abuse and mental health. The minority stress model suggests that marginalized communities experience both significant external stress, such as anti-LGBTQ discrimination in their relationships, as well as increased internal stress such as hypervigilance within their relationships, internalized homo/bi/transphobia, and the concealment of their identity to avoid stigma. Previous research on chronic anti-LGBTQ interpersonal discrimination and harassment suggests that these stressors, in turn, contribute to poor mental health (Mays & Cochran, 2001). The minority stress model additionally outlines protective factors that mitigate the effect of external and

internal stress. For example, previous research has found evidence that having a positive LGBTQ identity (Balsam & Mohr, 2007; Eliason & Schope, 2007; Hershberger & D'Augelli, 1995; Nuttbrock, Rosenblum, & Blumenstein, 2002) serves to buffer against the adverse effects of minority stress for LGBTQ individuals.

Despite the high prevalence of IPV in the LGBTQ community, we know little about this form of violence, including its nature, prevalence, and relationship to mental health. This study aims to address these gaps in the literature by exploring 1) the overall prevalence of identity abuse in a sample of LGBTQ respondents as well as within-group differences across subgroups of the LGBTQ community; 2) the relationship between identity abuse and mental health, focusing specifically on symptoms of depression and posttraumatic stress disorder (PTSD); and 3) the extent to which affirmative LGBTQ identity moderates the relationship between identity abuse and psychological distress.

We expect these findings will further illuminate the unique needs and experiences of a community that has received far too little attention in research and clinical practice. Implications drawn from these findings will lead to improvements in training and education for community members and service providers about the pervasiveness and effects of IPV in the LGBTQ community. Our improved understanding of the role of identity abuse and its contributing factors on mental health may help ameliorate the impact of IPV.

Chapter II: Literature Review

The conceptual frame for this study draws from multiple literatures and disciplines. The following review describes 1) this study's conceptualization of the LGBTQ community; 2) the prevalence and effects of IPV generally and within the LGBTQ community specifically; 3) the role of identity abuse as a dimension of IPV in the LGBTQ community; 4) how the minority stress model helps to explain the potential relationship between symptoms of identity abuse and symptoms of PTSD and depression among LGBTQ survivors; and 5) the potential role of an affirmative LGBTQ identity in this hypothesized relationship. From the outset, it is important to note the diversity within LGBTQ communities; as such, this literature review will describe within-group differences across race, gender and sexual identity to the extent that prior research allows.

Defining Terms

Before discussing the nature of IPV within the LGBTQ community, it is first necessary to describe how this study conceptualizes LGBTQ status. This study focuses primarily on gender and sexual *identity*, rather than expression; that is, how participants categorize and understand themselves, rather than their self-reported patterns of behavior. Regarding sexual orientation, the LGBTQ community includes those whose sexual attractions are primarily to those of the same gender identity (e.g., gay men and lesbian women) as well as those whose attractions are to members of more than one gender identity (e.g., bisexual, pansexual), and those who reject fixed sexual identity categories (e.g., queer). Ebin (2012) provides the useful umbrella term “multigendered sexuality” to describe individuals for whom the capacity for romantic partnerships cross gender identities. At times, we make use of this term for those who identify as bisexual,

pansexual or queer, or otherwise endorse multiple gender attractions (e.g., identifying both as gay and bisexual).

Regarding gender identity, the LGBTQ community includes those who identify as male and female, those who eschew fixed gender identities (e.g., queer, genderqueer, agender), and those whose gender identity is different from their sex assigned at birth; (e.g., transgender individuals; NCAVP, 2013; 2015). Regarding the latter, the word “transgender” is an umbrella term used to describe individuals who may hold a range of different identities, including transsexual, transgender man, transgender woman, F to M (female to male), M to F (male to female), two-spirit, queer, androgynous, genderqueer, and gender-nonconforming (Nadal, Skolnik, & Wong, 2012; Teich, 2012). We use the term transgender in this study as an umbrella term for all gender non-conforming participants.

In an effort to avoid conflating the experiences of distinct subgroups, previous studies on IPV in the LGBTQ community have sampled members of one distinct sub-community (e.g., only gay men or lesbian women). While we recognize the importance of understanding the distinct experiences of single subgroups within the LGBTQ community, we chose a more inclusive approach for two reasons: First, there is sufficient research evidence to suggest that the constructs under examination in this study (e.g., identity abuse, the minority stress model) are relevant to transgender, bisexual and queer communities as well as the more traditionally studied cisgender, gay, and lesbian communities. As we will describe in more detail in the section on identity abuse, the existing qualitative descriptions of these tactics in the LGB *and* T communities suggest that while the specific details of identity abuse tactics may differ for LGB and T

survivors, the categories of tactics (e.g., outing, undermining & belittling identity, isolating the survivor from the LGBTQ community) are indeed similar (FORGE, 2014). Similarly, although the majority of research on minority stress has focused upon the experiences of gay, lesbian and cisgender individuals (Balsam & Mohr, 2007; Hendriks & Testa, 2012), anecdotal and qualitative research suggests that these constructs are relevant across the LGBTQ community.

Second, the choice to include the LGBTQ community more broadly was informed by the historic underrepresentation of bisexual, transgender, and queer individuals within the LGBTQ literature generally, and IPV literature specifically (NCAVP, 2013; 2015). The majority of the research on IPV in the LGBTQ community focuses on gay men and lesbian women exclusively. This is particularly problematic given the evidence suggesting that people who transgress binary notions of gender and sexuality experience more harassment and discrimination (Friedman et al., 2014; Juak, 2013), bias-based physical and sexual assault (Harrison, Grant, & Herman, 2012) and IPV (Dank, Lachman, Zweig, & Yahner, 2014; van Erp, 2015) than those who assume more traditional gender and sexual orientation roles. The current exclusion of the experiences of people with non-binary gender and sexual orientation from the literature in turn reinforces their marginalized location within the LGBTQ community. Rather than preemptively exclude members of the LGBTQ community out of concern for possibly small recruitment numbers, this study chose instead to sample broadly and subsequently examine the data for group differences.

Prevalence of IPV in the LGBTQ Community

The following section reviews available empirical literature on IPV prevalence and psychological effects – generally and for LGBTQ individuals specifically -- and provides a brief overview of within group differences of violence prevalence.

As defined by the Center for Disease Control (CDC), IPV is any type of “physical, sexual, or psychological harm by a current or former partner or spouse” (CDC, 2014). Psychological harm includes both emotional abuse (e.g., name calling, humiliating, or insulting a partner) and coercion (e.g., behaviors intended to control, monitor, or threaten a partner; Black et al., 2010).

The most recent study released by the CDC reported that in a national probability sample of 18,049 respondents, 30.4% of women and 25.7% of men had experienced physical violence by a partner over the course of their adulthood. The rates of psychological aggression were higher, with 48.4% of female and 48.8% of male respondents reporting having experienced some degree of psychological aggression in their adulthood. Of the LGBTQ respondents, 43.8% of lesbian women and 61.1 % of bisexual women reported having experienced rape, physical violence, or stalking by an intimate partner at some point in their life. Similarly, of the male-identified respondents, 26% of gay men and 37.3% of bisexual men reported having experienced rape, physical violence, or stalking by an intimate partner in their lifetime (Black et al., 2010). These results support a growing body of literature suggesting that the prevalence rates of IPV in the LGBTQ community are similar to (Blosnich & Bossarte, 2009), if not higher than (Edwards et al., 2015; Greenwood et al., 2002; Messinger, 2011), the prevalence rates of IPV in heterosexual and cisgender communities.

The emerging literature on LGBTQ survivors of IPV also suggests that there are important within-group differences in both the type and severity of violence that survivors experience. As described next, one noticeable within-group difference emerging within the literature is the increased risk of physical, psychological, and sexual violence for individuals whose patterns of attraction do not lie within the gender binary (bisexual, queer, pansexual; Black et al., 2010; Dank et al., 2014), or individuals who do not ascribe to the gender binary (e.g., transgender, genderqueer; Bazargan & Galvan, 2012; Langenderfer-Magruder et al., 2014; Machtinger, Haberer, Wilson, & Weiss, 2012). The majority of this research focuses on bisexual and transgender survivors.

In the aforementioned national population based study of IPV conducted by the CDC, bisexual women had experienced a significantly higher prevalence of all forms of violence (e.g., sexual violence, stalking, IPV) than lesbian and heterosexual women in this sample (Black et al., 2010). Bisexual men and women both reported high lifetime prevalence rates of sexual violence, with 74.9% of bisexual women (as compared to 46.4% of lesbian women and 42.2% of heterosexual women) and 47% of bisexual men (as compared to 40.2% of gay men and 20.8% of heterosexual men) reported having experienced unwanted sexual contact, including being made to penetrate, sexual coercion, and unwanted sexual contact (Black et al., 2010).

Transgender communities may also experience disproportionate rates of IPV (Dank et al., 2014; Langenderfer-Magruder et al., 2014). Researchers analyzing the data from Colorado's anonymous 2011 LGBT Health Survey reported that of all respondents, transgender individuals reported significantly more lifetime exposure to IPV (38% of

transgender respondents as compared to 20.4% of cisgender respondents; Lafenderfer-Magruder et al., 2014). This is consistent with non-population based research such as one study of 220 Latina MTF individuals in Los Angeles California, in which 57% of respondents reported having experienced IPV (Bazargan & Galvan, 2012). In another study of 113 HIV-positive MTF participants in San Francisco investigating the relationship between violence exposure and anti-retroviral failure, participants were asked two trauma screening questions: “In the past 30 days have you been abused, threatened, or the victim of violence” and “Have you ever been abused, threatened or the victim of violence”. A total of 17.3% of the sample endorsed violence exposure in the past 30 days and 71.8% endorsed lifetime violence exposure (Machtinger et al., 2012). The increased violence exposure may remain consistent across the lifespan. One recent cross-sectional study surveying a large sample of non-LGBT and LGBT youth also found that transgender youth had higher rates of physical IPV victimization as compared to cisgender students (Dank et al., 2014).

Prevalence and type of violence also vary based on race. The 2015 NCAVP report described above found that overall, LGBTQ survivors who were people of color were 2.2 times more likely to experience physical violence and 1.7 times more likely to need medical attention than their white counterparts. These findings underscore the need to acknowledge and address intersectionality within the LGBTQ community (Bograd, 1999; Mendez, 1996; Meyer, 2010).

IPV and Mental Health Outcomes.

Mental health effects of IPV. A considerable body of evidence indicates that IPV is strongly associated with psychological distress (Black et al., 2010; Coker et al., 2002; Dutton et al., 2006; Pico-Alfonso et al., 2006). For example, one investigation that used data from the National Violence Against Women survey (6790 women, 7122 men), conducted by The National Institute of Justice (NIJ) and the Centers for Disease Control and Prevention (CDC) in 1995-1996 indicated that physical IPV is associated with depressive symptoms, substance use, and chronic mental illness (Coker et al., 2002). Similarly, CDC's more recent 2010 National Intimate Partner and Sexual Violence Survey, which drew from a national probability sample of 16,507 respondents (who completed the surveys) found that compared to those who had not experienced IPV, survivors of IPV (both physical and psychological) were significantly more likely to report poorer mental health, with 62.6% of female and 16.4% of male survivors of IPV endorsing at least one PTSD symptom (Black et al., 2010).

Both of the aforementioned investigations were cross-sectional, preventing causal conclusions to be made about this relationship between IPV and psychological distress. However, one comprehensive meta-analysis examined 22,000 records from 20 databases to find studies that were a) longitudinal, b) included male and female survivors of IPV, c) included both depressive symptoms and suicide ideation as outcome variables; and, d) broadly reported on depression, not simply on postpartum or antenatal depression. Sixteen studies (36,163 total participants) met these inclusion criteria, and thirteen focused exclusively on depression. Twelve of 13 studies demonstrated a positive association between the violence exposure and depressive symptoms among women, with

11 reaching statistical significance. Of the few of the studies included men, there was limited evidence that violence exposure contributes to depressive symptoms (Devries et al., 2013). Although these studies still must be interpreted with caution given the absence of an experimental design, they provide compelling evidence for the relationship between violence exposure and an increased risk for psychological distress.

Further, it seems that IPV is associated with psychological distress regardless of the type of abuse that one experiences. One study comparing 130 heterosexual and cisgender women who experienced IPV from male partners to a non-abused control sample of 52 women found that women exposed to IPV had higher incidence and severity of depressive and PTSD symptoms regardless of whether this violence was physical or psychological (Pico-Alfonso et al., 2006). Other literature indicates that psychological abuse that encompasses coercive control is more strongly correlated with depression than verbal abuse alone (Coker et al., 2002; Dutton et al., 2006). Taken together, this body of evidence suggests that IPV influences mental health regardless of its form, though poly-victimization, coercion, and control may be particularly damaging.

Although scholars have investigated a wide range of mental health outcomes (e.g., depression, anxiety, substance use, general psychological distress), there is evidence documenting that the most common psychological consequences of IPV are symptoms of depression and PTSD. One 1999 meta-analysis found the mean prevalence rate of depression in survivors of IPV to be 47.6% (across 18 studies) and the mean prevalence rate of PTSD to be 63.8% (across 11 studies); these percentages were substantively higher than those of suicidality (17.9% in 13 studies), alcohol abuse (18.5%

across 10 studies), and drug abuse (8.9% across 4 studies; Golding, 1999). Consequently, depressive and PTSD symptoms were selected as the focus of this current study.

Mental health impact of IPV in the LGBTQ community. The emerging literature on how IPV affects the mental health of LGBTQ survivors is mixed, with some studies indicating that outcomes are similar for LGBTQ and non-LGBTQ survivors, and other studies indicating that negative outcomes are more common for LGBTQ survivors than for non-LGBTQ survivors (Edwards et al., 2015). Notably, increasing literature indicates that bisexual and transgender survivors are particularly at risk for poor mental health outcomes.

Depression. LGBTQ survivors of IPV, like their heterosexual and cisgender counterparts, are particularly at risk of depression. Longitudinal research supports these findings: One study examining data from a nationally representative survey of adolescents (227 gay/lesbian adolescents, 345 bisexual adolescents, and 13,490 heterosexual adolescents; all ages 18-27) found that across all three groups, exposure to IPV was significantly related to increased depression – even after controlling for exposure to childhood physical or sexual abuse and homelessness or expulsion from one’s home by caregivers (McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012). This is consistent with a more recent meta-analysis examining 19 studies (13,797 participants), which found that male survivors of IPV at the hands of other men are more likely to use substances, suffer from depressive symptoms, have an HIV positive diagnosis, and engage in unprotected sex (Buller, Devries, Howard, & Bacchus, 2014). As a whole, this body of literature suggests that LGBTQ survivors, similar to their heterosexual and

cisgender counterparts, are at elevated risk for experiencing depression.

Looking more closely within the LGBTQ community, there is some evidence indicating that bisexual individuals may have disproportionately higher rates of depression as compared to gay and lesbian individuals (Bostwick et al., 2010). Theoretical work has posited that the relatively high mental health difficulties within the bisexual community may be attributable to the additional stressors of experiencing bi-negative attitudes from both heterosexual and LGTQ communities (Bostwick, 2012). In one study comparing rates of major depression among 34,653 lesbian, gay, bisexual and heterosexual adults from the National Epidemiologic Survey on Alcohol and Related Conditions, the authors found that among men and women, individuals reported bisexual *behavior* had higher lifetime rates of all mood disorders, including depression. When looking exclusively at participants who *identify* as bisexual, the pattern of results changed slightly. Bisexual women still had significantly higher rates of major depression as compared to heterosexual and lesbian-identified women. Bisexual men had higher rates of depression than heterosexual men, but lower rates of depression than gay men (Bostwick et al., 2010). While this indicates the need for further examination of the differences between those identify as bisexual and those with multigendered sexual behavior as a whole, one might expect bisexual survivors of IPV to be at particular risk for depression.

Likewise, there is scant research on the mental health impact of IPV for transgender and genderqueer survivors, although there is some existing literature on the relationship between physical, psychological, sexual, and gender-based violence more

broadly and their relationship to symptoms of depression. For example, in one cross-sectional study of over 591 MTF participants from the New York City area, 63% had depression scores in the clinical range. Further, violence that was related to gender identity, or gender abuse, was predictive of depression (Nuttbrock et al., 2014). These findings are consistent with another study of 6436 transgender-identified individuals, in which 19% of respondents had experienced domestic violence at the hands of a family member because of their chosen gender identity. This exposure to IPV was associated with over twice the rate of suicidality, with sixty-five percent (65%) of those who experienced domestic violence also reported having attempted suicide, compared to 32% of those who did not experience domestic violence (Grant et al., 2011). These findings are particularly important in light of this study's focus on identity abuse, indicating that bias-based attacks within intimate relationships may have a particularly damaging impact. Overall, while the literature remains inconclusive, transgender communities' elevated risk of polyvictimization and exposure to minority stress may place transgender survivors at higher risk for depression following IPV exposure.

PTSD. There is some initial evidence that IPV exposure increases the risk of PTSD symptoms in the LGBTQ community as it does in heterosexual/cisgender communities. The CDC's 2010 report on intimate partner violence, surveying 16, 507 adults (9,086 women, 7, 421 men) assessed several select symptoms of PTSD: having nightmares, intrusive thoughts of the traumatic experience, feeling constantly on guard, watchful or easily startled; and feeling numb or detached from others, activities, or surroundings. According to this report, 19.5% of lesbian women, 46.2% of bisexual women and 22.1% of heterosexual women report experiencing at least one symptom of

PTSD in response to an experience of IPV. The number of reports of IPV from bisexual, gay, and heterosexual men were too small to produce a reliable estimate, and were therefore excluded (Walters, Chen, & Breiding, 2013). However, one recent study provides some indication that these results may extend to male survivors. This study examined 178 gay and bisexual HIV-positive men, and found that partner abuse was independently related to both symptoms of depression and PTSD while controlling for each other (Pantalone, Hessler, & Simoni, 2010). Again, as one might expect, exposure to IPV is associated with higher rates of depression regardless of LGBTQ status.

Consistent with the findings on IPV and depression, there is initial evidence that bisexual survivors of IPV have higher rates of PTSD than gay and lesbian survivors. According to the most recent national study by the CDC, more than half of bisexual women (57.4%) who experienced physical or sexual violence or stalking reported at least experiencing some form of negative impact (e.g., experiencing PTSD symptoms, missing a day of school or work, feeling fearful or concerned for their safety) as compared to a third of lesbian women (33.5%), and a fourth of heterosexual women (28.2%). The rates of negative impact for gay and bisexual men were too small to report a reliable estimate (Black et al., 2010). These results, though methodologically limited, suggest that bisexual women may be at disproportionately higher risk for developing symptoms of PTSD after experiencing IPV. This is consistent with the results of the CDC's 2010 report on IPV in which significantly more bisexual women (46.2%) reported experiencing at least one symptom of PTSD as compared to lesbian (19.5%) and heterosexual women (22.1%; Walters, Chen, & Breiding, 2013).

Again, available literature examining the relationship between IPV and PTSD in transgender communities is limited. However, there is emerging literature to suggest that transgender individuals generally experience higher rates of IPV exposure overall as compared with heterosexual and LGB individuals (Langenderfer-Magruder et al., 2014; Machtinger et al., 2012). In addition to IPV specifically, transgender individuals also experience pervasive discrimination in the domains of education, health, family, and work (Grant et al., 2011). Given that multiple experiences of trauma are more likely to result in the development of clinical PTSD (Scott, 2007), it merits investigating whether exposure to IPV has a disproportionate impact for this community. As a whole, the literature on bisexual and transgender communities makes clear the need for researchers continue to investigate the distinct experiences of LGBTQ subgroups.

Systemic Barriers to Help-Seeking among LGBTQ Survivors

To understand the mental health impact of IPV in this community, it is critical to understand the range of systemic, institutional, and individual-level barriers that uniquely thwart their access to informal and formal support services (Edwards et al., 2015; Helfrich & Simpson, 2006). At the broadest level, cultural heterosexism and cis-sexism, which is reflected in the myth that IPV occurs only between men and women, contributes to the profound difficulty communities, survivors, and service professionals have in identifying and addressing IPV among LGBTQ couples (Blasko, Winek, & Bieschke, 2007; Brown & Groscup, 2008; Helfrich & Simpson, 2006; Seelau & Seelau, 2005). Even when service providers explicitly state that they wish to provide equitable treatment to LGBTQ individuals, cultural heterosexism may affect their ability to accurately identify IPV in this community (e.g., less likely to see survivors as victims; Basow &

Thompson, 2012).

Societal heterosexism and cis-sexism in turn filters down into institutional barriers that may disadvantage LGBTQ survivors. In fact, it has been noted that these barriers may actually be on the rise (NCAVP, 2013). For example, between 2010 and 2011, LGBTQ survivors reported an increase of incidences in which the police arrested both the abuser and victim when called (28.4% up from 21.9%), an increase in the percentage of LGBTQ survivors seeking shelter who were denied (61.6% up from 44.6%), and a decrease in the percentage of LGBTQ survivors who received requested orders of protection (78.1% down from 83.7%; NCAVP, 2013). Additional barriers include heterosexist language in program materials, relegation of survivors to a particular staff member who is tasked with serving LGBTQ clients, and ambiguously defined policies regarding service provision for LGBTQ survivors (Helfrich & Simpson, 2006). LGBTQ survivors may well anticipate discrimination both from staff members and the heterosexual survivors using these services and may worry that their sexual orientation or gender identity will be revealed should they actually seek help (Bornstein et al., 2006; McClennen, 2005; Helfrich & Simpson, 2006).

Here again, there are critical within-community differences in the nature and degree of institutional barriers; particularly for transgender communities. For example, transgender IPV survivors are 4.6 times more likely to experience police violence than other survivors, and over six times more likely to experience physical violence while interacting with the police than other survivors, more likely to experience hate violence in shelters (trans men, 3.5 times as likely, trans women 1.3 times as likely) than other

survivors (NCAVP, 2013). In short, transgender survivors experiencing identity abuse are likely to not only experience violence from their intimate partners, but may also experience even more re-traumatization and less access to formal support systems than LGB survivors. Consequently, they may opt out of seeking formal services (NCAVP, 2013).

The majority of LGBTQ survivors do not immediately seek help from the formal service system, but rely on their informal social support systems or their friends and families (Edwards et al., 2015). Here too, LGBTQ survivors face a range of barriers to receiving support. For example, LGBTQ survivors may be reluctant to seek help from friends and family given their own or their community's gendered beliefs about violence (e.g., women cannot be violent and men cannot be victimized; Seelau & Seelau, 2005; Walters, 2011). They may be particularly hesitant to seek help from heterosexual friends or family members if they have had previous experiences of heterosexism and cissexism within those relationships (Ard & Makadon, 2011). Survivors may have received messages that LGBTQ relationships themselves are "wrong" or "sick". Consequently, they may feel that admitting violence will only confirm these messages, conferring a sense of stigma on the victim and the relationship. Further, survivors who feel as though they are representing the LGBTQ community may feel that admitting IPV will harm the LGBTQ community at large (Balsam, 2008). Friends and resources may also be shared between the survivor and perpetrator to an even greater degree than in heterosexual relationships, further making it difficult to access support (Bornstein et al., 2006).

For those at the margins of the LGBTQ community (e.g., bisexual individuals),

the challenges continue. Systemic biphobia, for example, may contribute to bisexual survivors' isolation from the LGBTQ community. In a cross-sectional survey of 613 lesbian, gay, and bisexual respondents, Balsam & Mohr (2007) found that this group reported higher levels of identity confusion, lower levels of self-disclosure, and lower reported connection to the LGBTQ community than their lesbian/gay peers. As we will outline in more detail in the next section, these psychological supports have been identified as critical buffers of minority stress, and are being investigated as buffers of identity abuse. Consequently, it is possible that bisexual individuals will have fewer resources with which to protect themselves against IPV, and in turn have poorer mental health outcomes.

LGBTQ Identity Abuse

As noted earlier, psychological abuse (e.g., emotional or verbal abuse and coercive control) is a critical dimension of IPV (Coker et al., 2002; Dutton & Goodman, 2005). Psychological abuse is contextual and *intersectional*; that is, the nature of what is psychologically harmful, or coercive to a survivor, depends on their particular identity, social location, immediate context, and broader cultural and social forces (Bograd, 1999; Dutton & Goodman, 2005). Heterosexism and cissexism, for example, affect the very nature of the violence that the LGBTQ community experiences (Balsam & Szymanski, 2005; Bornstein et al., 2006; West, 1998).

Specifically, terms such as *homophobic control* (Hart, 1986), *LGB specific tactics of psychological aggression* (Balsam & Szymanski, 2005) and *bias-related IPV tactics* (NCAVP, 2013) all refer to a set of abusive tactics within an intimate partnership that

leverage heterosexism or cis-sexism. For the purposes of this study, we borrow the language of the practice community, and refer to these tactics as *LGBTQ identity abuse*, or simply *identity abuse* (GMDVP, 2014). Practice-based evidence (FORGE, 2014; NCDSV, 2014), theoretical writing on the subject of LGBTQ IPV (Hart, 1986; West, 1998) and more formal empirical investigations of LGBTQ IPV (Balsam & Szymanski, 2005; Bornstein et al., 2006; McClennen, Summers & Vaughn, 2008; NCAVP, 2013) each reveal a number of abusive tactics that fit under this umbrella.

To date, Balsam and Szymanski (2005) have done the most comprehensive work on this form of abuse, in a study examining the relationship between minority stress, relationship quality and IPV in lesbian and bisexual women. Balsam and Szymanski (2005) identified five “LGB-specific” forms of victimization: “I threatened to tell my partner’s employer, family, or others that she is lesbian/gay/bisexual”; “I forced my partner to show physical or sexual affection in public, even though she didn’t want to”; “I used my partner’s age, race, class, or religion against her”; “I questioned whether my partner was a ‘real’ lesbian, gay, or bisexual woman”; and, “I told my partner she deserves what she gets because she is a lesbian/gay/bisexual woman”. Balsam and Szymanski (2005) found that in this sample of LGB women, 34.4% of the sample endorsed experiencing LGB-specific victimization, and it was significantly correlated with internalized homophobia and outness. This provides compelling evidence that identity abuse is strongly related to minority stress, and that it is a prevalent feature of relationship violence in the LGB community.

At the same time, there were several limitations to this investigation of identity

abuse. First, it was not within the scope of the article to discuss the theoretical foundation or development of the “LGB-specific” victimization measure. Second, the items were developed to focus on women; there may have been particular kinds of identity abuse experienced by men or trans/genderqueer people not captured in this measure. Third, this investigation did not examine the relationship between these items and mental health outcomes. Upon reviewing the existing literature on identity abuse, we identified four domains, some of which were captured by the Balsam and Szymanski (2005) measure (e.g. outing, undermining and belittling identity), and others that were not (e.g., using homophobic/transphobic language, isolating the survivors from the LGBTQ community).

The following section summarizes the existing literature on LGBTQ identity abuse and synthesizes various descriptions our four proposed sub-categories: outing, undermining and belittling identity, using homophobic/transphobic language and isolating the survivor from the LGBTQ community. Each of these categories is further discussed in the following section.

Outing. The effect of disclosing one’s LGBTQ identity heavily depends on the person’s context and the available support afterwards (Sherriff, Hamilton, Wigmore & Giambrone, 2011). “Coming out” can increase an individual’s sense of authenticity and pride in their identity, potentially resulting in a greater sense of belonging (Vaughan & Waehler, 2010). However, it may also expose the individual to more harassment or bullying, threaten their employment or housing security, or limit their access to networks that may not be LGBTQ affirming. These consequences can be exploited by an abusive partner to assert control (Ard & Makadon, 2011; Balsam, 2008; Dank et al., 2014; Elliot,

1996; FORGE, 2014; Johnson & Ferraro, 2000; NCDSV, 2014). In one study of 100 lesbian-identified survivors of IPV, 11% indicated that their abuser had threatened to “bring them out” (Renzetti, 1992). In a replication study conducted with 60 gay male-identified survivors of IPV, 14.1% of respondents endorsed having their abusive partner “threaten to out you” (McClennen et al., 2008). Finally, in a study conducted in Scotland with 60 trans-identified survivors of IPV, 13% said that their partner “threatened to tell people about your trans identity or background who you don’t want to know” (Roche, Richie & Morton, 2010, p.15). In short, outing a partner may be used to amplify that partner’s experience of minority stress, while reducing their access to social support and consequently reducing their capacity to cope.

Undermining and belittling identity. Another form of identity abuse is specifically undermining, attacking, or denying a partner’s identity as an LGBTQ person (Balsam & Szymanski, 2005; FORGE, 2014; NCDSV, 2014; Roche et al., 2010). In one study based on focus groups with 22 LBT survivors of IPV, participants articulated how abusers had questioned or challenged their LGBTQ identities using tactics such as accusing the participant of being straight, questioning their authenticity (e.g., you’re not a “real” lesbian), or telling them they were not “good enough” at their chosen gender identity (Bornstein et al., 2006). Trans survivors of IPV describe tactics such as being made to feel ashamed about their trans identity, being prevented from expressing their gender identity (e.g., monitoring the survivors’ dress), being prevented them from using their preferred pronouns or name, and having a partner draw attention to parts of their body that they felt uncomfortable with (Roche et al., 2010). Actions such as these may undermine survivors’ sense of affirmative LGBTQ identity, and exacerbate internalized

homophobia and transphobia, which in turn may make them more vulnerable to minority stress.

Using homophobic/transphobic language. A third LGBTQ-specific tactic that practitioners describe is the use of slurs or derogatory language regarding the target's sexual orientation or gender identity (e.g., calling a partner a “tranny,” “fag,” “dyke”; FORGE, 2014; NCDSV, 2014). Although there is no empirical literature documenting the effect of such language, we can hypothesize that such direct verbal degradation could have an effect similar to that of heterosexist and cis-sexist harassment, or homophobic bullying, which indeed contribute to symptoms of both depression and PTSD (Lewis et al., 2003; Poteat et al., 2011; Szymanski & Balsam, 2011). To date, there has been no investigation as to whether there is an additional cost to individuals who are derided by their *partners* in this way as part of IPV.

Isolating the survivor from the LGBTQ community. Isolation is a well-documented tactic of violence. Moreover, barriers to formal support are especially formidable (Helfrich & Simpson, 2006) given that the majority of survivors who seek help do so from informal support systems (Edwards et al., 2015). When isolation is used against LGBTQ survivors, the result may be particularly damaging given that many LGBTQ couples share a single community (Bornstein et al., 2006; Walters, 2011). In one qualitative focus group study (Bornstein et al., 2006), 22 lesbian, bisexual, and transgender survivors of IPV identified isolation as a central tactic and noted that since survivors and abusers often shared the same small community, it was easy to cut the survivor off from their friends. Similarly, in a Scottish study of trans-identified

participants, 15% endorsed that they have had a partner “stop them from engaging with other trans people or attending transgender social groups and support groups” (Roche et al., 2010). Given the role of social support in buffering minority stress (Aneshensel, 2009; Szymanski, Kashubeck-West, & Meyer, 2008) this tactic could put survivors at greater risk for psychological distress.

These preliminary findings support the existence of identity abuse as a unique dimension of LGBTQ IPV. However, research has yet to investigate the psychological effect or full range of identity abuse acts among a broad-based community sample of LGBTQ individuals who have experienced IPV. In the subsequent section, the possible psychological impact of identity abuse is conceptualized using minority stress theory (Meyer, 2003), a predominant framework used for better understanding LGBTQ mental health.

Minority Stress Theory

Although all forms of abuse have a damaging effect on the psyche, minority stress theory suggests that identity abuse may be associated with especially poorer mental health outcomes for survivors. The next section provides an overview of each aspect of the minority stress framework and explains how the processes outlined in this model may help to explain the potential relationship between identity abuse and two outcome variables used in this study: symptoms of depression and PTSD.

The minority stress model. Stress is the state of arousal brought on by socio-environmental demands that tax individuals’ ability to cope (Aneshensel, 2009). The fundamental assumption of stress process models is that those with lower social status experience greater chronic and persistent stressors in the form of lack of access to

resources and stigma (Aneshensel, 2009; Kessler, 1979; Turner & Avison, 2003). This constant experience of stress can increase vulnerability to mental health difficulties (Aneshensel, 2009; Dohrenwend, 2000; Turner & Avison, 2003). Existing research supports the link between chronic stress and mental health difficulties and documents basic tenets of the stress-psychopathology relationship (for a broader discussion of this association, see Hankin & Abela, 2005). Underlying mechanisms of this relationship are multifaceted, with biological, psychological, and social components interacting in complex ways (Cicchetti & Toth, 1997; Hyman, 2013). Thus, there is a critical need for research to continue to examine various pathways from stress exposure to mental health outcomes.

Meyer's minority stress model (2003) extends the stress process model to the LGBTQ community and further outlines how heterosexist and cisgender systems of oppression are translated into the experience of chronic stress. External (distal) stressors are sources of stress external to the individual (e.g., discrimination, rejection, hate crimes; Herek & Garnets, 2007; Meyer, 2003). Research demonstrates that LGBTQ people experience repeated and chronic exposure to these kinds of prejudice events over the course of their lifetime (Grant et al., 2011; Mays & Cochran, 2001; Smith, Shin, & Officer, 2012). This exposure has psychological costs for LGBTQ individuals, as described later in the section.

Even if some LGBTQ individuals may be relatively protected from direct forms of LGBTQ-based discrimination, they have been socialized in a culture that privileges heterosexuality and binary gender expression. Consequently, many LGBTQ individuals

may internalize beliefs about the inferiority of their own gender and sexual identity (Frost & Meyer, 2012; Meyer, 2003). Meyer (2003) describes three distinct kinds of internal (proximal) stress. First, *internalized homophobia* refers to the devaluing of one's own identity, consciously or unconsciously (Newcomb & Mustanski, 2010). Second, in an attempt to protect against both experiences of discrimination and one's own experience of internalized homophobia, LGBTQ individuals may need to engage in *concealment of their identity* (Koh & Ross, 2006). Although concealing one's LGBTQ status may protect the individual from rejection or harassment in the short term, it is a major cause of psychological distress in the long term (Levahot & Simoni, 2011). Third, LGBTQ individuals may bear the additional psychological load of *anticipating and preparing for rejection* (Feinstien, Goldfried, & Davila, 2012). Although this anticipation may prepare the individual to cope with rejection as it comes, it also requires energy to chronically alert to the possibility of rejection.

The mental health effect of minority stress. The minority stress model postulates that internal and external minority stressors ultimately increase vulnerability to mental health difficulties; two of the most well-documented of which are symptoms of depression and PTSD. For example, Lewis, Derlega, Griffin and Krowinski (2003) found that among a sample of 204 gay, lesbian, and bisexual individuals, both “gay-related²” and life stress were independently associated with depressive symptoms, together accounting for 11% of the variance in depression. Analysis of individual minority stress variables indicated that stigma consciousness and gay-related stress explained unique

² “Gay-related stress” was operationalized using a 70-item scale developed by the authors. For more information on the individual items see Lewis et al., 2003.

variance in depressive symptoms.

More recent studies shed light on the particular pathways from aspects of minority stress to depression. Based on a sample of 1381 lesbian and bisexual-identified women, one recent study found that each of a series of minority stressors (LGB victimization, concealment, and internalized homophobia) was associated with decreased social-psychological resources, which were in turn associated with higher rates of depression (Levahot & Simoni, 2011). The model as a whole accounted for 54% of the variance in mental health outcome measures. Another study that used convenience sample of 218 lesbian and 249 gay-identified participants found that the relationship between experiences of discrimination and psychological distress (depression and social anxiety) was partially mediated by internalized homonegativity and rejection sensitivity (Feinstein, Goldfrie, & Davila, 2012). These results highlight how external stressors can be amplified by internal stress processes. Although there are gaps in our understanding of mechanisms by which minority stress leads to depression, this body of evidence strongly suggests an existing relationship between the two.

There is a growing body of theoretical evidence suggesting that minority stress also may be associated with PTSD. Several theorists have argued that chronic exposure to stigma-related stress, including heterosexism and cissexism, can be understood as a form of trauma – sometimes called *insidious trauma* -- similar to more overt and direct forms of assault (Root, 1992; Szymanski & Balsam, 2011). Not surprisingly, one study found a significant and positive relationship between perceived LGBTQ-related stigma and PTSD (Alessi, 2010). In another cross-sectional analysis of 409 LGB veterans, researchers

found experiences with concealment (i.e., feeling the need to hide their sexual orientation) were predictive of PTSD symptoms (Cochran et al., 2013). Again, although the exact mechanisms of these relationships remain unclear, the argument could be made that the increased psychological burden of minority stress might place LGBTQ individuals at higher risk for developing symptoms of PTSD.

LGBTQ Identity Affirmation as a moderator of identity abuse and mental health outcomes. Before describing the existing literature on LGBTQ identity affirmation, it is important to note that rather than understanding this as a moderator of minority stress, it would also be possible to consider identity affirmation as a mediator—or variable that explains the relationship between predictor and outcome variable (Frazier, Tix & Baron, 2004). For example, to hypothesize that LGBTQ identity affirmation will moderate (or buffer) the relationship between identity abuse and depression and PTSD is to say that those who have stronger LGBTQ identity affirmation will experience less psychological distress as a result of identity abuse than those with low LGBTQ identity affirmation scores. Their affirmative identity ‘buffers’ the impact of identity abuse. A mediation model, on the other hand, would hypothesize that those who are exposed to identity abuse may have poorer LGBTQ identity affirmation due to the abuse, and this in turn contributes to greater psychological distress.

Researchers typically choose a model based on theory and the existing data on the relationship between the predictor and outcome variable. According to Frazier et al. (2004), one typically looks for moderation effects if evidence for the effectiveness of a particular relationship is weaker than expected; this could be because the effect is

different for particular groups based on a third (“buffering”) factor. In contrast, one typically looks for mediators if there already is a strong relation between a predictor and an outcome and one wishes to explore the mechanism behind that relationship. Identity abuse itself is a new construct within the literature and by extension its relationship to symptoms of depression and PTSD is as of yet unexplored. Consequently, there is no empirical rationale for examining LGBTQ identity affirmation as a mediator or moderator. Given this study’s emphasis on examining protective factors for survivors experiencing identity abuse, we chose to examine LGBTQ identity affirmation as a moderator. This is consistent with research on resilience to stress (Masten, 2001), as well as previous literature on minority stress (Herek & Garnets, 2007).

Protective factors for LGBTQ survivors. LGBTQ individuals are not simply passive victims of their oppressive conditioning and environments (Meyer, 2010). A burgeoning literature points to *protective factors* that buffer the effects of minority stress. By definition, protective factors “modify the effects of risk in a positive direction” (Luther, 2006, p. 743) and can include qualities of the individual (e.g., intelligence) or external assets (e.g., a supportive friend; Lerner, 1995; Luther, 2006). In the case of LGBTQ survivors of IPV and of identity abuse in particular, this study explored affirmative LGBTQ identity as a protective factor.

LGBTQ identity. Developing a positive identity as a member of an oppressed group is central to the process of adapting to stigma (Balsam & Mohr, 2007; Eliason & Schope, 2007; Hershberger & D’Augelli, 1995; Nuttbrock et al., 2002). Specifically, LGBTQ identity affirmation has been well documented as being critical to positive mental health

outcomes. For example, one study investigating 165 lesbian, gay and bisexual youth found that family support and self-acceptance mediated the relationship between victimization and mental health (Hershberger & D'Augelli, 1995). Another study surveyed 613 lesbian, gay, and bisexual individuals and found that LGB individuals who have positive appraisals of their LGB identity and do not anticipate rejection from others have lower psychological distress (Balsam & Mohr, 2007). In a subsequent study, the same authors found that higher identity acceptance negatively correlated with measures of depression, guilt, fear, hostility, and sadness, and positively correlated with measures of general life satisfaction, self-assurance, and social self-esteem (Mohr & Kendra, 2011). In short, LGBTQ individuals who feel more positive about being LGBTQ are indeed able to cope more successfully with the challenge of minority stress.

Applying a minority stress framework to IPV in LGBTQ community. As a whole, the above reviewed literature suggests that the minority stress framework can provide a useful way to understand the relationship between oppression and mental health outcomes for the LGBTQ community. By extension, this framework provides insight into how identity abuse might be particularly harmful to survivors, given that identity abuse emphasizes LGBTQ survivors' marginalized position and denigrates an aspect of their identity formerly threatened by internalized, interpersonal, cultural, and structural heterosexism and gender oppression. Moreover, LGBTQ victims of IPV and identity abuse may be cut off from resources that potentially buffer minority stress (e.g., affirmative LGBTQ identity). Given that LGBTQ survivors may experience identity abuse as an additional form of violence, and may be uniquely alienated from protective support against minority stress, they may have a greater likelihood of experiencing

symptoms of PTSD and depression. Although there is no research to date in direct support of this hypothesis, research on other forms of bias-based victimization (e.g., bullying, hate crimes) indicates that these crimes often have greater associations with poorer mental health outcomes than harassment or violent crimes alone (Herek, Cogan, Gillis, & Glunt, 1998; Poteat et al., 2011).

Rationale for Current Study

Although previous studies have begun to explore the role of identity abuse as an added dimension of IPV for LGBTQ survivors (Balsam & Szymanski, 2005; NCVAP, 2011), this current study will be the first to 1) examine the overall prevalence of identity abuse in a sample of LGBTQ respondents as well as within-group differences across subgroups of the LGBTQ community; 2) examine the relationship between identity abuse and mental health, focusing specifically on symptoms of depression and posttraumatic stress disorder (PTSD); and 3) explore the extent to which affirmative LGBTQ identity moderates the relationship between identity abuse and psychological distress.

Current Study

This study will examine the following research questions.

Question #1: In a sample of 734 LGBTQ individuals, exposure to identity abuse will significantly differ across gender, sexual orientation, and race/ethnicity.

Hypothesis 1a: Adult identity abuse exposure will differ significantly across gender.

Hypothesis 1b: Past year identity abuse exposure will differ significantly across gender.

Hypothesis 1c: Adult identity abuse exposure will differ significantly across sexual orientation.

Hypothesis 1d: Past year identity abuse exposure will differ significantly across sexual orientation.

Hypothesis 1e: Adult identity abuse exposure will differ significantly across race.

Hypothesis 1f: Past year identity abuse exposure will differ significantly across race.

Question #2: In a sample of 734 LGBTQ individuals, exposure to identity abuse will uniquely contribute to symptoms of depression and PTSD while controlling for demographic variables.

Hypothesis 2a: Adult identity abuse exposure will contribute uniquely to variance in depressive symptoms while holding demographic variables constant.

Hypothesis 2b: Adult identity abuse exposure will contribute uniquely to variance in PTSD symptoms while holding demographic variables constant.

Hypothesis 2c: Past year identity abuse exposure will contribute uniquely to variance in depressive symptoms while holding demographic variables constant.

Hypothesis 2d: Past year identity abuse exposure will contribute uniquely to variance in PTSD symptoms while holding demographic variables constant.

Question #3: In a sample of 734 LGBTQ survivors of IPV, exposure to identity abuse in adulthood will contribute uniquely to variance in symptoms of depression and PTSD while controlling for other forms of adult abuse exposure and demographic variables.

Hypothesis 3a: Adult identity abuse exposure will contribute uniquely to variance in

depressive symptoms independent of adult exposure to physical/sexual assault and psychological abuse, respectively while holding demographic variables constant.

Hypothesis 3b: Adult identity abuse exposure will contribute uniquely to variance in PTSD symptom scores independent of adult exposure to physical/sexual assault and psychological abuse respectively while holding demographic variables constant.

Hypothesis 3c: Past year identity abuse exposure will contribute uniquely to variance in depressive symptoms while holding demographic variables constant.

Hypothesis 3d: Past year identity abuse exposure will contribute uniquely to variance in PTSD symptoms while holding demographic variables constant.

Question 4: In a sample of 734 LGBTQ survivors identity affirmation will moderate the relationship between identity abuse exposure and mental health outcomes while holding demographic variables constant.

Hypothesis 4a: LGBTQ identity affirmation will moderate the relationship between adult identity abuse exposure and symptoms of depression while holding demographic variables constant.

Hypothesis 4b: LGBTQ identity affirmation will moderate the relationship between adult identity abuse exposure and symptoms of PTSD while holding demographic constant.

Hypothesis 4c: LGBTQ identity affirmation will moderate the relationship between past year identity abuse exposure and symptoms of depression while holding demographic variables constant.

Hypothesis 4d. LGBTQ identity affirmation will moderate the relationship between past year identity abuse exposure and symptoms of PTSD while holding demographic constant.

Question #5: In a sample of 734 LGBTQ survivors identity affirmation will moderate the relationship between identity abuse exposure and mental health outcomes while holding demographic variables and exposure to other forms of violence constant.

Hypothesis 5a: LGBTQ identity affirmation will moderate the relationship between adult identity abuse exposure and symptoms of depression while holding demographic variables & other forms of violence exposure constant.

Hypothesis 5b. LGBTQ identity affirmation will moderate the relationship between adult identity abuse exposure and symptoms of PTSD while holding demographic variables & other forms of violence exposure constant.

Hypothesis 5c: LGBTQ identity affirmation will moderate the relationship between past year identity abuse exposure and symptoms of depression while holding demographic variables & other forms of violence exposure constant.

Hypothesis 5d. LGBTQ identity affirmation will moderate the relationship between past year identity abuse exposure and symptoms of PTSD while holding demographic variables & other forms of violence exposure constant.

Chapter III: Methods

This chapter will describe the methodology of the current study including the study design, research participants, instruments, data collection procedures, and data analysis plan.

Research Design

This study utilized multiple regression models to analyze a convenience sample of 734 LGBTQ individuals. Inferences about the predictor variables (physical violence, sexual violence, psychological abuse, and LGBTQ-specific identity abuse) were made based on variations in the criterion variables (depressive symptoms and PTSD symptoms) after partialing out the variance accounted for by key covariates (gender, sexual orientation, racial identity, and level of education). This study also investigated the extent to which LGBTQ identity affirmation moderated these relationships. This correlational design did not allow for causal inferences; however, it provides critical information about the relationship between these constructs (Cook, Campbell & Day, 1979). Figure 13 lists the specific analyses to be performed to test each hypothesis listed above.

Procedure

Participants were recruited through several LGBTQ-specific online forums and listservs that focused on either IPV or LGBTQ concerns, or a combination of both (See Appendix A for list of recruitment sites). These recruitment sites were chosen given that they are highly trafficked sites by LGBTQ individuals, and the general public. This was intended to solicit a wide section of the LGBTQ community, including both people who may identify as survivors of abuse and those who may not, though they have experienced acts that constitute violence by this study's definition. We also made use of snowball

sampling, by sending this announcement out to colleagues and friends connected to the LGBTQ community with a request to forward the announcement on.

If sites had a moderator (as in the case of listservs) they were contacted to obtain permission to forward a study announcement to its members or directly post on the site. Participants were required to be at least 18 years of age and identify as a sexual or gender minority individual. We made a concerted effort to recruit racially and ethnically diverse participants by oversampling LGBT participants of color through culturally-specific groups as well as online forums and listservs. Overall, we contacted 122 LGBTQ community groups specifically geared toward LGBTQ communities of color, and 301 community groups in total. A total of 1044 participants started the survey, and 692 participants completed the survey in its entirety.

Measures

Specific measures used in this study are described below; the survey itself can be found in Appendix B.

Demographics. Demographic variables included participants' age, gender identity, educational attainment, racial/ethnic identity, and sexual orientation.

Physical and sexual assault severity. To assess severity of history of physical or sexual violence, this study used the CTS2S (Straus & Douglas, 2004), a short form of the Revised Conflict Tactics Scale (CTS2). This measure contains 20 items that assess victimization and perpetration of violence in 4 domains: assault, injury, psychological aggression, and sexual coercion. Participants responded using an 8-point Likert scale that

captures both past-year frequency and prevalence in adulthood (e.g., since age 18). Previous literature has indicated the concurrent validity between the short form and full scales of the CTS2 as ranging from .6 to .94 for those who report being victimized (Straus & Douglas, 2004). For this study, we used the victimization items, choosing to exclude the psychological aggression items, given that we had a separate measure to assess this construct. The four physical assault items and two sexual assault items were analyzed as separate subscales in the preliminary analyses and OLS regression models to explore distinctions between physical and sexual violence. For each subscale, two variables were created: A continuous variable was created for “past year frequency” that is the sum of the physical assault items from 0 “did not occur” to 6 “occurred more than 20 times”. This is consistent with the scoring for the “annual chronicity score” for the full-scale Conflict Tactics Scale (Straus, 2004). A second dummy variable was created for ‘adult victimization prevalence’ by assigning a score of 1 if one or more instances of the items occurred in adulthood (including the past year), and 0 if no instances occurred. For this investigation, the Cronbach’s alpha for past year CTS was $\alpha = .89$.

Psychological abuse. To assess psychological abuse history, we used the short form version of the psychological maltreatment of women inventory (PMWI; Tolman, 1999). This measure contained 14 items that assess psychological violence in relationships, and consisted of two subscales: domination/isolation and emotional/verbal abuse. The response options asked how frequently each item occurred in the past six months, with choices including *never*, *rarely*, *occasionally*, *frequently*, or *very frequently* (scaled 1-5). An initial investigation into the psychometric characteristics of the scale indicated relatively high internal consistency; the dominance/isolation subscale

demonstrating an alpha of .88 and the emotional/verbal subscale demonstrating an alpha of .92 (Tolman, 1999). We made three adjustments to this scale. First, we shifted the reference time period to match that of the CTS2 (one year). Second, we changed the response options to match the CTS2; including identical past year frequency questions, and a question about whether these behaviors happened in adulthood rather than in the past year. Finally, given that the scale was originally created for women who experienced abuse by male intimate partners, we adjusted the wording of the measure so that it would apply to survivors and perpetrators of all genders.

As with the CTS-2 two variables were created from these scores: A continuous variable was created for “past year frequency” that summed responses from 0 “did not occur” to 6 “occurred more than 20 times”. A second dummy variable was created for ‘adult victimization prevalence’ by assigning a score of 1 if one or more instances of the items occurred in the participant’s adulthood (including the past year), and 0 if no instances occurred. For this investigation, the Cronbach’s alpha for past year PMWI was $\alpha = .87$.

Identity abuse. We adapted a set of items developed by Balsam and Syzmanski (2005) intended to measure identity abuse experienced by lesbian and bisexual women. We used the original five items of this scale and added two items drawn from qualitative literature on LGBTQ DV including: a) the power and control wheel for LGBTQ survivors (NCDSV, 2014); and, b) transgender-specific forms of victimization described by the FORGE Forward (an anti-violence program specifically working with transgender survivors; FORGE, 2014). The items were written to ensure that the measure reflected the larger LGBTQ community and was comprehensive and consistent with other literature on

identity abuse as a component of IPV. The resulting items fell into the following categories: a) Outing, or revealing one's LGBTQ status; b) Undermining/ Belittling Identity; c) Using Homophobic/Transphobic Language; and, d) Isolating a survivor from the LGBTQ community (See Appendix B for a full list of items). Using an 8-point Likert scale that captured past-year frequency and adulthood prevalence, the response format mirrored that of the CTS2. As with the CTS-2 two variables were created from these scores. A continuous variable was created for "past exposure" that summed each item response that indicated exposure in the past year. A second dummy variable was created for 'adult victimization prevalence' by assigning a score of 1 if one or more instances of the items occurred in the participant's adulthood (including the past year), and 0 if no instances occurred. Six experts of LGBTQ IPV and professionals with expertise working with groups historically excluded from LGBTQ research (e.g., racial and ethnic minority communities, transgender and gender non-conforming communities) reviewed these items and confirmed that the items were culturally appropriate to the best of their knowledge and reflected the underlying construct of identity abuse for the target population. For this investigation, the Cronbach's alpha for past year CTS was $\alpha = .79$.

Depressive symptoms. To measure depressive symptoms, we used the Center for Epidemiological Studies Depression Scale, Revised (CESD-R; Van Dam, & Earlywine, 2011). This 20-item scale assesses the frequency of symptoms over the course of the previous two weeks. The CESD-R is a revised version of the CESD (Radloff, 1977), updated to reflect current criteria of depression (Van Dam & Earlywine, 2011). This measure has been used with IPV survivors (Sabri et al., 2013) and in research on minority stress in the LGBTQ community (Lick et al., 2012). In a recent validation study

of this measure using a large general population sample ($n = 7389$), the CESD-R demonstrated strong psychometric properties with a Cronbach's alpha of .93 (Van Dam & Earleywine, 2011). For this investigation, the Cronbach's alpha for the CESD-R was $\alpha = .95$.

Symptoms of PTSD. To measure symptoms of PTSD, we used the PTSD Checklist Civilian Version (PCL-C; Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). This 17-item measure assesses symptoms in relation to generic "stressful experiences" and asks participants to rate each item on a 5-point scale according to how much it has bothered them "in the past month." The study of its initial development reported a test-retest reliability of .96, and an internal consistency score of .94. The PCL-C was selected for its ability to assess for multiple traumas and its previous use with samples of survivors of sexual assault and IPV (Blanchard et al., 1996; Woodcock, 2007). The response items were modified to ask about the previous two weeks, to make the response time consistent with the CESD-R. For this investigation, the Cronbach's alpha for the PCL-C was $\alpha = .92$.

LGBTQ identity: To assess LGBTQ identity the identity affirmation subscale of the Lesbian Gay and Bisexual Identity Scale (Mohr & Kendra, 2011) was used. Response options ranged from 1 (*disagree strongly*) to 6 (*agree strongly*). Mean internal consistency estimates across samples ranged from .75 to .91, and 6-week test-retest correlations ranged from .70 to .92 (Mohr & Kendra, 2011). We modified the items to refer to the more inclusive acronym "LGBTQ" for items that referred to "LGB" as identity labels. For this investigation, the Cronbach's alpha for LGBTQ identity was $\alpha = .88$.

This study involved online recruitment from a broad array of LGBTQ-specific and IPV-specific listservs (See Appendix A for a full list of recruitment sites and recruitment materials). Recruitment materials included a link to the secure online survey (see Appendix A). The survey included an informed consent document, demographics questionnaire, and the measures listed above. Participants were asked to read the online consent form (see Appendix C), which clearly stated that clicking on the ‘continue’ button represented their voluntary consent to participate in the study. Participants were also informed that should they agree to participate, and they wanted to provide an email address, that they would be entered to receive one of five \$25 Amazon gift cards. The survey offered a list of resources participants could access if they needed help or services.

Chapter IV: Results

Participants

Participants were 734 sexual minority adults, who ranged in age from 18 to 61 years ($M_{age} = 33.49$, $SD = 12.91$). Participants were able to select more than one gender identity label that described them. Many people simultaneously identified having a non-binary or transgender gender identity while also selecting other gender identities (e.g., male, female). The participants who selected more than one gender and indicated that they had a non-binary gender identity, were grouped together and a new category was created: “trans/non-binary” (12.9%). Participants who identified as transgender and specified as men or women were grouped together under a second category “trans-binary” (5.1%), recognizing that there are likely important differences in the experiences of transgender participants and participants who identify as having a non-binary gender. However, after running initial analyses with these two groups, there were no significant

differences between non-binary and trans-binary individuals on any of the violence or outcome measures. These groups were combined to improve power, and will be referred to under the umbrella term ‘transgender’ for the remainder of this study. After these analyses were conducted, about half of the sample’s participants identified as women (53.1%), a third (27.1%) identified as men, and the remainder (19.4%) identified as transgender.

As with gender, participants were able to select more than one sexual identity label that described them. The majority of the sample endorsed holding only one identity label (72.65%), though 17.3% claimed two labels, 7.6% claimed three labels, and 2.4% claimed more than three labels. To increase our ability to look at within group differences, participants with multiple sexual identity labels were assigned the label of the most encompassing identity. For example, if a participant endorsed both lesbian and bisexual—given that the bisexual label captured the participants’ attractions across gender, bisexual was retained rather than lesbian. Queer was selected over all other terms given its status as an umbrella identity.

Twenty-eight participants identified as heterosexual. Of those original 28 participants, 17 offered some indication of another LGBTQ identity status (e.g., identifying their gender as non-binary or transgender, and selecting more than one sexual identity label). After examining the remaining 11 participants’ responses to the measures of anti-LGBT discrimination, LGBTQ identity, and connection to the LGBT community, two participants who identified as having experienced discrimination due to their LGBTQ status were included in the study. The remaining 9 participants offered no

indication of LGBTQ status, heterosexist harassment or discrimination, LGBTQ identity, or connection to the LGBTQ community and thus were not included in the study. After recoding these response options, participants identified their sexual orientation as gay (23.6%), bisexual (13.8%), lesbian (23.1%), and queer or pansexual (29.2%).

Participants were able to endorse multiple racial/ethnic identity options, and identified as White (81.1%), Black or African American (3.7%), Hispanic or Latina/o American (6.5%), Biracial or Multiracial 4.5%), Asian, Asian American or Pacific Islander (7.5%), First Nation, Native American, American Indian, or Alaska Native (2.0%), Middle Eastern or Arab American (1.6%), Native Hawaiian or other Pacific Islander (0.6%) or as a different race/ethnicity identity label that was not listed in the response options (3.7%). Given the small percentage of respondents in several of these subgroups, racial/ethnic groups were collapsed into the following categories: those who identified as White (78.5%), those who had any identification with a community of color (15.9%), and those who felt we didn't have an option that described their racial/ethnic identity ("other"; 5.6%).

Participants reported living in the following U.S. regions: Northeast (33 %), West or Northwest (26.3%), Midwest (16.9%), South/Southwest (18.7%), or other U.S. Territories (5.0%). Participants varied across the following educational levels: some high school or a GED or equivalent (15.5%), bachelors or associate degree (38.1%), master's degree (30.1%), or a doctoral or professional degree (16.25%).

Preliminary Analyses

Missing data. Missing data were located, analyzed, and addressed using the Missing Values Analysis procedure for IBM SPSS Statistics Version 22 (IBM Corp, 2013). First,

all participants with more than 40% missing data were excluded from the study, or 305 of the 1045. Six more were deleted: one who identified as under 18, and five who did not show any indication of holding an LGBTQ identity. Of the remaining 734 participants who were included in the study, nearly half (47.4%) had missing data. Missing data percentages ranged from 0% to 1.6% for demographic and violence exposure measures- a nearly negligible amount as defined by Scholmer (2010).

Outliers and influential points. The dataset for this study was examined for outliers and influential points. Outliers were defined as cases whose standardized variable values exceeded ± 4 on at least one or more predictor or moderator measures. Two cases were identified as outliers using this method (624, 863). The studentized residuals and mahalanobis distance for these two cases were examined across each of the thirty-six regression models to determine whether they were consistently multivariate outliers as well as univariate outliers (Hair et al 2010). The two cases were not consistently multivariate outliers, and consequently these participants were retained in the analyses.

Variable transformation. After cleaning the data, imputing missing data, and computing the study's measures, the data distribution was examined by looking at patterns of skewness and kurtosis. In a normal distribution, skew and kurtosis equal zero. However, skew scores within the range of -1 to +1 and kurtosis within the range of ± 3 are generally considered as permissible to meet the assumptions of normality for linear regression (Hair et al, 2010). Examining the skew and kurtosis ranges (see Table 2) as well as examining histograms of each independent variable, we identified three variables that did not meet the assumption of normality: all three past year violence

exposure variables. In line with recommendations from Hair et al (2010), the past year violence exposure variables were transformed using log transformations.

To complete these log transformations, a constant of 1 was added to address the large number of participants with a score of zero (Hair et al., 2010). This transformation brought skew and kurtosis values closer to acceptable ranges (see Table 2). Although the past year physical and psychological abuse variables remained positively skewed even after transformation, we elected not to use a more severe transformation, such as an inverse transformation, to avoid complicating the interpretation of the results, and given that linear regression is robust to violations of normality.

Correlations. Due to the large number of variables, we chose to report on pairwise correlations between the main variables of interest in Table 3 for simple descriptive purposes. The correlations were based on computed scales. The variables were associated in conceptually consistent directions.

Exploratory factor analysis. Given that this is the first use of the measure of identity abuse, we examined validity and reliability of the 7-item Identity Abuse (IA) measure in a sample of 734 LGBTQ adults. As a first step, we assessed the quality of our items by examining their inter-item correlations and the frequency of missing responses (Clark & Watson, 1995; DeVellis, 2011; Worthington & Whittaker, 2006). Moderate correlation indicates that the items capture distinct aspects of the underlying latent construct of IA. Inter-item correlations ranged from $r = .24$ to $r = .65$, falling within the recommended range or $r = .15$ to $r = .50$ (Clark & Watson, 1995). There was no missing data on the IA items for the 734 participants.

The next step was to conduct an exploratory factor analysis (EFA). The Kaiser-Meyer-Olkin index (.85) indicated good sampling adequacy and Bartlett's test of sphericity was 1697.73 ($df = 21, p < .001$), suggesting that the correlation matrix was appropriate for EFA. We then determined the number of factors to extract based on the Kaiser eigenvalue rule (e.g., eigenvalues over 1) and the scree plot (DeVellis, 2011; Worthington & Whittaker, 2006). We used principal-axis factoring as an extraction method with varimax rotation which yielded a unidimensional factor structure (eigenvalue = 3.50; variance accounted for = 50.06%; factor loadings = .52, .53, .56, .67, .68, .77; and, .77). Communalities were at an acceptable level (from .37 to .64; $M = .50$), and internal consistency was high (Cronbach's alpha = .80). The factor loadings of the individual items are presented in Table 15.

After completing the EFA, we developed a past year frequency variable by summing the past-year response options, and an adult exposure variable that coded participants with any exposure to any of the items, past year or adulthood, as having exposure and those without as not. Means and standard deviations are presented in Table 2. Frequency of exposure for each item is reported in Table 16.

Regression Diagnostic Analyses

To examine hypotheses #2 through #8, we used ordinary least squares (OLS) regression analysis. OLS regression analysis explains variability in one dependent variable as a function of the variability of a number of independent variables. To use OLS, a set of assumptions must first be met. These are the assumptions of independence, normality, homoscedasticity, and linearity (Pedhauzer, 1997).

Independence. Independence refers to the assumption that the observations are

sampled independently, or in other words, any pair of errors E_i and E_j are independent. The assumption of independence is largely met during data collection. However, violations may be evident in the plots of the studentized residuals versus each of the predictors. Studentized residual plots were run for each model and did not indicate violations of independence.

Normality. As reported above, the descriptive analyses of the data (skew and kurtosis) indicated that the past year violence variables were not normally distributed (see Table 2). All three past year violence exposure variables were transformed using log transformations. In addition to measuring skew and kurtosis, the normal distribution for each of the models was examined using plots of studentized residuals vs. unstandardized predicted values, studentized residual histograms overlaid with a normal curve, and pp plots. These also indicated mild violations of normality.

Homoscedasticity. The assumption of homoscedasticity is the assumption that the error variance is the same for all values of X . To test for this assumption, after each regression model was run, studentized residuals (SRESID) were plotted against predicted values. If there is homoscedasticity of variance the data points will be equally dispersed across the plot. Alternately, if there is not homoscedasticity of variance there may be a clustering of data points at different predicted values of the outcome variable. These plots were run for each of the regression models, and indicated no severe violations of homoscedasticity.

Linearity. Regression analyses are based on the assumption that the relationship between the predictor variable and outcome variable is linear. To examine the assumption

of linearity, scatterplots were created for each of the predictor variables by the two outcome variables (CESD-R and PCL-C). Further, partial regression plots were also used to confirm linearity. These plots are described below.

Depression. These scatterplots indicated linear and positive relationships between symptoms of depression and all past year violence exposure measures. They also indicated relatively weaker, but still positive and linear relationships between symptoms of depression and adult violence exposure. As expected, the data indicated a linear negative relationship between symptoms of depression and identity affirmation.

PTSD. Similarly, scatterplots indicated linear and positive relationships between symptoms of PTSD and all past year violence exposure measures. They also indicated relatively weaker, but still positive and linear relationships between PTSD scores and adult violence exposure. As expected, the data indicated a linear negative relationship between PTSD scores and identity affirmation.. There was no indication that any of the variables violated the assumption of linearity.

Scatterplots of the standardized residuals by the fitted values of each regression model were created to examine the assumption of linearity. There was no evidence of a curving on the graph, which might indicate a curvilinear relationship, lending further evidence that the assumption of linearity was appropriately met.

Multicollinearity. Multicollinearity between the predictor variables was tested for each regression model using the VIF score. Although there is no definitive cutoff score for VIF, a score of 1 indicates little to no multicollinearity and scores of 5 and higher indicate significant multicollinearity. VIF scores all fell under 2 (highest VIF score =

1.67) indicating no serious concern of multicollinearity (Hair, 2010).

Hypotheses

Hypothesis 1: In a sample of 734 LGBTQ individuals, exposure to identity abuse will significantly differ across gender, sexual orientation, and race/ethnicity.

Hypothesis 1a. Adult identity abuse exposure will differ significantly across gender.

Hypothesis 1b. Past year identity abuse exposure will differ significantly across gender.

Hypothesis 1c. Adult identity abuse exposure will differ significantly across sexual orientation.

Hypothesis 1d. Past year identity abuse exposure will differ significantly across sexual orientation.

Hypothesis 1e. Adult identity abuse exposure will differ significantly across race.

Hypothesis 1f. Past year identity abuse exposure will differ significantly across race.

ANOVA analyses were used to test for significant differences on adult exposure to identity abuse. ANOVA analyses are omnibus tests, and when significant, they indicate that there are significant differences between categories of a variable overall. Alone, they do not indicate which categories were significantly different from one another. For this reason, when significant differences were found, these results were further explored using a Scheffé post hoc test to determine where those significant differences were.

Given that adult IPV exposure and each of the demographic variables were both categorical variables, Chi Square test of association analyses were conducted to examine group differences. Although comparing Chi Square statistics to a critical value can indicate significance, the statistic alone does not offer a clear indication of the magnitude of the difference between groups. For this reason, when significant differences were found, these results were further explored by computing odds ratios. The results are reported below for gender, sexual orientation, and race.

Gender. There was support for hypothesis 1a, with chi-square results yielding significant gender differences in reported adult identity abuse exposure ($\chi^2(2) = 17.74, p < .0001$). Non-binary/transgender participants reported the highest rates of adult identity abuse exposure (49.3%) followed by women (42.8%), and men (28.4%). While the chi-square test indicates significant gender differences, it does not point to the magnitude of that difference. Thus, to better understand the relationships between each of these dichotomous variables, odds ratios were calculated. The odds of transgender participants and women having been exposed to identity abuse in adulthood were higher as compared to the odds of men being exposed to identity abuse; the odds of transgender participant having exposure to identity abuse in adulthood were almost 2.5 times higher than the odds of men having exposure to identity abuse (OR = 2.46, $p < .0001$, 95% CI = 1.57, 3.85), and the odds of women having exposure to identity abuse in adulthood were nearly two times higher than those of men (OR = 1.89, $p < .001$, 95% CI = 1.31, 2.73). There were no significant differences between transgender and women participants in reported adult identity abuse exposure.

Consistent with hypothesis 1b, there were also significant gender differences in past year identity abuse exposure. Past year identity abuse exposure is a continuous variable and was examined using ANOVA analyses ($F = 4.76, p < .01; \eta^2 = .01$). ANOVA results indicated that transgender participants had the highest rates of past year identity abuse exposure ($M = .18, SD = .34$) followed by women ($M = .10, SD = .27$) and men ($M = .09, SD = .26$). Using Scheffe's post-hoc test to examine these differences more closely indicated that there were no significant differences between men and women, but that there were significant differences in the scores of transgender participants and men, and differences between transgender participants and women.

Sexual orientation. There was support for hypothesis 1c, with Chi-square analyses indicating sexual orientation differences in adult identity abuse exposure ($\chi^2(3) = 28.01, p < .0001$). Queer participants had the highest reported rates of identity abuse (48.6%) followed by bisexual participants (48%), lesbian participants (35.3%), and gay participants (26%). While the chi-square test indicates significant gender differences; it does not indicate the magnitude of that difference. To better understand the relationships between each of these dichotomous variables, odds ratios were calculated. The odds of queer participants having exposure to identity abuse were almost three times higher than the odds of gay participants ($OR = 2.69, p < .0001, 95\% CI = 1.78, 4.06$). The odds of bisexual participants being exposed to identity abuse were almost three times higher than the odds of gay participants ($OR = 2.63, p < .0001, 95\% CI = 1.56, 4.41$). The odds of bisexual and queer participants being exposed to identity abuse were also almost two times higher than the odds of lesbian participants (*bisexual*: $OR = 1.69, p < .05, 95\% CI$

= 1.02, 2.80; *Queer*: OR = 1.73, $p < .05$, 95% CI = 1.17, 2.56). However, there was not support for hypothesis 1d, with no significant group differences across sexual orientation found on past year exposure of identity abuse.

Race. Contrary to hypothesis 1e and 1f, chi-square and ANOVA analyses indicated that there were no significant differences in past year or adult identity abuse exposure by race.

Hypothesis 2: Exposure to identity abuse in adulthood will uniquely contribute to symptoms of depression and PTSD while controlling for demographic variables.

Hypothesis 2a: Adult identity abuse exposure will contribute uniquely to variance in depressive symptoms while holding demographic variables constant.

Hypothesis 2b: Adult identity abuse exposure will contribute uniquely to variance in PTSD symptoms while holding demographic variables constant.

Hypothesis 2c: Past year identity abuse exposure will contribute uniquely to variance in depressive symptoms while holding demographic variables constant.

Hypothesis 2d: Past year identity abuse exposure will contribute uniquely to variance in PTSD symptoms while holding demographic variables constant.

Consistent with hypothesis 2a, adult identity abuse exposure explained significant variance in participants' depressive symptom scores after controlling age, race, gender, sexual orientation, and education level (see Table 4). These demographic variables were controlled for across all future models as well, and will be referred to only as

“demographic variables” from here on. Depressive symptom scores were regressed on the dichotomous indicator of adult identity abuse with demographic variables included as covariates. Adult identity abuse exposure significantly contributed to the model ($\beta = .14, p < .01$) accounting for an additional 2% of the variance in the model. Consistent with hypothesis 2b, adult identity abuse exposure also explained significant variance in participant’s PTSD symptoms scores after controlling for age, race, gender, sexual orientation, and education ($\beta = .18, p < .01$; see Table 4).

Similarly, and consistent with hypothesis 2c, past year identity abuse exposure contributed significant variance to participants’ depressive symptoms scores after controlling for demographic variables (see Table 5; $\beta = .16, p < .01$). Depressive symptom scores were regressed on the continuous indicator of past year identity abuse with demographic variables included as covariates. Consistent with hypothesis 2d, past year identity abuse exposure contributed significant variance to participants’ PTSD scores. PTSD symptom scores were regressed on the continuous indicator of past year identity abuse with demographic variables included as covariates ($\beta = .23, p < .01$; see Table 5).

Hypothesis 3. Exposure to identity abuse in adulthood will contribute uniquely to variance to symptoms of depression and PTSD while controlling for other forms of adult abuse exposure and demographic variables.

Hypothesis 3a: Adult identity abuse exposure will contribute uniquely to variance in depressive symptoms independent of adult exposure to physical/sexual assault and psychological abuse, respectively while holding demographic variables constant.

Hypothesis 3b: Adult identity abuse exposure will contribute uniquely to variance in PTSD symptom scores independent of adult exposure to physical/sexual assault and psychological abuse respectively while holding demographic variables constant.

Hypothesis 3c: Past year identity abuse exposure will contribute uniquely to variance in depressive symptoms while holding demographic variables constant.

Hypothesis 3d: Past year identity abuse exposure will contribute uniquely to variance in PTSD symptoms while holding demographic variables constant.

The next set of hypothesis examined the contribution of identity abuse to symptoms of depression and PTSD while controlling for both demographic variables and other forms of IPV (physical and psychological). Depressive symptom scores were regressed on the dichotomous indicator of adult identity abuse with demographic variables and adult exposure to physical and psychological violence included as covariates. Consistent with hypothesis 3a, adult identity abuse exposure continued to explain variance in depression scores while controlling for other forms of IPV and demographic variables ($\beta = .10, p < .01$; see Table 6). PTSD symptom scores were then regressed on the dichotomous indicator of adult identity abuse with demographic variables and adult exposure to physical and psychological violence included as covariates. Similarly, and consistent with hypothesis 3b, adult identity abuse accounted for an additional 1% of the variance in PTSD symptoms while controlling for other forms of IPV and demographic variables ($\beta = .11, p < .01$; see Table 6).

Past year identity abuse exposure similarly contributed significantly to mental

health outcomes. Depressive symptom scores were regressed on the continuous indicator of past year identity abuse with demographic variables and adult exposure to physical and psychological violence included as covariates. Consistent with hypothesis 3c, past year identity abuse exposure contributed slightly less than 1% additional variance in depressive symptoms while controlling for other forms of IPV and demographic variables ($\beta = .09, p < .05$; see Table 7). PTSD symptom scores were regressed on the continuous indicator of past year identity abuse with demographic variables and adult exposure to physical and psychological violence included as covariates. Consistent with hypothesis 3d, past year identity abuse exposure contributed about 1% additional variance in PTSD symptoms while controlling for other forms of IPV exposure and demographic variables ($\beta = .14, p < .01$; see Table 7).

Hypothesis 4: Identity affirmation will moderate the relationship between identity abuse exposure and mental health outcomes while holding demographic variables constant.

Hypothesis 4a: LGBTQ identity affirmation will moderate the relationship between adult identity abuse exposure and symptoms of depression while holding demographic variables constant.

Hypothesis 4b. LGBTQ identity affirmation will moderate the relationship between adult identity abuse exposure and symptoms of PTSD while holding demographic constant.

Hypothesis 4c: LGBTQ identity affirmation will moderate the relationship between past year identity abuse exposure and symptoms of depression while holding demographic variables constant.

Hypothesis 4d. LGBTQ identity affirmation will moderate the relationship between past year identity abuse exposure and symptoms of PTSD while holding demographic constant.

To test for moderation effects, we used the steps outlined by Frazier, Tix and Barron, 2004. We centered the variables of each main effect (i.e., adult identity abuse and past year identity abuse) the moderator variable (i.e., affirmative LGBTQ identity) by creating a Z score value for each variable.

Additionally, we computed the interaction effect of the main effect and moderator. Demographic variables were entered into the first step of the regression equation, the centered main effect variable and moderator variable in the second step, and the interaction term in the third step of the regression equation. For significant moderator effects, we further examined the results by testing two simple slope regressions. We split participants into two groups based on whether their scores on the identity affirmation subscale were $\frac{1}{2}$ standard deviation below the mean (e.g low affirmation; $n = 188$) or $\frac{1}{2}$ standard deviation above the mean (e.g., high affirmation; $n = 294$).

Consistent with hypothesis 4a, identity affirmation significantly moderated the relationship between adult identity abuse exposure and symptoms of depression ($\beta = -.07, p < .05$; see Table 8; Figure 3). Consistent with our hypothesis we found that adult identity abuse exposure predicted depression symptoms in the low-affirmation group ($\beta = .21, p < .01$) but not for those in the high identity affirmation group. However, contrary to hypothesis 4b, identity affirmation did not moderate the relationship between adult identity abuse exposure and symptoms of PTSD. With regard to past year identity abuse, and consistent with hypothesis 4c, identity affirmation significantly moderated the

relationship between past year identity abuse exposure and symptoms of depression ($\beta = -.09, p < .05$; see Table #9; Figure 4). As with hypothesis 4a, we further examined the moderation effect by testing two simple slope regressions for each of the identity affirmation groups described above (e.g., low, high) in which the predictor was past year identity abuse exposure and the outcome was symptoms of depression. Consistent with our hypothesis we found that past year identity abuse exposure predicted depression symptoms in the low-affirmation group ($\beta = .27, p < .01$) but not for those in the high affirmation group. Finally, contrary to hypothesis 4d, identity affirmation did not moderate the relationship between past year identity abuse exposure and symptoms of PTSD.

Hypothesis 5: Identity affirmation will moderate the relationship between identity abuse exposure and mental health outcomes while holding demographic variables and exposure to other forms of violence constant.

Hypothesis 5a: LGBTQ identity affirmation will moderate the relationship between adult identity abuse exposure and symptoms of depression while holding demographic variables & other forms of violence exposure constant.

Hypothesis 5b. LGBTQ identity affirmation will moderate the relationship between adult identity abuse exposure and symptoms of PTSD while holding demographic variables & other forms of violence exposure constant.

Hypothesis 5c: LGBTQ identity affirmation will moderate the relationship between past year identity abuse exposure and symptoms of depression while holding demographic variables & other forms of violence exposure constant.

Hypothesis 5d. LGBTQ identity affirmation will moderate the relationship between past year identity abuse exposure and symptoms of PTSD while holding demographic variables & other forms of violence exposure constant.

This hypothesis was nearly identical to hypothesis #4, with the distinction of controlling for previous physical and psychological violence as well as demographic variables. We completed the steps for moderation analyses described above, outlined by Frazier, Tix and Barron, 2004. Demographic variables and physical and psychological violence exposure were entered into the first step of the regression equation, the centered main effect variable and moderator variable in the second step, and the interaction term in the third step of the regression equation. For significant moderator effects, we further examined the results by testing simple slope regressions. We split participants into two groups based on whether their scores on the identity affirmation subscale was $\frac{1}{2}$ standard deviation below the mean (e.g. low affirmation; $n = 188$) or $\frac{1}{2}$ standard deviation above the mean (e.g., high affirmation; $n = 294$).

Consistent with hypothesis 5a, identity affirmation significantly moderated the relationship between adult identity abuse exposure and symptoms of depression ($\beta = -.07, p < .05$; see Table #10, Figure 5). We further examined the moderation effect by testing two simple slope regressions for each of the identity affirmation groups described above (e.g., low, high) in which the predictor was adult identity abuse exposure and the outcome was depressive symptoms. Consistent with our hypothesis we found that adult identity abuse exposure predicted depression symptoms in the low-affirmation group ($\beta = .19, p < .01$) but not for those in the high affirmation group. However, contrary to hypothesis 5b, identity affirmation did not moderate the relationship between adult

identity abuse exposure and symptoms of PTSD. With regard to past year identity abuse, and consistent with hypothesis 5c, identity affirmation significantly moderated the relationship between past year identity abuse exposure and symptoms of depression ($\beta = -.09, p < .01$; see Table #11, Figure 6). We again further examined the moderation effect by testing two simple slope regressions for each of the identity affirmation groups described above (e.g., low, high) in which the predictor was past year identity abuse exposure and the outcome was symptoms of depression. Consistent with our hypothesis we found that past year identity abuse exposure predicted depression symptoms in the low-affirmation group ($\beta = .28, p < .01$) but not for those in the high affirmation group. Contrary to hypothesis 5d, identity affirmation did not moderate the relationship between past year identity abuse exposure and symptoms of PTSD.

Analysis of Semi-partial Variance. Given the likelihood that physical, psychological and identity abuse co-occur, and to gain a better understanding of the relative strength of the relationship between each of these forms of violence and symptoms of depression and PTSD, we analyzed the semi-partial variance of identity abuse and each of the mental health variables. Semi-partial coefficients of correlations are usually used to assess the specific effect of each independent variable on the dependent variable.

We ran a regression analysis using physical, psychological and identity abuse as predictor variables and either depressive or PTSD symptom scores as outcome variables; and we examined the semi-partial correlation for each of the three violence statistics to better understand the relative strength of each of these variables in relationship to the mental health variables. With regard to depressive symptoms, the semi-partial

correlation between identity abuse and symptoms of depression ($SR^2 = .13$; $p < .01$) and physical abuse and symptoms of depression ($SR^2 = .13$; $p < .01$) were both significant. The semi-partial correlation between psychological abuse and depression symptoms was not significant. With regard to PTSD the semi-partial correlation between identity abuse and symptoms of PTSD ($SR^2 = .13$; $p < .01$) and physical abuse and symptoms of PTSD ($SR^2 = .15$; $p < .01$) were both significant. Again, the semi-partial correlation between psychological abuse and PTSD was not significant. These results indicate that the strength of the relationship between identity abuse and symptoms of depression and PTSD is similar to the strength of the relationship between physical abuse and symptoms of depression and PTSD.

Chapter V: Discussion

Despite recent significant social and legal gains for the LGBTQ community, ongoing discrimination continues to place this population at heightened risk for poor physical and mental health (Meyer, 2003). This is particularly true for LGBTQ survivors of IPV, who in addition to the impact of abuse also contend with societal and institutional oppression related to their minority social status (Basow & Thompson, 2012; Edwards Sylaska & Neal, 2015; Turell & Herrmann, 2008). Moreover, stigma-related stress also uniquely impacts LGBTQ IPV. For instance, LGBTQ people may be subject to abusive tactics that leverage systemic and cultural discrimination (i.e., identity abuse; Ard & Makadon, 2011; Balsam, 2001; Balsam & Szymanski, 2005; FORGE, 2014; Gay Men's Domestic Violence Project, 2014; National Center on Domestic & Sexual Violence, 2014; West, 2012). Examples of identity abuse include denying or belittling an individual's

LGBTQ identity (e.g., refusing to use preferred gender pronouns) or restricting access to a supportive LGBTQ community (NCDSV, 2014). Despite emerging evidence documenting the existence of identity abuse, little is known about its prevalence across specific subgroups of the LGBTQ population, nor its relationship to mental health. Such knowledge is critical given that bias-based victimization, including identity abuse, may be more damaging than non bias-based victimization (Meyer, 2003).

This study attempted to fill this gap by: 1) developing a measure of identity abuse that can be empirically-validated; 2) documenting the prevalence of identity abuse in the LGBTQ community; 3) identifying differences in rates of identity abuse across various demographics; 4) investigating the relationship between identity abuse and mental health with a specific focus on symptoms of depression and posttraumatic stress disorder (PTSD); and 5) investigating the extent to which affirmative LGBTQ identity buffers the relationship between identity abuse and mental health. Findings related to each of these explorations are presented next.

Developing a Measure of Identity Abuse within the LGBTQ Community

The identity abuse measure used for this current study was adapted from Balsam and Symanski's (2005) work on identity abuse, the literature from community practitioners working with LGBTQ IPV survivors (FORGE, 2014; Gay Men's Domestic Violence Project, 2014), and qualitative literature drawing on the experience of identity abuse in general (West, 2012). As noted in chapter two, our investigation into the existing literature led to four sets of changes to the Balsam and Szymanski (2005) measure. First, we added two items to cover specific aspects of identity abuse not included in the original measure: using homo/bi/transphobic language and isolation. Second, we changed the

language of the item, “I used my partner’s age, race, class, or religion against her,” to apply more specifically to using gender and sexual orientation against the survivor. Third, we changed the language of all items to apply across gender since the original measure was written for sexual minority women exclusively. Finally, we discussed all items with clinicians, researchers and activists with expertise in working with the LGBTQ community, and made minor language edits based on their feedback.

Factor analyses indicated that this measure has high internal consistency ($\alpha = .79$). Although scores on the measure were significantly and positively correlated to past year and adult exposure to physical abuse and psychological abuse respectively, the correlations were within the moderate range, indicating that identity abuse is conceptually distinct from other forms of intimate partner violence. In other words, it appears that identity abuse is a distinct form of abuse experienced by the LGBTQ community that has not yet been captured by existing measures of IPV.

Prevalence of Identity Abuse

The results of this study indicate that identity abuse exists in the LGBTQ community and indeed occurs frequently. Participants in this study reported experiencing identity abuse at about the same rate as physical abuse. For instance, nearly a fifth of the sample (16.8%) reported experiencing at least one item from the identity abuse scale in the past year as compared to 13.2% who reported experiencing an act of physical violence. Further, 40.1% of the sample reported identity abuse at some point in adulthood as compared to 39.1% of the sample that reported physical abuse. These statistics are consistent with Balsam and Szymanski’s (2005) findings that 14.6% of LGB women

experienced identity abuse in the past year, and 34.8% experienced identity abuse in adulthood. Although one limitation of this study is use of a convenience sample rather than a probability sample, it is nevertheless striking that almost half of participants reported experiencing identity abuse at some point since age 18. Identity abuse is not a rare form of abuse experienced by an unlucky few; but a common feature of IPV within the LGBTQ community.

Identity Abuse Exposure Patterns in LGBTQ Communities

Members of the LGBTQ community have multiple intersecting identities (e.g., transgender people of color) that shape exposure to different types and degrees of abuse (Bograd, 1999; Mendez, 1996; Meyer, 2010). In an effort to better understand how intersecting identities relate to identity abuse, we explored within-group variations of identity abuse exposure based on gender, sexual orientation, and race/ethnicity. Findings suggest that identity abuse differs across two aspects of identity: gender and sexual orientation.

Gender: With regard to gender, women experienced significantly more exposure to identity abuse in adulthood than men, though there were no differences in exposure over the past year. Consistent with previous research, transgender participants also reported experiencing higher rates of identity abuse in adulthood and in the last year compared to their cisgender counterparts (Langenderfer-Magruder et al., 2014; Langenderfer, 2014).

Two theoretical perspectives help explain these findings: From a feminist perspective on abuse in relationships, women may experience higher rates of IPV because these acts take place in a larger culture of sexism, in which it is culturally

acceptable to control women's behavior through violence (Hamby, 2009). Previous research has linked gender inequity with increased violence against women both at an international level (Martin, Vieraitis, & Britto, 2006; Straus, 1994; Whaley & Messner, 2002) and neighborhood level (Lei et al., 2014). However, scholars have noted that feminist theory fails to adequately explain and predict abuse in the LGBTQ community (Erbaugh, 2007) and in some cases leads to biases. For example, one might assume that a partner who is more masculine-of-center in gender presentation or transgender men would use abuse in their relationships more often than feminine-of-center or transgender women due to gender socialization and cultural acceptance of violence against women. However, qualitative and quantitative investigation does not support this theory (Balsam & Szymanski, 2005; Basow & Thompson, 2012). With regard to our findings, Feminist theory could explain the higher prevalence of abuse in adulthood for women as compared to men. However, its ability to explain the disproportionate rates of abuse for transgender participants is less direct and clear.

Although less prominent, an additional perspective that may be helpful in understanding these results is social dominance theory (SDT). SDT argues that societies contain three distinct systems of group-based hierarchies: 1) age systems (privileging adults over children); 2) gender systems (privileging men over women); and, 3) arbitrary-set systems in which groups are segregated by arbitrary constructs (e.g., LGBTQ status; Pratto, Sidanius, & Levin, 2006). In this framework, one could understand cis-gender status as an arbitrary-set system related to, but distinct from, patriarchy. In this case, cis-gender status is valued over transgender identity. This perspective, like feminist theory, argues that there is more societal permission for violence against those communities that

hold less power in society. However, SDT is distinct from feminist theory in that it does not focus on patriarchy as the central domain of inequality, making it more applicable within the LGBTQ community. In examining the results from this perspective, the differences across gender can be understood as the expression of institutional practices of inequality (e.g., pay inequality), and cultural beliefs about inequality (e.g., misogyny, transphobia), that trickle down to make those at the bottom of the hierarchy more vulnerable as the acts of abuse targeting these individuals are less recognizable. For example, if a transgender-identified survivor's community, church, employer, and media believe that transgender peoples' identities are not "real" (for example, by refusing to use preferred pronouns) then they may not recognize that a partner who is intentionally refusing to acknowledge their gender identity is engaging in abusive behavior. Rather they (and their community) may find such behavior 'normal', even though it is indeed destructive to the survivor.

It is important to note that while SDT may explain patterns of acceptance of violence against particular subgroups in a society or culture, it does not shed light on the dynamics of a the particular relationship dynamic of any given couple. A partner who has more access to privilege could still be the target of identity abuse by their partner. Further, there are interpersonal dynamics and dimensions of power and control that exist within partnerships that extend beyond LGBTQ identity. Rather than providing an answer to who uses identity abuse against whom, social dominance theory provides a framework for understanding structural and cultural norms that may give rise to such abuse.

Sexual orientation: With regard to sexual orientation, bisexual and queer-identified participants experienced higher rates of identity abuse exposure than their lesbian and gay counterparts. There are several possible explanations for these findings: First, consistent with SDT, it is possible to make the case that there are social hierarchies of sexual orientation in which heterosexual relationships receive the highest degree of privilege, followed by gay and lesbian relationships, and then bisexual and queer relationships. This hierarchy is supported by biphobia and binegativity literature, which largely indicates that bisexual individuals experience prejudice not only from straight people but also from lesbians and gay men (Mohr & Rochlen, 1999). Further, heterosexual individuals' attitudes toward lesbians and gay men are generally more favorable than their attitudes toward bisexual individuals (Eliason, 1997; Herek, 2002; Steffens & Wagner, 2004). Thus, cultural biphobia in LGBTQ and heterosexual communities may filter down to an interpersonal level, contributing to greater rates of perpetration and implicit acceptance of identity abuse.

Regarding the finding of higher rates of identity abuse among queer identified participants, this is hard to interpret given the dearth of research that includes "queer" as a sexual identity label. One possibility may be that bisexual and queer identities overlap so much that the former group may be perceived as part of the latter, and consequently experience stigma associated with this label. Indeed, one survey of participants at the 2004 United Kingdom Bisexual Conference indicated that 54% of the attendees identified as queer as well as bisexual (Barker, Richards, & Bowes-Catton, 2009).

There is also emerging research to suggest critical sociodemographic differences between queer and bisexual individuals. For example, findings suggest that queer

identified participants may be more likely to be partnered with gender non-conforming individuals, or be gender non-conforming themselves (Kuper, Nussbaum, & Mustanski, 2011; Meier, Pardo, Labuski, & Babcock, 2013) and may choose to identify as queer to capture this complexity. In this case, higher rates of identity abuse exposure may be more related to devaluing of non-binary gender than sexual orientation. In reality, individuals may hold multiple and conflicting positions within a number of identity domains (Sokoloff & Dupont, 2005), highlighting the complexity that intersectionality lends to SDT.

Race/ethnicity: Interestingly, there were no differences in exposure to any form of abuse (i.e., physical, psychological, identity based) across race/ethnicity in this current sample. This finding is surprising given the existing literature suggesting that LGBTQ people of color experience higher rates of abuse as well as barriers to assistance in the service system (NCAVP, 2013; 2015). We propose three explanations for these findings.

First, it is possible that LGBTQ communities of color do not experience higher rates of abuse than their white counterparts. Existing research documenting such disparities has focused on convenience samples; often those seeking help at social service agencies. It is possible that the differences in abuse exposure across race/ethnicity are characteristic for a service-seeking sample, but not a broader sample such as that reached by this study. This could be further investigated by examining data from population-based survey methodology.

Alternatively, it is possible that this study did not have an adequate sample of LGBTQ people of color (LGBTQ POC) to accurately assess differences in abuse exposure across race/ethnicity. Despite attempting to oversample among LGBTQ POC,

the response rate was low (15.9%). It is possible that the restricted sample size did not offer adequate power for existing differences in rates of abuse to emerge. As will be discussed in further detail in the limitations sections, engaging LGBTQ communities of color in research is difficult even for projects specifically focused on understanding communities of color (Todos, 2013). This project joins the many others that highlight the need for more creative and thoughtful ways to understand the particular needs of LGBTQ POC and to increase representation of LGBTQ POC in all aspects of research design.

With regard to the lack of differences in rates of identity abuse specifically, it is also possible that LGBTQ POC *do* experience more identity abuse, but in a way that is qualitatively different than white LGBTQ individuals. As highlighted by intersectionality theory, focusing on LGBTQ identity alone may not capture the complexity of interpersonal violence for people who hold multiple intersecting marginalized identities (Crenshaw, 1991; Lewis & Neville, 2015). Additionally, there is emerging evidence that suggests that there may be substantive differences in the kinds of stereotypes and discriminatory statements individuals experience based on their intersecting identities (Lewis & Neville, 2015; Nadal, 2013). In their 2011 article, Balsam et al. developed a LGBT People of Color Microaggressions Scale, highlighting some examples of the ways that racism and hetero/cis-sexism intersect. Some of these items include, “Having to educate white LGBT people about race issues”, “Feeling unwelcome at groups or events in your racial/ethnic community”, and “Being seen as a sex object by other LGBT people because of your race/ethnicity” (Balsam et al 2011). These items may extend to LGBTQ communities of color, and even to the experience of identity abuse itself. Some possible examples could include, threatening out a partner within an unsupportive racial/ethnic

community, denying a partner's LGBTQ or racial/ethnic identity because they 'can't be both', telling a partner they deserve what they get- or that they won't be loved due to their dual minority status, or a partner denying racism in the white LGBTQ community. However, further qualitative research is needed to better understand the extent to which this is a dimension of the abuse that LGBTQ POC survivors' experience.

The Relationship between Identity Abuse and Mental Health

The next set of questions explore whether identity abuse was associated with two pervasive mental health outcomes of IPV: symptoms of depression and PTSD. Specifically, this study examined whether identity abuse predicted depression and PTSD symptoms generally, and in addition, while controlling for physical and psychological abuse exposure.

Findings from this current study indicate that past year and adult identity abuse exposure were associated with symptoms of both depression and PTSD. Adult identity abuse exposure contributing to 2% of the variance in depressive symptom scores and 3% of the variance in PTSD scores; past year identity abuse exposure contributing to 2% of the variance in depressive symptom scores, and 6% of the variance in PTSD symptom scores. Though these contributions were relatively small, they were nonetheless significant. Further, identity abuse's relationship to symptoms of depression and PTSD is of a comparable magnitude to physical abuse's relationship to these mental health outcomes. While this study design prevents causal conclusions, these findings indicate that LGBTQ people who experience identity abuse report significantly more symptoms of PTSD and depression than those who do not experience identity abuse.

Notably, these findings are consistent with our predictions based on the minority stress model. According to this perspective, systems of oppression are translated into the experience of chronic stress (Meyer, 2003). Identity abuse may indeed be one such experience. Akin to discrimination, rejection and hate crimes, identity abuse adds an additional psychological burden, taxing individuals' ability to cope (Aneshensel, 2009; Meyer, 2003). This may in turn increase vulnerability to mental health difficulties (Aneshensel, 2009; Dohrenwend, 2000; Turner & Avison, 2003), such that LGBTQ individuals who experience identity abuse report increased symptoms of depression and PTSD.

Affirmative LGBTQ Identity as a Protective Factor

Returning to the minority stress model, a burgeoning literature points to protective factors that buffer the effects of minority stress. In the case of LGBTQ survivors of IPV and of identity abuse in particular, this study explored a positive LGBTQ identity as a protective factor.

Developing a positive identity as a member of an oppressed group is central to the process of adapting to stigma (Balsam & Mohr, 2007; Eliason & Schope, 2007; Hershberger & D'Augelli, 1995; Nuttbrock, Rosenblum, & Blumenstein, 2002), and has been associated with lower psychological distress, less frequent anticipation of rejection, and greater self-esteem, self-assurance, and life satisfaction (Balsam & Mohr, 2007; Mohr & Kendra, 2011). Consistent with this literature, our results indicated that an affirmative LGBTQ identity did indeed weaken the relationship between exposure to past year and adult identity abuse, respectively, and depressive symptoms. Those with an affirmative LGBTQ identity may be better equipped to avoid internalizing the

stigmatizing messages inherent in identity abuse, resulting in fewer symptoms of depression, particularly those related to negative self-concept (e.g., feelings of worthlessness and guilt; APA, 2013). Further, those with stronger affirmative LGBTQ identities may need to expend fewer cognitive resources to actively protect against the stigma that identity abuse elicits. They may therefore be less psychologically taxed and may experience fewer cognitive symptoms of depression (e.g., decrease in energy, lack of focus; APA, 2013; Hatzenbueler et al, 2009).

This same buffering effect was not found for PTSD symptoms. This is surprising given that one of the explanations for greater distress following bias-based victimization compared to other forms of victimization is that it triggers victims' negative schemas about themselves and the world, which are in turn associated with PTSD symptoms (Kaysen, Lostutter & Goines, 2005). In the case of identity abuse, we had predicted that affirmative LGBTQ identity could prevent survivors from internalizing negative beliefs about themselves- namely the anti-LGBTQ messages of the abuse itself. However, change in cognition and mood constitutes only one of four core domains of PTSD (e.g., re-experiencing, avoidance, negative cognitions and mood, arousal; APA, 2013). Thus, it is possible that even if affirmative LGBTQ identity protects against the development of negative cognitions about the self and world, it has no impact on the somatic processes of PTSD - such as central nervous system, neuroendocrine, and immune dysfunction (Gupta, 2013) – and therefore fails to buffer the impact of ID abuse on PTSD symptoms.

Study Limitations and Implications

Despite its contributions to the existing literature, this study was limited in key ways related to 1) study design, 2) sampling and generalizability, 3) measurement; and, 4) the conceptual framework. Each is described in more detail below.

Design limitations. The cross sectional design of this study limits interpretation of results in that causality or order of associations cannot be assumed. For example, although one might interpret these findings to indicate that exposure to identity abuse leads to poorer mental health, it is also possible that those with poorer mental health are then exposed to more identity abuse. Further, a third unmeasured variable could be related to both identity abuse and poor mental health. For instance, perhaps low self-esteem contributes to greater endorsement of depression and PTSD symptoms, and is also associated with having more abusive relationships. Only longitudinal research designs can comprehensively tease out the order of associations.

Sampling limitations. Despite deliberate oversampling in LGBTQ communities of color and gender-diverse communities, the sample overrepresented White and cisgender participants. This limits the generalizability of the findings to LGBTQ communities of color and transgender and gender non-conforming people. This is a serious limitation given reports that LGBTQ POC and transgender individuals are disproportionately affected by IPV (NCAVP, 2013; 2015).

Measurement limitations. While the measures included in this study were carefully selected and developed with consultation from multiple stakeholders from the LGBTQ community, there remain several important limitations. These include: 1) limitations of the intersectionality of the identity abuse measure, 2) the use of limiting

and non-inclusive language, 3) limitations of the measurement of IPV; and, 4) limitations of the measurement of minority stress.

The identity abuse measure inquires about LGBTQ identity as though it were separate from other domains of identity, which may not capture the complexity of people who hold intersecting marginalized identities (e.g., transgender people of color) (Crenshaw, 1991). There is emerging evidence to suggest that there are substantive differences in the kinds of stereotypes and discriminatory statements individuals experience based on their intersecting identities (Balsam et al, 2011; Lewis & Neville, 2015; Nadal, 2013). This may extend to LGBTQ communities of color, and even to the experience of identity abuse itself. There may be specific ways in which LGBTQ communities of color experience identity abuse (e.g., “outing” the survivor, dismissing identity, preventing access to a supportive LGBTQ community) that are not better captured by these items as they are currently written.

Regarding the other measures, we received feedback about several points within the survey regarding the chosen language that was not inclusive of a particular sub-community. For example, participants made note that the gender options did not include an option to list “sex assigned at birth” and listed “Female” and “Male” rather than “Woman” and “Man” as gender identity options. Given that “Female” and “Male” refer to sex rather than gender, this conflation of sex and gender and the absence of “sex assigned at birth” may have signaled to potential transgender participants that the survey did not have a trans-affirming framework. Future research should carefully consider all members of the transgender and gender non-conforming community when developing response categories (Cahill & Makadon, 2014).

Regarding the measures of abuse, several participants noted that for those who practice bondage, dominance, submission, and masochism (BDSM), the physical and psychological abuse items could have been answered “yes” without signaling the presence of abuse. Rather, these acts could have occurred within the context of a consensual sexual or romantic relationship. Assessing the context of ‘violent’ acts would help clarify this issue in future studies. Further, the CTS-2 does not distinctly capture variability between participants who experienced one act of violence in their adult life and those who have been in ongoing abusive relationships for many years. Therefore, critical differences between high and low violence exposure were not adequately captured in this study. Finally, although the CTS-2 can measure both acts of violence experienced and acts of violence perpetrated, in this study we only focused on acts of violence that the participants experienced. To better understand the context in which violence occurred, future research should focus on both victimization and perpetration. Further to better understand how power dynamics may influence violence, future research should inquire about demographic variables (e.g., race, gender, sexual identity) of the partner perpetrating violence.

Finally, this study builds on the minority stress model developed by Meyer (2003) to better understand how bias-based victimization in IPV may disproportionately lead to worse mental health. However, this study focused primarily on distal (i.e., external) sources of minority stress rather than proximal (i.e., internal) sources of stress. Research on the minority stress model has identified a number of internal factors that interact with external ones to influence outcomes, including disclosure of LGBTQ identity (Lewis, Derlega, Griffin, & Krowinski, 2003), internalized homo/bi/transphobia (Newcomb &

Mustanski, 2010), and rejection sensitivity (Feinstein, Goldfried, & Davila, 2012). For example, we did not gather information on how “out” participants were, which may have influenced participants’ experience of abuse. Those who are less “out” may be more vulnerable to internalizing the messages of identity abuse due to lack of contact with supportive LGBTQ community. Future research should include additional dimensions of the minority stress model to create a more comprehensive and nuanced picture of the pathways from exposure to identity abuse to mental health.

Conceptual limitations. Finally, there were limitations to our conceptual frame, including: a) conceptualizing the LGBTQ ‘community’ as a cohesive group; b) the relative emphasis on the abuse in LGBTQ relationship and psychological distress as compared to the strengths of LGBTQ survivors, and c) the conceptualization of IPV as the presence or absence of violent events rather a broad coercive dynamic.

The decision to broadly sample members of the LGBTQ community was made due to evidence that the constructs under examination in this study are relevant to transgender, bisexual and queer communities as well as the more traditionally studied cisgender, gay, and lesbian communities. We wanted to avoid reinforcing the historic underrepresentation of bisexual, transgender and queer individuals within the LGBTQ literature generally, and IPV literature specifically (NCAVP, 2013; 2015). However, it is important to acknowledge that posing questions about participants’ LGBTQ identity more broadly also had trade-offs. Potentially most important is that the wording of some items may have prevented more nuanced findings about the distinct experiences across sexual orientation and gender identity. For example, with regard to the LGBTQ identity affirmation measure, one item is: “I am proud to be LGBTQ”. This item may have forced

participants to choose between their sexuality and gender. A respondent who identifies both as gay and transgender, for example, could feel very proud of their gay identity but still be struggling with internalized transphobia, and feel less proud to be transgender (or vice versa). By asking about experiences with the LGBTQ community in this way, important nuance may have been lost. This speaks to the need for a broader program of research on identity abuse within each subgroup of the LGBTQ community to ensure that the within group differences of these communities are accurately captured.

Although this study did attempt to bring a strengths-based focus by including questions about protective factors, it may have had a disproportionate focus on risk rather than resilience. Several participants noted, for example, that the survey did not offer enough space to identify the positive aspects of being LGBTQ. Future work should not only include the negative effects of minority stress on mental health but also the powerful resilience of members of the LGBTQ community. This could include an initial qualitative investigation into what LGBTQ survivors identify as their individual and community level strengths.

Finally, in effort to limit the burden of completing the survey- particularly given how difficult to reach this population can be- we chose to assess for physical, psychological, and identity abuse using measures based on the CTS. As noted above in the section on limitations in the study measures, however, the CTS defines IPV as the presence of single acts of violence without assessing for the context of the violence (e.g., violence intended to control vs. violence intended for self-defense). Further, we did not assess whether or not the participants themselves engaged in violence, which in turn meant we could not assess whether the IPV was bi-directional or unidirectional. It is

important to note that participants were not recruited based on self-identified survivor status. Consequently, participants themselves may not understand the acts they experienced as part of IPV. As noted above, research on IPV has suggested that there are many subtypes of violence, distinct in their etiology and treatment. Future research must be conducted to better understand how identity abuse relates to these subtypes of IPV, and whether there are distinct differences in its impact based on the context of the violence.

Implications for Theory and Research

Despite the limitations described above, findings from this study have important implications for future theory and research related to: a) the construct of identity abuse; b) the minority stress model, and c) methods for future research within the LGBTQ community. The following section explains each of these in turn.

Implications for construct of identity abuse. Most importantly, results of this study support and build on extant LGBTQ practice-based scholarship pointing to identity abuse as a unique dimension of IPV not otherwise captured by general measures of abuse (Gay Men's Domestic Violence Project, 2014; FORGE, 2014; NCDSV, 2014). As noted above, the identity abuse measure was found to have adequate internal validity, and was related to, but conceptually distinct from physical and psychological abuse. It was experienced at about the same rate as physical IPV, indicating that this is a common experience within the LGBTQ community. Identity abuse also contributed to symptoms of PTSD and depression, suggesting that it is a critical problem for the psychological well being of the LGBTQ community at large. Taken together, these results support the

hypothesis that identity abuse is a pervasive albeit understudied form of abuse that threatens the psychological well-being of the LGBTQ community.

This study produced a measure of identity abuse that could be further empirically validated and used for future research, including nationally representative investigations of identity abuse, an exploration of the relationship between identity abuse and aspects of the minority stress model that were not included in this investigation (e.g., concealment, rejection sensitivity), and studies evaluating the extent to which prevention and intervention efforts can, respectively, reduce the use of identity abusive tactics within the LGBTQ community, and ameliorate their effects. Further, identity abuse likely extends to other systemically disadvantaged identities such as ableism, racism, and immigration status. Future research could extend the construct of identity abuse to explore its application in other marginalized groups of IPV survivors

Implications for minority stress model. Results from this study also provide further evidence for the utility of the minority stress model in predicting mental health for the LGBTQ community. For instance, these findings indicate that bias-based victimization is a distinct form of abuse experienced by minority group members, which may contribute to poorer psychological well-being. This also fits with previous research on the mental health impact of bias-based victimization generally (Herek et al., 1996; Poteat et al., 2013).

Further, given that findings were similar across sexual and gender identity, it suggests that the minority stress model may be useful in work with queer, transgender, and gender non-conforming communities. While there has been theoretical application of the minority stress model to transgender and gender non-conforming communities

(Hendricks & Testa, 2012), there are relatively few studies that have made associations between exposure to cis-sexism and mental health outcomes.

This study included gender and sexual identity labels that are less often used in LGBTQ research to date, including pansexual, asexual, queer, and non-binary gender identities. There were enough queer-identified individuals to analyze as a separate group, and the minority stress model seemed to apply for this group in a way that was consistent with theory. Future research should focus on continuing to extend the minority stress model to these communities in an effort to understand within group differences, particularly given that these communities may be marginalized within the LGBTQ community which may raise unique risks for psychological well being. For example, the literature indicates that biphobia from both the heterosexual and lesbian and gay communities creates a “double closet” for bisexual individuals (Ebin, 2012). It is possible that dealing with prejudice from heterosexual, cisgender, and LGBTQ communities may affect aspects of the minority stress model, such as concealment and internalized prejudice for identities marginalized within the LGBTQ community (e.g., bisexual, queer, transgender).

Methods for future research with the LGBTQ community. Finally, this study yielded several important lessons for conducting research in the LGBTQ community. Most importantly, it raises critical concerns related to sampling: LGBTQ focused research has predominantly centered on lesbian women and gay men. Not only does this exclude bisexual and transgender/gender non-conforming individuals, as scholars more recently have pointed out, it also excludes identities that have more recently begun to emerge in the LGBTQ community including queer, asexual, pansexual, agender, and fluid individuals. This study offered participants a wider range of gender and sexual

identity labels than have historically been offered in psychological research; and findings suggest that a substantial subsection of the LGBTQ community embraces a label outside of lesbian, gay or bisexual.

Do these distinctions matter? The results of this study indicate that they do; for example, there were meaningful differences between the outcomes of lesbian, gay, bisexual, and queer identified participants. This raises questions about whether studies that force participants to choose only one label miss the complexity of this community. LGBTQ-focused medical providers, such as Fenway Health, have moved toward offering sexual orientation and gender identity (SOGI) options that offer both prescribed categories, and space for participants to self-identify. Although these options introduce more variation in response, which can be a challenge for research, they increase participation in answering SOGI questions. Further, expanding such options may allow researchers and practitioners a way of identifying and engaging with new and emerging subgroups of this community (Cahill & Makadon, 2014). Allowing for more inclusive self-identification may enable LGBTQ researchers to better understand the true complexity of the community, as well as the relative risks and strengths of previously excluded identities and experiences.

It is also critical that future researchers attend to the critical intersectionality of LGBTQ identities and race/ethnicity. Although this study was limited in its recruitment endeavors due to funding and time constraints, there have been several recommendations made to increase participation within racial and ethnic minority communities. Studies that explicitly focus on recruiting participants from racial and ethnic minority communities emphasize recruiting using personal contact, word-of-mouth dissemination and

community involvement by project staff (Yancy, Ortega & Kumanyika, 2006). Others suggest conducting focus groups with key stakeholders in communities of color and trans communities, or leveraging cultural insiders who can offer better insight into how the research can be most useful to the community (CNPAAEMI, 2000).

It is important to note that both transgender communities and communities of color have historical legacies of research - related violence (Martin & Meezan, 2003; 2009). Consequently, members of these communities may be justifiably hesitant to participate in formal research. Given this history, research methodologies that emphasize higher levels of community participation in various aspects of the research process (e.g., community based participatory research; Minkler & Wallerstein, 2011) may be more successful at developing trust with, and participation in research endeavors.

Implications for Practice and Social Justice

Finally, study findings suggest a range of strategies for improving the mental health of LGBTQ survivors of intimate partner violence. The next section discusses implications of our findings for individual mental health practitioners and for social service agencies at a more structural level.

Implications for practitioners. Given that nearly half of this sample reported experiencing identity abuse in adulthood, it is likely that advocates, psychologists, psychiatrists, social workers, and mental health clinicians will work with a client who has experienced such abuse. However, in the absence of training on LGBTQ IPV generally and identity abuse specifically, service providers are likely underequipped to assist survivors to identify it as violence, or to provide services to address it. This could impair clinical decision making; failure to recognize identity abuse as a dimension of IPV could

mean a service provider doesn't make a referral to an appropriate IPV related resource, or invalidates a survivors' experience of abuse leading to a sense of alienation from the service system.

Discussion of identity abuse in the LGBTQ community should therefore be a central part of training for domestic violence advocates, practitioners who work with the LGBTQ community, and mental health clinicians more generally. Components of such training should include redefining IPV to include identity abuse as a central type of abuse and helping practitioners understand the importance of acknowledging identity abuse and its destructive consequences. In a similar vein, given our findings indicating that affirming support networks and affirmative LGBTQ identity may be critical to buffering the impact of identity abuse, practitioners should consider using interventions that bolster these individual strengths; such as discussing LGBTQ identity as part of their mental health treatment.

Implications for agencies. These findings also have implications for how broader social service agencies work with the LGBTQ community. These include implications for: 1) screening and assessment; 2) Leveraging affirmative LGBTQ identity into programming, and 3) Prevention programming.

With regard to screening and assessment, identity abuse items should become regular parts of any intake assessment that includes questions about physical and psychological abuse - both in domestic violence programs and in other clinical and social service settings (e.g., medical centers, university health centers). For example, initiatives currently in place in medical centers that ask patients whether they are currently experiencing abuse in their relationship could ask a follow up question such as, "Has

your partner ever used your sexual identity or gender identity against you?” with follow up prompts to assess for domains of outing, belittling identity, homo/bi/transphobic language and isolation. Such assessment could serve as an opportunity for interpersonal intervention and education about identity-based abuse.

At an organizational level, programs should examine the extent to which their organization is affirming of LGBTQ identities generally and as they intersect with other marginalized identities such as immigration status, race/ethnicity, class, and ability status. This could involve asking clients about what identities are most important to them, and incorporating this information into their work. Clinical training programs can work with students to better prepare them to have conversations about sexual identity, race, class, and gender within their clinical work. Organizations can prepare their staff to work with LGBTQ clients through formal organizational assessment and greater diversity training. Several authors have outlined suggestions for improving the LGBTQ-affirming nature of organizations (e.g. Helfrich & Simpson, 2006; The Joint Commission, 2011).

Finally, regarding prevention, efforts might borrow from the example of bystander education programs developed to address sexual assault. These programs work to educate and empower peers to intervene in preventing sexual violence and have been shown to effect long-term change in attitudes and behavior (Banyard, Moynihan, & Plante, 2007). Similarly, prevention efforts addressing identity abuse could focus on educating peers about how to speak up when witnessing hetero or cis-sexist microaggressions or identity abuse.

Summary and Conclusions

The Institute of Medicine ended their report on health disparities in the LGBTQ community by stating, “Lesbian, gay, bisexual, and transgender individuals have unique health experiences and needs, but as a nation, we do not know exactly what these experiences and needs are” (IOM, 2011, p. 4). This study represents a significant step toward illuminating one critical set of experiences and needs in the LGBTQ community, those related to identity abuse. This study consolidates and further substantiates previous theoretical and empirical work on identity abuse, demonstrating that it is distinct from other forms of psychological abuse, prevalent in the LGBTQ community, and associated with poorer mental health. Importantly, it also indicates affirmative LGBTQ identity can also be protective against the negative consequences of identity abuse. Taken together, these findings provide concrete next steps to close the health disparity gap for LGBTQ survivors and a compelling rationale for further study of identity abuse in the LGBTQ community.

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Zimet, G.D., Powell, S.S., Farley, S.W. & Berkoff, K.A.(1990). Psychometric characteristics of the multidimensional scale of perceived social support. *Journal of Personality Assessment*, 55(3-4), 610-617.

Figures

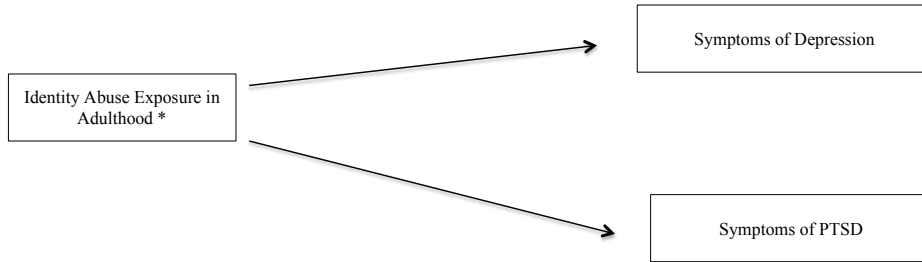


Figure 1. Model of hypotheses #2 and #3:

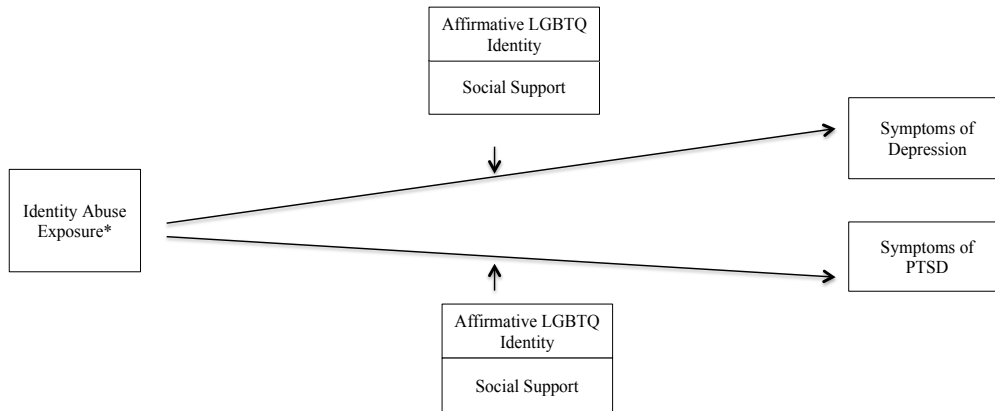


Figure 2. Model of hypothesis #4, #5, #6, #7:

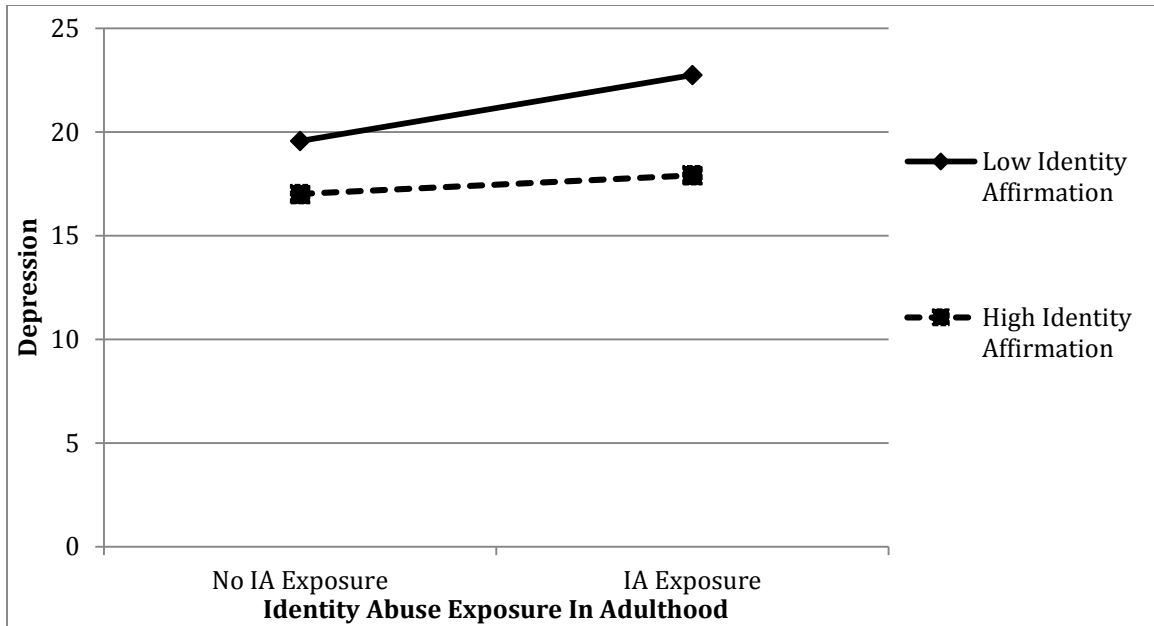


Figure 3. Hypothesis 4a Moderation Graph: LGBTQ identity affirmation (Lesbian, Gay and Bisexual Identity Scale: Identity Affirmation Subscale; Mohr & Kendra, 2011)

moderated the relationship between adult identity abuse exposure (Based of the identity abuse scale: 0 = no exposure; 1 = exposure) and symptoms of depression (CES-D;

Radloff, 1977) while holding demographic variables constant ($R^2 = .12$; $p < .01$).

Consistent with our hypothesis we found that adult identity abuse exposure predicted depression symptoms in the low-affirmation group ($\beta = .21$, $p < .01$) but not for those in the high identity affirmation group

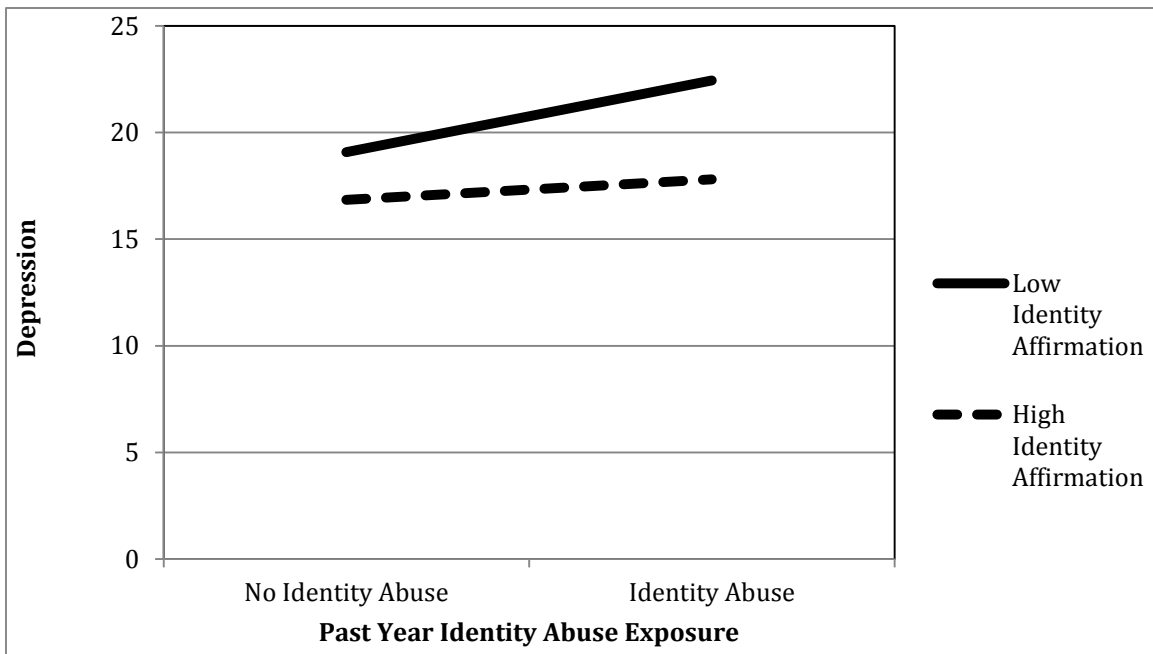


Figure 4. Hypothesis 4c Moderation Graph: LGBTQ identity affirmation (Lesbian, Gay and Bisexual Identity Scale: Identity Affirmation Subscale; Mohr & Kendra, 2011) moderated the relationship between past year identity abuse exposure (continuous variable, log transformed and then centered by creating a z score) and symptoms of depression (CES-D; Radloff, 1977) while holding demographic variables constant ($R^2 = .18$; $p < .01$). Consistent with our hypothesis we found that past year identity abuse exposure predicted depression symptoms in the low-affirmation group ($\beta = .27, p < .01$) and moderate affirmation groups ($\beta = .25, p < .01$) but not for those in the high affirmation group.

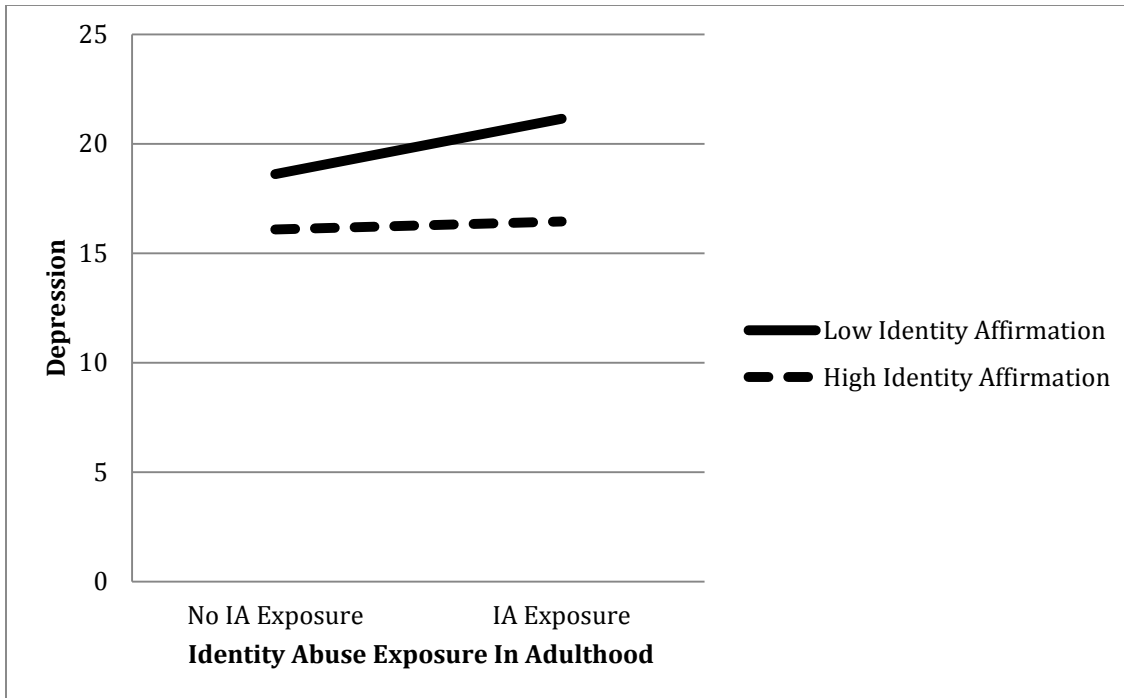


Figure 5. Hypothesis 5a Moderation Graph: LGBTQ identity affirmation (Lesbian, Gay and Bisexual Identity Scale: Identity Affirmation Subscale; Mohr & Kendra, 2011) moderates relationship between adult identity abuse exposure (7-item identity abuse scale: 0 = no exposure; 1 = exposure) and symptoms of depression (CES-D; Radloff, 1977) when controlling for adult exposure to physical (CTS2s; Straus & Douglas, 2004; 0 = no exposure 1 = exposure) and psychological violence (PMWI; Tolman, 1999; 0= no exposure 1= exposure) and demographic variables constant ($R^2 = .18$; $p < .01$). Consistent with our hypothesis we found that adult identity abuse exposure predicted depression symptoms in the low-affirmation group ($\beta = .19, p < .05$) and moderate affirmation groups ($\beta = .15, p < .05$) but not for those in the high affirmation group.

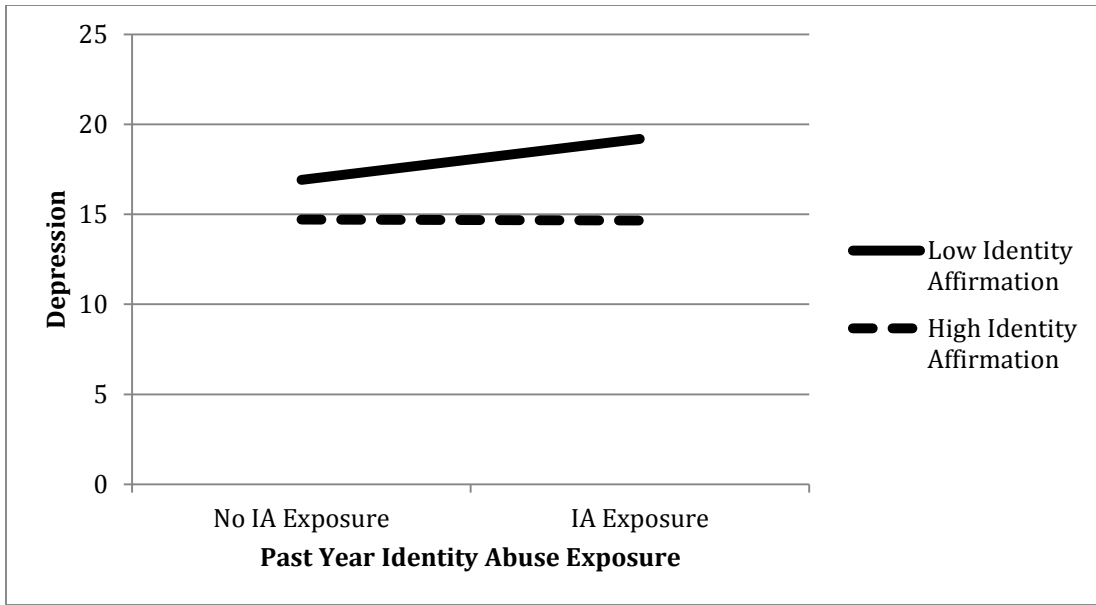


Figure 6. Hypothesis 5c Moderation Graph: LGBTQ identity affirmation (Lesbian, Gay and Bisexual Identity Scale: Identity Affirmation Subscale; Mohr & Kendra, 2011) moderates relationship between past year identity abuse exposure (7-item identity abuse scale, continuous past year variable, log transformed and z score centered) and symptoms of depression (CES-D; Radloff, 1977) when controlling for adult exposure to physical (CTS2s; Straus & Douglas, 2004; continuous past year variable, log transformed and z score centered) and psychological violence (PMWI; Tolman, 1999; continuous past year variable, log transformed and z score centered) and demographic variables constant ($R^2 = .19$; $p < .01$). Consistent with our hypothesis we found that past year identity abuse exposure predicted depression symptoms in the low-affirmation group ($\beta = .28, p < .01$) but not for those in the high affirmation group.

Significant	
Non-significant	
Dependent Variable	DV

Hypothesis	Sub-Hypothesis	Data Analysis
Hypothesis #1: Exposure to identity abuse will significantly differ across gender, sexual orientation, and race/ethnicity.	Hypothesis 1a. Adult identity abuse exposure will differ significantly across gender.	<ul style="list-style-type: none"> • Chi Square analysis • Odds ratios for post-hoc analyses
	Hypothesis 1b. Past year identity abuse exposure will differ significantly across gender.	<ul style="list-style-type: none"> • ANOVA analysis
	Hypothesis 1c. Adult identity abuse exposure will differ significantly across sexual orientation.	<ul style="list-style-type: none"> • Chi Square analysis • Odds ratios for post-hoc analyses
	Hypothesis 1d. Past year identity abuse exposure will differ significantly across sexual orientation.	<ul style="list-style-type: none"> • ANOVA analyses
	Hypothesis 1e. Adult identity abuse exposure will differ significantly across race.	<ul style="list-style-type: none"> • Chi Square analysis • Odds ratios for post-hoc analyses
	Hypothesis 1f. Past year identity abuse exposure will differ significantly across race.	<ul style="list-style-type: none"> • ANOVA analyses
Hypothesis #2: Exposure to identity abuse in adulthood will uniquely contribute to symptoms of depression and PTSD while controlling for demographic variables.	Hypothesis 2a: Adult identity abuse exposure will contribute uniquely to variance in depressive symptoms while holding demographic variables constant.	DV: Depression OLS multiple linear regression analysis steps: <ul style="list-style-type: none"> • Step one of the model: demographic variables. • Step two of the model: adult exposure to identity abuse •
	Hypothesis 2b: Adult identity abuse exposure will contribute uniquely to variance in PTSD symptoms while holding demographic	DV: PTSD OLS multiple linear regression analysis steps: <ul style="list-style-type: none"> • Step one of the model: demographic

	variables constant.	<p>variables.</p> <ul style="list-style-type: none"> • Step two of the model: adult exposure to identity abuse
	Hypothesis 2c: Past year identity abuse exposure will contribute uniquely to variance in depressive symptoms while holding demographic variables constant.	<p>DV: Depression</p> <p>OLS multiple linear regression analysis steps:</p> <ul style="list-style-type: none"> • Step one of the model: demographic variables. • Step two of the model: past year exposure to identity abuse
	Hypothesis 2d: Past year identity abuse exposure will contribute uniquely to variance in PTSD symptoms while holding demographic variables constant.	<p>DV: PTSD</p> <p>OLS multiple linear regression analysis steps:</p> <ul style="list-style-type: none"> • Step one of the model: demographic variables. • Step two of the model: past year exposure to identity abuse
Hypothesis #3: Exposure to identity abuse in adulthood will contribute uniquely to variance in symptoms of depression and PTSD while controlling for other forms of adult abuse exposure and demographic variables.	Hypothesis 3a: Adult identity abuse exposure will contribute uniquely to variance in depressive symptoms independent of adult exposure to physical/sexual assault and psychological abuse, respectively while holding demographic variables constant	<p>DV: Depression</p> <p>OLS multiple linear regression analysis steps:</p> <ul style="list-style-type: none"> • Step one of the model: demographic variables and adult exposure to physical and psychological violence variables. • Step two of the model: adult exposure to identity abuse
	Hypothesis 3b: Adult identity abuse exposure will contribute uniquely to variance in PTSD symptom scores independent of adult exposure to physical/sexual assault and psychological abuse respectively while holding demographic	<p>DV: PTSD</p> <p>OLS multiple linear regression analysis steps:</p> <ul style="list-style-type: none"> • Step one of the model: demographic variables and adult exposure to physical and psychological violence variables.

	variables constant.	<ul style="list-style-type: none"> • Step two of the model: adult exposure to identity abuse
	Hypothesis 3c: Past year identity abuse exposure will contribute uniquely to variance in depressive symptoms while holding demographic variables constant	<p>DV: Depression OLS multiple linear regression analysis steps:</p> <ul style="list-style-type: none"> • Step one of the model: demographic variables and past year exposure to physical and psychological violence variables. • Step two of the model: past year exposure to identity abuse
	Hypothesis 3d: Past year identity abuse exposure will contribute uniquely to variance in PTSD symptoms while holding demographic variables constant.	<p>DV: PTSD OLS multiple linear regression analysis steps:</p> <ul style="list-style-type: none"> • Step one of the model: demographic variables and past year exposure to physical and psychological violence variables. • Step two of the model: past year exposure to identity abuse
Hypothesis #4: Identity affirmation will moderate the relationship between identity abuse exposure and mental health outcomes while holding demographic variables constant	Hypothesis 4a: LGBTQ identity affirmation will moderate the relationship between adult identity abuse exposure and symptoms of depression while holding demographic variables constant.	<p>DV: Depression OLS multiple linear regression analysis steps:</p> <ul style="list-style-type: none"> • Step one of the model: demographic variables • Step two of the model: centered LGBTQ Identity affirmation score and centered adult

		<p>identity abuse exposure</p> <ul style="list-style-type: none"> • Step three: Moderator variable of LGBTQ identity affirmation X adult identity abuse exposure
	<p>Hypothesis 4b. LGBTQ identity affirmation will moderate the relationship between adult identity abuse exposure and symptoms of PTSD while holding demographic constant</p>	<p>DV: PTSD</p> <p>OLS multiple linear regression analysis steps:</p> <ul style="list-style-type: none"> • Step one of the model: demographic variables • Step two of the model: centered LGBTQ Identity affirmation score and centered adult identity abuse exposure • Step three: Moderator variable of LGBTQ identity affirmation X adult identity abuse exposure
	<p>Hypothesis 4c: LGBTQ identity affirmation will moderate the relationship between past year identity abuse exposure and symptoms of depression while holding demographic variables constant.</p>	<p>DV: Depression</p> <p>OLS multiple linear regression analysis steps:</p> <ul style="list-style-type: none"> • Step one of the model: demographic variables • Step two of the model: centered LGBTQ Identity affirmation score and centered past year identity abuse exposure • Step three: Moderator variable of LGBTQ identity affirmation X past year identity abuse exposure
	<p>Hypothesis 4d. LGBTQ</p>	<p>DV: PTSD</p>

	<p>identity affirmation will moderate the relationship between past year identity abuse exposure and symptoms of PTSD while holding demographic constant</p>	<p>OLS multiple linear regression analysis steps:</p> <ul style="list-style-type: none"> • Step one of the model: demographic variables • Step two of the model: centered LGBTQ Identity affirmation score and centered past year identity abuse exposure • Step three: Moderator variable of LGBTQ identity affirmation X past year identity abuse exposure
<p>Hypothesis #5: Identity affirmation will moderate the relationship between identity abuse exposure and mental health outcomes while holding demographic variables and exposure to other forms of violence constant.</p>	<p>Hypothesis 5a: LGBTQ identity affirmation will moderate the relationship between adult identity abuse exposure and symptoms of depression while holding demographic variables & other forms of violence exposure constant.</p>	<p>DV: Depression OLS multiple linear regression analysis steps:</p> <ul style="list-style-type: none"> • Step one of the model: demographic variables and adult physical and psychological abuse variables • Step two of the model: centered LGBTQ Identity affirmation score and centered adult identity abuse exposure • Step three: Moderator variable of LGBTQ identity affirmation X adult identity abuse exposure
	<p>Hypothesis 5b. LGBTQ identity affirmation will moderate the relationship between adult identity abuse exposure and symptoms of PTSD while holding demographic variables & other forms of</p>	<p>DV: PTSD OLS multiple linear regression analysis steps:</p> <ul style="list-style-type: none"> • Step one of the model: demographic variables and adult physical and psychological abuse

	violence exposure constant.	<p>variables</p> <ul style="list-style-type: none"> • Step two of the model: centered LGBTQ Identity affirmation score and centered adult identity abuse exposure • Step three: Moderator variable of LGBTQ identity affirmation X adult identity abuse exposure
	Hypothesis 5c: LGBTQ identity affirmation will moderate the relationship between past year identity abuse exposure and symptoms of depression while holding demographic variables & other forms of violence exposure constant.	<p>DV: Depression</p> <p>OLS multiple linear regression analysis steps:</p> <ul style="list-style-type: none"> • Step one of the model: demographic variables and past year physical and psychological abuse exposure • Step two of the model: centered LGBTQ Identity affirmation score and centered past year identity abuse exposure • Step three: Moderator variable of LGBTQ identity affirmation X past year identity abuse exposure
	Hypothesis 5d. LGBTQ identity affirmation will moderate the relationship between past year identity abuse exposure and symptoms of PTSD while holding demographic variables & other forms of violence exposure constant.	<p>DV: PTSD</p> <p>OLS multiple linear regression analysis steps:</p> <ul style="list-style-type: none"> • Step one of the model: demographic variables and past year physical and psychological abuse exposure • Step two of the model: centered LGBTQ Identity

		affirmation score and centered past year identity abuse exposure <ul style="list-style-type: none">• Step three: Moderator variable of LGBTQ identity affirmation X past year identity abuse exposure
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Figure 7. Summary of dissertation hypotheses

Tables

Table 1

Sample Demographics

	Participants Included (n = 734)
Age (n=733)	33.49
Gender (n= 733)	
Man	27.4%
Woman	53.1%
Transgender/ Non-binary	19.4%
Race/Ethnicity (n=734)	
White	78.5%
People of Color	15.9%
Other	5.6%
Sexual Orientation (n= 734)	
Bisexual	13.6%
Gay	23.6%
Lesbian	22.8%
Queer/Pansexual	39.2%
Highest Level of Education (n= 734)	
Some High School, high school or GED	15.5%
Bachelors or Associates Degree	38.1%
Master's Degree	30.1%
Doctoral/professional degree or Higher	16.2%
Geographic Location (n=733)	
Midwestern U.S.	16.9%
Northeastern U.S.	33%
West and Northwestern U.S.	26.3%
Southern and Southwestern U.S.	18.7%
Other (other U.S. Territory, International)	5%

Table 2

Study Measures

Descriptive Statistics										
	N	Range	Min	Max	Mean	SD	Variance	Reliability	Skew	Kurtosis
Conflict Tactics Scale (CTS2) –Past Year	734	33	0	33	.57	2.09	4.356	.89	7.95	94.51
CTS2 Log Transformed	734	1.53	0	1.53	.078	.23	.05		3.08	9.27
Conflict Tactics Scale- (CTS2)- Adulthood	734	1	0	1	.39	.49	.24		.47	-1.79
Psychological Abuse (PMWI)- Past Year	733	69	0	69	7.23	12.85	168.55	.87	2.46	6.38
PMWI Log Transformed	733	1.85	0	1.85	.50	.58	.34		.69	-.996
Psychological Abuse (PMWI) - Adulthood	733	1	0	1	.77	.42	.18		-1.26	-.40
Identity Abuse (IA)- Past Year	741	36	0	36	.94	3.41	11.63	.80	5.86	41.17
IA Log Transformed.	734	1.57	0	1.57	.11	.29	.08		2.7	6.95
Identity Abuse (IA) – Adulthood	734	1	0	1	.40	.49	.24		.41	-1.84
Center for Epidemiological Studies Depression Scale, Revised (CESD-R)-Total score	730	80	0	80	17.04	14.37	206.38	.95	1.21	1.46
PTSD Checklist Civilian Version (PCL-C) Total	732	51	17	68	29.15	10.44	108.99	.92	1.08	.78
Identity Scale: Affirmation	723	5	1	6	5.02	1.02	1.03	.88	-1.16	1.48

Table 3

Inter-Correlations of Variables of Interest

1	Past year physical abuse								
2	Adult physical abuse	.32**							
3	Past year psych. abuse	.39**	.24**						
4	Adult psych. Abuse	.08*	.34**	.31**					
5	Past year identity abuse	.44**	.20**	.57**	.13**				
6	Adult identity abuse	.11**	.40**	.24**	.33**	.34**			
7	Depression	.18*	.19**	.21**	.07	.23**	.20**		
8	PTSD	.18**	.2**	.29**	.16**	.30**	.23**	.79**	
9	LGBTQ Identity	-.05	-.03	-.02	-.003	-.06	-.04	-.12**	-.09*

* $p < .05$. ** $p < .01$.

Variables as measured by:

1. The 6-item short form of the Revised Conflict Tactics Scale (CTS2S; Straus & Douglas, 2004)
2. The Revised Conflict Tactics Scale dichotomized into adult exposure/no exposure
3. The 14-item Psychological Maltreatment of Women Inventory (PMWI; Tolman, 1999).
4. The Psychological Maltreatment of Women Inventory dichotomized into adult exposure/no exposure
5. The 7-item Identity Abuse Scale
6. The Identity Abuse Scale dichotomized into adult exposure/no exposure
7. The 20-item Center for Epidemiological Studies Scale of Depression (CES-D) (CES-D; Radloff, 1977))
8. The 17-item PTSD Checklist Civilian Version (PCL-C; Blanchard, Jones-Alexander, Buckley, & Forneris, 1996).
9. The 8-item Lesbian Gay and Bisexual Identity Scale: Identity Affirmation Subscale (Mohr & Kendra, 2011).

Table 4

Hypothesis 2a & b: Adult identity abuse in adulthood and depression and PTSD w/o other forms of violence

	Depression		PTSD	
	R^2	β	R^2	β
Step 1	.13**		.08**	
Age		-.11**		-.04
Race		-.03		.03
Lesbian		.05		-.01
Bisexual		.02		.01
Queer		.13		.04
Education level		.20**		.20**
Women		.01		.08
Transgender		.14*		.15*
Step 2	.15**		.11**	
Adult Identity Abuse		.14**		.18**
N	706			

Note. The following variables were dichotomously coded: race (white =0 POC =1); education (more than GED = 0; GED or below =1). Gender was dummy coded using the male as the comparison group. Sexual orientation was coded using gay as the comparison group. Age was left as a continuous variable.

* $p < .05$. ** $p < .01$.

Table 5

Hypothesis 2c & 2d. *Identity abuse in the past year and depression and PTSD w/o other forms of violence*

	Depression		PTSD	
	R^2	β	R^2	β
Step 1	.13**		.08**	
Age		-.11**		-.04
Race		-.03		.03
Lesbian		.05		.00
Bisexual		.03		.02
Queer		.15*		.07
Education level		.19**		.18**
Women		.02		.08
Transgender		.14*		.14*
Step 2	.15**		.14**	
Past Year Identity Abuse		.16**		.23**
N	706			

Note. The following variables were dichotomously coded: race (white =0 POC =1); education (more than GED = 0; GED or below =1). Gender was dummy coded using the male as the comparison group. Sexual orientation was coded using gay as the comparison group. Age was left as a continuous variable.

* $p < .05$. ** $p < .01$.

Table 6

Hypothesis 3a,b Identity abuse in adulthood and depression and PTSD w/o other forms of violence

	Depression		PTSD	
	R^2	β	R^2	β
Step 1	.15**		.13**	
Age		-.11**		-.04
Race		-.03		.02
Lesbian		.04		-.03
Bisexual		.02		.00
Queer		.11		.02
Education level		.20**		.19**
Woman		.02		.09
Transgender		.14**		.15
Adult phys. abuse		.11**		.14**
Adult psych. abuse		-.01		.07
Step 2	.16**		.14**	
Adult identity abuse		.10**		.11**
N	706			

Note. The following variables were dichotomously coded: race (white =0 POC =1); education (more than GED = 0; GED or below =1). Gender was dummy coded using the male as the comparison group. Sexual orientation was coded using gay as the comparison group. Age was left as a continuous variable.

* $p < .05$. ** $p < .01$.

Table 7: Hypothesis 3c &d: *Identity abuse in the past year and depression and PTSD w/o other forms of violence*

	Depression		PTSD	
	R^2	β	R^2	β
Step 1	.16**		.14**	
Age		-.10*		-.02
Race		-.02		.03
Lesbian		.03		-.02
Bisexual		.02		.01
Queer		.13*		.06
Education level		.20**		.19**
Woman		.04		.11
Transgender		.15**		.15**
Past Year phys. abuse		.08*		.07
Past year psych abuse		.09*		.14**
Step 2	.17**		.16**	
Past year identity abuse		.09*		.14**
N	706			

Note. The following variables were dichotomously coded: race (white =0 POC =1); education (more than GED = 0; GED or below =1). Gender was dummy coded using the male as the comparison group. Sexual orientation was coded using gay as the comparison group. Age was left as a continuous variable.

* $p < .05$. ** $p < .01$.

Table 8

Hypothesis 4a: Moderation of identity affirmation between adult exposure to identity abuse exposure and symptoms of depression.

	Depression	
	R^2	β
Step 1	.13**	
Age		-.12**
Race		-.04
Lesbian		.05
Bisexual		.01
Queer		.12
Education level		.19**
Woman		.01
Transgender		.15**
Step 2	.16**	
LGBTQ identity		-.10**
Adult identity abuse		.13**
Step 3	.16**	
LGBTQ Identity X Adult identity abuse		-.07*
N	699	

Note. The following variables were dichotomously coded: race (white =0 POC =1); education (more than GED = 0; GED or below =1). Gender was dummy coded using the male as the comparison group. Sexual orientation was coded using gay as the comparison group. Age was left as a continuous variable.

* $p < .05$. ** $p < .01$.

Table 9

Hypothesis 4c: Moderation of identity affirmation between past year exposure to identity abuse exposure and symptoms of depression.

	Depression	
	R^2	β
Step 1	.13**	
Age		-.12**
Race		-.03
Lesbian		.06
Bisexual		.02
Queer		.14*
Education level		.19**
Woman		.02
Transgender		.15**
Step 2	.16**	
LGBTQ identity		-.09*
Past year identity abuse		.14**
Step 3	.17**	
LGBTQ identity X Past year identity abuse		-.09*
N	696	

Note. The following variables were dichotomously coded: race (white =0 POC =1); education (more than GED = 0; GED or below =1). Gender was dummy coded using the male as the comparison group. Sexual orientation was coded using gay as the comparison group. Age was left as a continuous variable.

* $p < .05$. ** $p < .01$.

Table 10

Hypothesis 5a: *Identity Affirmation moderating the relationship between identity abuse exposure in adulthood and depression; controlling for exposure to physical and psych abuse.*

	Depression	
	R^2	β
	.15**	
Step 1		
Age		-.12**
Race		-.04
Lesbian		.04
Bisexual		.01
Queer		.11
Education level		.19**
Woman		.02
Transgender		.15**
Adult phys. Abuse		.10**
Adult psych. Abuse		-.01
Step 2	.16**	
LGBTQ identity		-.10**
Adult identity abuse		.09*
Step 3	.17*	
LGBTQ identity * Adult identity abuse		-.07*
N	704	

Note. The following variables were dichotomously coded: race (white =0 POC =1); education (more than GED = 0; GED or below =1). Gender was dummy coded using the male as the comparison group. Sexual orientation was coded using gay as the comparison group. Age was left as a continuous variable.

* $p < .05$. ** $p < .01$.

Table 11

Hypothesis 5c: Identity Affirmation moderating the relationship between identity abuse exposure in the past year and depression; controlling for exposure to physical and psych abuse.

	Depression	
	R^2	β
Step 1	.16**	
Age		-.11**
Race		-.03
Lesbian		.04
Bisexual		.02
Queer		.12
Education level		.19 **
Woman		.04
Transgender		.16**
Past Year phys. abuse		.08*
Past year psych abuse		.09*
Step 2	.18**	
LGBTQ identity		-.09*
Past year identity abuse		.07
Step 3	.18**	
LGBTQ identity * Past year identity abuse		-.09*
N	704	

Note. The following variables were dichotomously coded: race (white =0 POC =1); education (more than GED = 0; GED or below =1). Gender was dummy coded using the male as the comparison group. Sexual orientation was coded using gay as the comparison group. Age was left as a continuous variable.

* $p < .05$. ** $p < .01$.

Table 12

Identity Abuse Measure Factor Loadings Using Principal Axis Factoring

Identity Abuse Scale Item	Factor 1
Item 6: The person called me pejorative names that have to do with my LGBTQ status.	.77
Item 5: The person told me I deserve what I get because of my sexual orientation or gender identity.	.77
Item 1: The person threatened to tell my employer, family, or others about my sexual orientation or gender identity.	.68
Item 3: The person used my sexual orientation or gender identity against me.	.67
Item 7: The person prevented me from seeking support within the LGBTQ community.	.56
Item 2: The person forced me to show physical or sexual affection in public, even though I didn't want to.	.53
Item 4: The person questioned whether my sexual orientation or gender identity was 'real'	.52

N = 734

Table 13

Identity Abuse Item Frequencies

	% Past Year Exposure (n=734)	% Adult Exposure (n =734)
Item 1: The person threatened to tell my employer, family, or others about my sexual orientation or gender identity.	1.9%	6.3%
Item 2: The person forced me to show physical or sexual affection in public, even though I didn't want to.	4.5%	12.8%
Item 3: The person used my sexual orientation or gender identity against me.	6.7%	17.7%
Item 4: The person questioned whether my sexual orientation or gender identity was 'real'	11.4%	28.3%
Item 5: The person told me I deserve what I get because of my sexual orientation or gender identity.	3%	8.2%
Item 6: The person called me pejorative names that have to do with my LGBTQ status.	3.5%	10.9%
Item 7: The person prevented me from seeking support within the LGBTQ community.	4.2%	9.9%
Total % with any exposure	16.8%	40.1%

Appendices

Appendix A

Recruitment Materials

Recruitment Websites and Group Listservs

API PFLAG NYC

Consortium of Higher Education Lesbian Gay Bisexual Transgender Resource Professionals!

Polytechnic Institute of New York University, Brooklyn LGBTQ Student Center
"The List"/Queer Exchange

Adodi National

Affinity Community Services

Afrekete Alumnae and Allies of Spelman's Lesbian and Bisexual Community

African American Office of Gay Coalitions

African American Office of Gay Concerns a Center for HIV/AIDS Testing, Prevention & Resources...

African Asian Latin Lesbians United

Aids Services in Asian Communities

ALMA: Association of Latinos Motivating for Action

Amherst College

Amigos Latinos

Anna Maria College

API Equality

API family pride

API pride council

Amplified ASU--Alabama State LGBT

Asian Pacific Islander Community AIDS project (APICAP)

Asian Pacific Islander Queer Sisters

Asian Pacific Islanders for Human Rights

Asian Women's Shelter

Assal East Coast

Association for Latino Men of Action

Auburn Gay and Lesbian Association

Auburn GLB Caucus

Audre Lorde Project

Autostraddle (FB)

Babson College

Barangay

Bard College at Simon's Rock

Bay Area American Indian Two Spirits

Bay State College

BC GLC

Becker College
Bentley University
Berkeley City College GSA
Berklee College of Music
Berkshire Community College
Bien Estar
Bisexual Resource Center listserv
Bisexual Women of Color BIWOC (FB)
Black Femmes Talking (FB Group)
Black Men's Initiative
Blackstripe Magazine
Boston Architectural College
Boston College Counseling Listserv
Boston College Graduate Pride Alliance Listserv
Boston College School of Social Work Spectrum Listserv
Boston Conservatory
Boston Graduate School of Psychoanalysis
Boston Latino Pride
Boston MASALA
Boston University
Brandeis University
Bridgewater State University
Bristol Community College
Brooklyn Boihood (New York Based gender non-conformative educational supportive social group)
Bunker Hill Community College
California State Long Beach LGBT Center
Cambridge College
Camille Beredjick; @cberedjick author of <https://www.facebook.com/GayWrites>
Campus Pride
Campus Pride
Carleton College
Carls in Boston Facebook
Casa Ruby LGBT Community Center
Cascades Rainbow Center
Case Western Reserve LGBT Center
Celebrate Sisterhood
City College of San Francisco LGBTQ Studies
Clark Atlanta University
Clark University
Coalition for Justice & Respect
Color Coordination
Columbia Queer Alliance
Consortium of Higher Education LGBTQ Professionals
Craigslist

Curry College
Dallas Gay & Lesbian Alliance
DC LGBT Black Center FB Page
DC LGBT Center
DC LGBT Latino Center FB Page
Dear Asian Pacific Lesbian Bisexual Transgender Network
Diversity Center
Diversity Center of Santa Cruz-Conexiones Group
Diversity Center of Santa Cruz-Genera
Dragonflies of Dallas
Duke QPOC group
East Carolina University LGBT Resource Center
Elixher
Emerson College
Emmanuel College
Entre Hermanos
Equality Forum
Fierce NYC Staff
Fire and Ink
Fitchburg State University
FORGE
Framingham State University
Fuerza Latino institute
Gala Choruses
Galai Queer Latino group of Philly
Gay and Lesbian Arabic Society
Gay Asian & Pacific Islander Men of NY
Gay Asian Support Network Staff
gayasian subreddit
GLSEN
GSA at Alameda College
GSA at the College of San Mateo
GSA Network Staff
Hampshire College
Harlem One Stop NYC
Harlem Pride
Harvard University
HGBC
Hispanic Black Gay Coalition
Hispanic Coalition of NY
Holyoke Community College
Howard University-- OUTLAW
<http://queerandpresentdanger.tumblr.com/>
<http://www.reddit.com/r/lgbt>
<https://www.facebook.com/survivorspathwaycenter?fref=ts>

If you can feel it you can speak it' GLBT of color spoken word group
In the Life Atlanta
Indiana Black Pride
Ingersoll Center
Jewish LGBT Network
Karibu House
Kick
KICK: the agency for LGBT African Americans
Lasell College
Latino Equality Alliance
Latino GBLT History Project
Latino Pride Center
Latino Services @ San Diego LGBT Community Center
Latino USA
Lazeeza: Arab Lesbians Online
Lesley University
LGBT Aging Center
LGBT Faith Leaders of African Descent
LGBT Latino Forum of OUT Boulder
LGBTQ People of Color Film Festival
LGBTQA Center at North Carolina University
Los Angeles City College Spectrum Alliance
LYRIC
Mangos with Chili
Maranatha: Riversiders for LGBT Concerns
Mass Asian and Pacific Islanders
Massachusetts College of Art and Design
Massachusetts College of Liberal Arts
Massachusetts Institute of Technology
Massachusetts School of Law
Massachusetts School of Professional Psychology
Massasoit Community College
Metropolitan Hospital Comprehensive LGBT Health Centre
MGH Institute of Health Professions
Milwaukee LGBTQ Center Facebook Page
Mocha
Montclair State University QPOC group
Montserrat College of Art
Mount Holyoke College
Mount Ida College
Muslims for Progressive Values
National Black Gay Men's Advocacy Network
National Aids Education Services
National Black Justice Coalition
National Black Justice Coalition

National Center for Transgender Equality
National Coalition for LGBT Health
National Gay and Lesbian Task Force
National Queer Asian Pacific Islander Alliance
Network LaRed
Network on Religion and Justice for API people
New England School of Law
New York City Anti Violence Project
Nivneh: The Alliance for LGBTQ jewish youth and allies
Northeastern University
Northern Essex Community College
Northwest LGBT access
O-Musubi
OASIS (Older Asian Sisters in Solidarity)
Our Lives Madison Facebook
OUTreach Resource Center
PFLAG Northern California Chinese Chapter
Philadelphia Black Pride
Pomona QPOC group
Portland Gay Latino Pride
Portland Q Center
Pridelines Youth Services
Pro Latino de San Jose
Professional Queer Women of Color PWQOC (Boston based)
Provincetown Women of color Weekend Group FB
Purple Moon dance project
QAPA
QPOC at Sarah Lawrence
QPOC at University of Washington-Seattle
QPOC Liberation Project
QPOC United
Queer and Asian (Q&A) at San Jose State University (SJSU)
Queer and Asian Services
Queer Asian Spirit NYC
Queer Asians at the University of Michigan
Queer Association of Asian & Pacific Islanders
Queer Muslims of Boston
Quincy College
QWOC Boston
QWOC MAP
Race forward
Raices Latino Pride
Rainbow Center Olympia
Regis College
Rivers at Rehoboth

Roxbury Community College
Rutgers LGBT Center
Saheli Boston
Salem State University
Salt Lake Community College LGBT Center
San Francisco Gay Men's Chorus (SFGMC)
Sankofa Way Spiritual Services
Sarbat: Sikh LGBT Group
Satany Staff
Satrang
SF LGBTQ Center
SFSU Queer Resource Center
SGV API PFLAG
Shades of yellow
Simmons College
Singaporean and Malaysian Bisexual and Lesbians
Smith College
Somos Familia
Somos Latinos
Song that Radio Staff
Soulful Salon Staff
Southerners On New Ground
Southwest Asian and North African Bay Area Queers
SSSS Talk
Stonewall Seniors
Suffolk University
Sylvia Rivera Law Project
Texas A&M GLBT Resource Center
Texas Southern University Gay and Lesbian African American Student Society
The Brookline Center Staff Email (ask Laura)
The Community Center Boise
The Northwest Network
The Welcoming Committee
Trans women of color collective
Tufts University
Two Spirit Press Room Staff
UC Davis LGBTQ Center
UC Riverside Names & Neighbors
UC Santa Cruz LGBT Student group
UCBerkley QPOC groups
UCLA LGBTQ Student Groups
Unid@s: National Latin@ Human Rights Organization
Unity Coalition
University of California-San Francisco
University of Illinois at Chicago Queer Resource Center

University of Manoa
University of Maryland College Park LGBT equity center
University of Massachusetts Amherst
University of Massachusetts Boston
University of Massachusetts Dartmouth
University of Massachusetts Lowell
University of Massachusetts Medical School
University of Minnesota LGBTQ center
University of Missouri QPOC group
University of Pennsylvania QPOC group
University of Southern California QPOC
University of Tampa
University of Texas El Paso LGBT Alumni Network
University of Texas Pan American
University of Vermont QPOC group
University of Washington LGBT groups
Urban College of Boston
USC POC student group
USC QPOC group
UW Madison
Wellesley College
Wheelock College
World Pride and Power
WPATH
Yale LGBTQ Center
Zami
Zuna Institute
API Equality-LA
Asian & Pacific Islander LGBT Pride
API pride Portland
Asian and Pacific Islander Roundtable through CLGS
Rutgers Quee & Asian Group
Out POC PAC
Clergy caucus on the network on religion and justice for API LGBT Persons
Trikone Bay Area
HONOR Pac
Ambiente Magazine
University of Hawaii West Oahu GSA
Caltech Prism Staff

Advertisement for Websites:

I am a doctoral student conducting an online study on relationships in the LGBTQ community with the goal of improving counseling and support services for our community. I would like to request your permission to forward the below study announcement to members of your listserv/forum. **To express our gratitude for their participation, we will offer respondents the opportunity to enter a lottery to win one of five \$25 Amazon gift cards.** The study has been approved by the Boston College Institutional Review Board and is supervised by Dr. Lisa Goodman, a faculty member in the Counseling Psychology Program. I would greatly appreciate your help with this study and consequent contribution to the wellbeing of the LGBTQ community.

Letter for Online Moderators of Forums/Listservs:

Dear Group/Listserv Administrator,

I am a doctoral student conducting an online study on relationships in the LGBTQ community with the goal of improving counseling and support services for our community. I would like to request your permission to forward the below study announcement to members of your listerv/forum. **To express our gratitude for their participation, we will offer respondents the opportunity to enter a lottery to win one of five \$25 Amazon gift cards.** The study has been approved by the Boston College Institutional Review Board and is supervised by Dr. Lisa Goodman, a faculty member in the Counseling Psychology Program. I would greatly appreciate your help with this study and consequent contribution to the wellbeing of the LGBTQ community. Please feel free to pass this announcement on to other people who might be interested in participating Thank you very much for considering my request

Appendix B Survey Items

1/10/2016

Qualtrics Survey Software

Block 7

Raffle Information

Thank you for participating in the study. We greatly appreciate your time and your commitment to advancing LGBTQ individuals' well-being and resilience.

Please complete the below information in order to be entered to win one of five \$25 Amazon Gift Cards. What is your email address?

Getting to Know You

Please enter your current age in years

What is your current gender identity? (Check all that apply)

- Male
- Female
- Transgender
- Non-binary (e.g., genderqueer, agender)
- You don't have an option that describes my gender (please specify)

What is the highest level of education you have completed?

- Some high school
- High school degree or equivalent (GED)
- Associates degree
- Bachelor's degree
- Master's degree
- Doctoral/ professional degree or higher

How would you describe your current geographic location?

- Midwestern U.S.
- Northeastern U.S.
- Northwestern U.S.
- Southern U.S.
- Southwestern U.S.
- Western U.S.
- Other U.S. Territory
- International, Non-U.S. Territory

How would you describe your racial/ethnic identity (Check all that apply)

- Black or African American/Afro-Caribbean American
- Asian/Asian American or Pacific Islander
- Biracial or Multiracial (please specify):
- Hispanic, Latino/a
- Middle Eastern/Arab or Arab-American
- First Nation, Native American, American Indian, or Alaska Native
- White (non-Hispanic)
- You don't have an option that describes my racial/ethnic identity (please specify):

How would you describe your sexual orientation? (Check all that apply)

- Bisexual
- Pansexual
- Gay
- Heterosexual/Straight
- Lesbian
- Queer
- Asexual
- You don't have an option that describes my sexual orientation (please specify)

How You Feel

Please read each statement below and answer how often you felt this way during the **past two weeks**.

	Rarely or none of the time	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)	Nearly every day for two weeks
My appetite was poor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I could not shake off the blues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I had trouble keeping my mind on what I was doing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt depressed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My sleep was restless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt sad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I could not get going	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Rarely or none of the time	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)	Nearly every day for two weeks
Nothing made me happy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt like a bad person	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I lost interest in my usual activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I slept more than usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt like I was moving too slowly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt fidgety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I wished I were dead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Rarely or none of the time	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)	Nearly every day for two weeks
I wanted to hurt myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was tired all the time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I did not like myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I lost a lot of weight without trying to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I had a lot of trouble getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I could not focus on the important things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Rarely or none of the time	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)	Nearly every day for two weeks

of the time 2 days) (3-4 days) days) weeks

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences.

Please read each one carefully, and mark the box that best indicates how much you have been bothered by that problem in the **past two weeks**.

	Not at all	A little	Moderately	Quite a bit
Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful experience from the past?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repeated, disturbing <i>dreams</i> of a stressful experience from the past?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it?)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling very upset when something reminded you of a stressful experience from the past?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Not at all	A little	Moderately	Quite a bit
Avoid activities or situations because they remind you of a stressful experience from the past?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble remembering important parts of a stressful experience from the past?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of interest in things that you used to enjoy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling distant or cut off from other people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling emotionally numb or being unable to have	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

loving feelings for those close to you?

Feeling as if your future will somehow be cut short?

Not at all

A little

Moderately

Quite a bit

Trouble falling or staying asleep?

Feeling irritable or having angry outbursts?

Having difficulty concentrating?

Being on "super alert" or watchful on guard?

Feeling jumpy or easily startled?

Not at all

A little

Moderately

Quite a bit

Relationship Status Questions

The following set of questions asks about your experiences in intimate relationships. For the purpose of this study, intimate relationships could include casual romantic or sexual relationships, dating relationships, partnerships, and/or marriages.

1. Have you been in an intimate relationship in the last year?

Yes

No

If you have been in a relationship in **the past year**, what is your current relationship status?

Single (not dating)

Dating

Exclusive monogamous relationship (not living together)

Exclusive monogamous relationship (living with partner)

Open relationship (not living together)

Open relationship (living with a primary partner)

Married with no legal recognition/status

Married with legal recognition status (registered domestic partnership, civil union, civil marriage)

Separated/Divorced

Other

If no, have you ever been in an intimate relationship?

- Yes, I have been in an intimate relationship
- I have never been in an intimate relationship

How long did this relationship last?

How long ago was your last intimate relationship?

What best describes your last intimate relationship?

- Single
- Dating
- Exclusive monogamous relationship (not living together)
- Exclusive monogamous relationship (living with partner)
- Open relationship (not living together)
- Open relationship (living with a primary partner)
- Married with no legal recognition/status
- Married with legal recognition status (registered domestic partnership, civil union, civil marriage)
- Separated/Divorced
- Other

Your Relationships

Below is a list of things that you may have experienced in the last twelve months in an intimate relationship.

For the purpose of this study, intimate relationships could include casual romantic or sexual relationships, dating relationships, partnerships, and/or marriages.

If you have experienced some of these behaviors **since turning 18, but not in the last year**, mark “Not in the past year, but it did happen”. If it **never** happened, mark “This has never happened”.

Once in the past	Twice in the past	3-5 times in the past	6-10 times in the past	11-20 times in the past	More than 20 times in the past	Not in the past year, but it did	This has never
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	year	year	year	year	year	year	happen	happened
I had a sprain, bruise, or small cut, or felt pain the next day because of a fight with the person.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person pushed shoved or slapped me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person punched or kicked or beat me up.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I went to see a doctor (M.D.) or needed to see a doctor because of a fight with this person	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person used force (like hitting, holding down, or using a weapon) to make me have sex.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person insisted on sex when I did not want to or insisted on sex without a condom (but did not use physical force)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Below is a list of things that you may have experienced in the last twelve months in an intimate relationship.

For the purpose of this study, intimate relationships could include casual romantic or sexual relationships, dating relationships, partnerships, and/or marriages.

If you have experienced some of these behaviors **since turning 18, but not in the last year**, mark “Not in the past year, but it did happen”. If it **never** happened, mark “This has never happened”.

	Once in the past year	Twice in the past year	3-5 times in the past year	6-10 times in the past year	11-20 times in the past year	More than 20 times in the past year	Not in the past year, but it did happen	This has never happened
The person called me names.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person swore at me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person yelled and screamed at me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person treated me like an inferior.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person monitored my time and made me account for my whereabouts.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

More Not in

	Once in the past year	Twice in the past year	3-5 times in the past year	6-10 times in the past year	11-20 times in the past year	than 20 times in the past year	the past year, but it did happen	This has never happened
The person used our money or made important financial decisions without talking to me about it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person was jealous or suspicious of my friends.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person accused me of having an affair.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person interfered in my relationships with other family members.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person tried to keep me from doing things to help myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Once in the past year	Twice in the past year	3-5 times in the past year	6-10 times in the past year	11-20 times in the past year	More than 20 times in the past year	Not in the past year, but it did happen	This has never happened
The person restricted my use of the telephone.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person told me my feelings were irrational or crazy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person blamed me for their problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person tried to make me feel crazy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Once in the past year	Twice in the past year	3-5 times in the past year	6-10 times in the past year	11-20 times in the past year	More than 20 times in the past year	Not in the past year, but it did happen	This has never happened

Below is a list of things that you may have experienced in the last twelve months in an intimate relationship.

For the purpose of this study, intimate relationships could include casual romantic or sexual relationships, dating relationships, partnerships, and/or marriages.

If you have experienced some of these behaviors **since turning 18, but not in the last year**, mark “Not in the past year, but it did happen”. If it **never** happened, mark “This has never happened”.

	3-5	6-10	11-20	More than 20	Not in the past
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Once in the past year	Twice in the past year	times in the past year	times in the past year	times in the past year	times in the past year	year, but it did happen	This has never happened
The person threatened to tell my employer, family or others about my sexual orientation or gender identity.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person forced me to show physical or sexual affection in public, even though I didn't want to.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person used my sexual orientation or gender identity against me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person questioned whether my sexual orientation or gender identity was 'real'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person told me I deserve what I get because of my sexual orientation or gender identity.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person called me pejorative names that have to do with my LGBTQ status (e.g., "fag", "dyke", "tranny").	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person prevented me from seeking support within the LGBTQ community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Besides those hurtful experiences that you just reported in the context of an intimate relationship, below is a list of hurtful experiences that you may have experienced **over the course of your lifetime** as an LGBTQ person. Read each statement, and respond whether:

- This has NEVER happened to you
- This has happened ONCE IN A WHILE
- This has happened SOMETIMES
- This has happened OFTEN

	This has NEVER happened to you	This has happened ONCE IN A WHILE	This has happened SOMETIMES	This has happened OFTEN
Have you been treated unfairly in your family by <u>someone other than an intimate partner</u> because you are LGBTQ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you been called a name like dyke, lezzie, faggot, sissy, Tranny or other names by someone other than an intimate partner?

Have you been made fun of, picked on, pushed, shoved, hit, or threatened by someone other than an intimate partner because you are LGBTQ?

Have you been rejected by family members other than an intimate partner because you are LGBTQ?

Have you been rejected by friends because you are LGBTQ?

This has NEVER happened to you This has happened ONCE IN A WHILE This has happened SOMETIMES This has happened OFTEN

Have you heard anti-LGBTQ remarks from family members other than an intimate partner?

Have you been verbally insulted by someone other than an intimate partner because you are LGBTQ?

Have you been treated unfairly by teachers or employers because you are LGBTQ?

Have you been treated unfairly by people in service positions or strangers because you are LGBTQ?

Have you been treated unfairly by people in helping jobs (by doctors, nurses, psychiatrists, caseworks, dentists, school counselors, therapists, pediatricians, school principals, gynecologists and others) because you are LGBTQ?

This has NEVER happened This has happened ONCE IN A WHILE This has happened SOMETIMES This has happened OFTEN

happened to you WHILE SOMETIMES OFTEN

Support and Community

For each of the following questions, please mark the response that **best indicates your current experience** as an LGBTQ person. Please be as honest as possible: Indicate how you really feel now, not how you think you should feel. There is no need to think too much about any one question. Answer each question according to your initial reaction and then move on to the next.

	Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Agree Strongly
My sexual/gender identity is an insignificant part of who I am	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My sexual/gender identity is a central part of my identity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
To understand who I am as a person, you have to know that I'm LGBTQ	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being an LGBTQ person is a very important aspect of my life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I believe being LGBTQ is an important part of me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am glad to be an LGBTQ person.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I'm proud to be part of the LGBTQ community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I'm proud to be LGBTQ	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

	Very strongly disagree	Strongly disagree	Mildly disagree	Are neutral	Mildly agree	Strongly agree	Very strongly agree
There is a special person who is around when I am in need	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There is a special person with whom I can share my joys and sorrows	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My family really tries to help me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I get the emotional help and support I need from my family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Very strongly disagree	Strongly disagree	Mildly disagree	Are neutral	Mildly agree	Strongly agree	Very strongly agree
I have a special person who is a real source of comfort to me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My friends really try to help me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I can count on my friends when things go wrong	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I can talk about my problems with my family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Very strongly disagree	Strongly disagree	Mildly disagree	Are neutral	Mildly agree	Strongly agree	Very strongly agree
I have friends with whom I can share my joys and sorrows	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There is a special person in my life who cares	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My family is willing to help me make decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I can talk about my problems with my friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Very strongly disagree	Strongly disagree	Mildly disagree	Are neutral	Mildly agree	Strongly agree	Very strongly agree

Below are a series of statements about the LGBTQ community. Please rate to which you agree with the item statements on a scale ranging from "Agree Strongly" to "Disagree Strongly".

	Agree Strongly	Agree	Disagree	Disagree Strongly
You feel you're part of the LGBTQ community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Participating in the LGBTQ community is a positive thing for you	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You feel a bond with the LGBTQ community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You are proud of the LGBTQ community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is important for you to be politically active in the LGBTQ community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If we work together, gay, bisexual, lesbian, transgender, questioning and queer people can	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

1/10/2016

Qualtrics Survey Software

solve problems in the
LGBTQ community

You really feel that any
problems faced by the
LGBTQ community are
also your own problems

You feel a bond with
other LGBTQ people

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Qualitative Questions

How did you hear about this study?

If you experienced hurtful behaviors in your intimate relationship, how did these experiences affect you?

If you experienced hurtful behaviors in your intimate relationship, did your LGBTQ status influence how you experienced these behaviors? If so, how?

If you experienced hurtful behaviors in your intimate relationship, what was most helpful to you in dealing with these hurtful behaviors?

Your perspective is extremely valuable to us. If there is anything we haven't asked you yet that you think is

Appendix C

Consent form

**Boston College
Consent Form
Boston College, School of
Education**

**Informed Consent for Participation in the LGBTQ
Relationships Study**

Introduction

- You are being asked to participate in a survey for a research study conducted by Julie Woulfe, MS and Dr. Lisa Goodman at Boston College
- We hope that the results of this study will help us understand more about the experiences of relationships and mental health in the LGBTQ community.
- We are hoping to survey 300 members of the LGBTQ community for this study.

Why have I been asked to participate in this study?

- You were invited to participate in this project because you identify as LGBTQ and are at least 18 years of age.

What do I do first?

- Please read this page before agreeing to be in the study.

What is this study about?

- The purpose of this study is to better understand helpful and harmful aspects of intimate relationships and how they affect LGBTQ individuals' mental health and well-being.

If I agree to take part, what will I be asked to do?

- If you agree to participate, you will be asked to complete the following online survey containing demographic questions, questions about a range of hurtful behaviors you may have experienced in romantic/intimate relationships, attitudes and emotions about your mental health, and attitudes and emotions about the LGBTQ community.
- This study will be conducted through this online survey. The survey should take you approximately 30 minutes to complete.

IDENTITY ABUSE

- To express our gratitude for your participation, we will offer you the opportunity to enter a lottery to win one of five \$25 Amazon gift cards. Please enter your email address at the end of the survey if you wish to be entered to win an Amazon gift card. Your email address, like any other identifying information, will be kept in a password-protected file and separated from your survey results. It will be deleted after all five Amazon gift cards are distributed.
- There are no other direct benefits to you or compensation, but you may feel gratified in knowing that you helped further the scholarly work in this research area and contributed to the health and wellbeing of the LGBTQ community.

What are the risks to being in the study?

- Some of what you talk about or answer in the survey might bring up painful feelings or memories. Because of this, after the survey, there will be a list of resources including a number of hotlines for LGBTQ-identified people.

What are the benefits of being in the study?

- You are helping to make a difference by adding to our understanding of intimate relationships in the LGBTQ community. Such information will help to make programs designed to support LGBTQ people the best they can be.
- You also may find that the survey will help you think about your experiences in new ways.

What are the costs of being in the study?

- There is no cost to you to participate in this research study.

How will you keep my privacy?

- The Principal Investigator will exert all reasonable efforts to keep your responses and your identity confidential.
- All identifying information will be removed from your survey responses.
- The records of this study will be kept private.
- In any sort of report we may publish, we will not include any information that will make it possible to identify a participant.
- Research records will be kept in a locked file.
- All electronic information will be coded and secured using a password-protected file. Identifying information will be stored in a separate password protected file different from participants' responses to the survey, and in a different locked location.
- Access to the records will be limited to the researchers; however, please note that the Institutional Review Board and internal Boston College auditors may review research records.

What if I choose to not take part, or to leave the study?

IDENTITY ABUSE

- Taking part in the study is completely voluntary.
- If you choose to participate in the research, you may withdraw from participation at any time. You do not have to answer any question you do not want to answer.
- There are no penalties for withdrawing or skipping questions.
- If you choose to withdraw early from the study, you will no longer be eligible to enter the raffle.

Whom do I contact if I have questions?

- If you have questions or concerns concerning this research you may contact the Principal Investigator, Julie Woulfe, M.A., at woulfej@bc.edu. She is being supervised by Dr. Lisa A. Goodman in the Department of Counseling, Developmental, and Educational Psychology in the Lynch School of Education at Boston College. You can contact Dr. Goodman with questions or concerns at lisa.goodman@bc.edu
- If you have questions about your rights as a research participant, you may contact the Office for Research Protections, Boston College, at 617-552-4778 or irb@bc.edu.

If you agree to the statements above and agree to participate in this study, please press the arrow button below to begin the study

Julie M. Woulfe

EDUCATION

Boston College

Ph.D. Counseling Psychology

Expected 2016

Dissertation Title: "LGBTQ survivors of identity abuse: Heterosexist and gender oppressive tactics of violence and the mental health outcomes of LGBTQ survivors of intimate partner violence"

University of Wisconsin-Madison M.S. in Counseling Psychology

May 2010

Emphasis: Community Counseling

Thesis Title: "From the client's chair: Client understandings of multicultural competence"

Carleton College

B.A. in Psychology

May 2004

Magna Cum Laude, With Distinction

Senior Comprehensive Project: "Cognitive theories for the social criteria of autism spectrum disorder"

FELLOWSHIPS, GRANTS, AWARDS

Society for the Psychological Study of Social Issues (SPSSI) Grants-in-Aid Program, 2015

Lynch School of Education Dissertation Fellowship Award, 2014

Lynch School of Education Graduate Assistantship Award, 2012-2014

Carleton College Mortar Board, 2003, 2004

Carleton College Distinction in Psychology Major, 2004

Carleton College Distinction on Senior Comprehensive Project, 2004

SUPERVISED CLINICAL EXPERIENCE

Psychology Intern, Cambridge Health Alliance/Harvard Medical School June 2015-16

Supervisors: Marla Eby, Ph.D., Pedro Barbosa, Ph.D., Larry Rosenberg, Ph.D., Rachel Barbanel-Fried, Psy.D., Maggie Lanca, Ph.D., Elizabeth Bauman, Ph.D

IDENTITY ABUSE

RISE Program Rotation:

- Provide therapy for adolescents and emerging adults following their first experience with psychosis
- Co-facilitate a cognitive processing therapy skills group for 8 to 10 adults ages 18-39 focused on self-care and psychosis management
- Administer batteries for psychotic and mood symptoms
- Conduct short-term skills-based therapy for a caseload of 4 clients

Gender Identity Clinical Consultation Service

- Assist in developing a consultation service for transgender and gender non-conforming youth at CHA.

Psychiatric Emergency Service:

- Assess high-risk cases for inpatient treatment for suicidal and homicidal related issues and section 12 eligibility
- Create and disseminate psychiatric evaluations
- Facilitate recommendations to medical and clinical staff regarding appropriate level of care for patients

Adult Outpatient Clinic:

- Hold a caseload of 10 patients with diagnoses of PTSD, depression, anxiety, and psychosis
- Engage in weekly meetings within an interdisciplinary treatment team including psychiatrists, social workers, and psychologists

Psychodynamic Research Clinic:

- Conduct twice weekly psychotherapy with a select client
- Attend a weekly seminar on the principles of dynamic treatment
- Collaborate in current research including drafting a psychodynamic formulation of the client's presenting concerns

Clinical Intern, Brookline Community Mental Health Center Sep 2013-May 2015

Supervisors: Kate Scherzo, Ph.D., Mitch Pomerantz, Psy.D.

Direct Client Hours: 388; Supervision Hours: 76; Total Hours: 657

- Managed caseload of 12-15 clients ages 5 to 65 with issues related to PTSD, major depression, and borderline personality disorder
- Provided weekly individual therapy
- Conducted a long-term adult interpersonal process group

Assessment Intern, Brookline High School

Sep 2012-June 2013

Supervisor: Andrea Weiss, Ph.D.

Direct Client Hours: 119; Supervision Hours: 68; Total Hours: 337

- Conducted 12 batteries integrating psychological, cognitive, and neuropsychological, testing with adolescent clients receiving services at a large public high school
- Shared results from integrated test batteries at interdisciplinary IEP meetings
- Used test findings to assist clients' access appropriate services in school

IDENTITY ABUSE

- Provided weekly individual therapy with 5 clients ages 14-18

Behavioral Health/Violence Recovery Program Intern, Fenway Health Sep 2011-12

Supervisors: Rhonda Linde, Ph.D., Kelcie Cooke, LICSW

Direct Client Hours: 261; Supervision Hours: 134; Total Hours: 688

- Managed caseload of 15 clients ages 18 to 64 with issues related to PTSD, sexual orientation, gender dysphoria, anxiety, OCD, schizoaffective disorder, and borderline personality disorder
- Provided weekly individual and group therapy primarily for lesbian, gay, bisexual, transgender, and queer (LGBTQ) survivors of domestic violence and hate crimes from psychodynamic and cognitive behavioral perspectives
- Conducted 10 behavioral health diagnostic intake assessments for clients seeking therapy and psychopharmacology consultation
- Conducted 8 LGBTQ domestic violence screening intake assessments for clients seeking advocacy and individual therapy
- Facilitated weekly group therapy providing stage one trauma psychoeducation and coping skills for clients recently diagnosed with PTSD using CBT and DBT skills
- Facilitated weekly group therapy for clients ages 18-50 exploring their sexual identity

First Year Experience Practicum, Reaching Out About Depression Sep -June 2012

Supervisor: Lisa Goodman, Ph.D.

- Applied knowledge of mental health to a non-traditional and social-justice oriented counseling role
- Offered crisis support and psycho-education for a grassroots organization run by and for low-income women with chronic depression

Clinical Intern, Counseling Psychology Training Clinic Sep 2009-June 2010

University of Wisconsin-Madison

Supervisors: Teresa Bear, Ph.D., Baine Alexander, LICSW

Direct Client Hours: 200; Supervision Hours: 173; Total Hours: 600

- Managed caseload of 14 clients ages 17 to 54 for issues related to major depression, anxiety, school-related adjustment, and PTSD
- Conducted weekly individual and couples therapy
- Received weekly live and taped supervision on site

OTHER CLINICAL EXPERIENCE

Volunteer Group Coordinator, East Bay Community Recovery Project Jan 2007-08

- Facilitated a weekly trauma skills group for 8 mothers transitioning from incarceration and in recovery from substance dependence
- Applied curriculum from Seeking Safety Curriculum developed by Lisa Najavits

IDENTITY ABUSE

Prevention Education Program Co-Coordinator, Rape Trauma Services 2005- 06

- Facilitated weekly group counseling for 5 adolescent clients
- Provided crisis counseling and advocacy for survivors of sexual violence
- Served as a medical and legal advocate for survivors of sexual violence

Child Resiliency Program Coordinator, Hope Center Sep 2004-Aug 2005

- Completed 40 hour domestic violence crisis counseling training
- Coordinated services for children who witnessed domestic violence
- Provided weekly individual crisis counseling and advocacy for survivors of sexual violence
- Facilitated weekly group therapy for adult survivors of childhood sexual abuse

ONGOING RESEARCH EXPERIENCE

Principal Investigator, LGBTQ Survivors of Identity Abuse Sep 2013-present

Boston College Department of Counseling, Developmental, and Educational Psychology
Supervisor: Lisa Goodman, Ph.D.

Research focus: Impact of minority stress on LGBTQ-specific identity abuse among intimate partner violence survivors

Co-Investigator, Bisexual Men and Women's Health June 2013-present

Principal Investigator: Ethan Mereish, Ph.D.

Research Focus: Effects of discrimination and health among bisexual-identified individuals

COMPLETED RESEARCH EXPERIENCE

Research Coordinator, Counseling Psychology Department, Boston College 2010-2014

Supervisor: Lisa Goodman, Ph.D.

Research focus: Development of trauma-informed safety-related empowerment and survivor-centered practice measures

- Co-authored 4 published papers
- Trained and managed a research lab of 10 Master's level research assistants
- Coordinated data collection process from 17 local domestic violence agencies
- Proficient at MANOVA, chi-square, t-test, and regression analyses using SPSS
- Coordinated focus group studies and analyze data using a qualitative descriptive approach

Research Assistant, Counseling Psychology Department, Boston College 2010- 2011

Supervisor: Anderson J. Franklin, Ph.D.

Research focus: John Winthrop after school programming project

- Collaborated with an elementary school in Dorchester, MA to improve their afterschool programming for youth

IDENTITY ABUSE

- Conducted 2 focus groups and collected and analyzed 150 parent surveys to identify afterschool programming needs and barriers to participation
- Compiled data and disseminated results to school community and administrators in the form of research briefs

Research Assistant, Counseling Psychology Department, UW-Madison Sep 2009- 10
Supervisor: Carmen Valdez, Ph.D.

Research focus: Adult survivors of intergenerational trauma

- Co-authored 1 published manuscript
- Engaged in a 2-year research project using phenomenology qualitative methodology

Research Assistant, East Bay Community Recovery Project Sep 2007-08
Supervisor: Judith B Cohen, Ph.D.

- Collected, managed, and analyzed data on client progress to inform program development
- Wrote and successfully secured a \$15,000 grant application from Mutual of America foundation

Research Assistant, Department of Psychology, Stanford University Jan 2007-08
Supervisor: Nicole Stephens, Ph.D.

Research Lab: Mind, Culture, and Society Lab

- Conducted qualitative data analysis for an ongoing study on impact of class on individualistic and collectivistic thought

Grant Project Manager, Carleton College Psychology Department Sep 2004- 05
Supervisor: Kathleen Galotti, Ph.D.

Research focus: Parents Making School Choice Decision Project

- Oversaw data collection and analysis for the final year of a three-year longitudinal study on decision-making
- Managed an 8-student undergraduate research lab and provided ongoing training and professional development, to team

OTHER PROFESSIONAL EXPERIENCE

Project Assistant, Population Health Institute Sep 2009-Aug 2010

Supervisors: Susan Zahner, Ph.D., MPH, RN and Tom Oliver, Ph.D., MHA

Project Focus: Mobilizing Action Through Community Health

- Identified successful multi-sector partnerships working to improve population 2015
- Conducted comprehensive literature review on collaboration in population health to identify best practices of multi-sector partnership

IDENTITY ABUSE

Education Program Co-coordinator, Rape Trauma Services Aug 2005-Dec 2006

- Coordinated agency community education program
- Developed and presented curriculum addressing issues of violence and violence prevention to community college and high school programs throughout San Mateo County

Child Resiliency Program Coordinator, Hope Center Sep 2004-Aug 2005

- Developed several service plans for youth survivors of abuse and neglect
- Coordinated community youth services for survivors
- Developed and presented curriculum for youth survivors and domestic violence agencies

TEACHING, SUPERVISION, AND APPLIED PSYCHOLOGY EXPERIENCE

Undergraduate Level

PY241: Instructor, Interpersonal relations

Spring 2015

Teaching Mentor: Oh Myo Kim, Ph.D.

Master's Level

Counseling Psychology Department, Boston College

Fall 2013- Spring 2014

Internship Counseling I and II

Supervisor: Jamie Aaronson, Ph.D.

- Instructor and clinical supervisor of a course that accompanies second year Master's students' internship placements. The course functions to foster students' professional and personal development as beginning counselors through discussion of clinical and professional issues that emerge during the internship experience
- Developed syllabus; led weekly seminars and supervision meetings; initiated and maintained contact with students' field supervisors; visited internship sites

Teaching Fellow/ Clinical Supervisor

Counseling Psychology Department, Boston College

Fall 2011-Spring 2012

PY440 The Social Justice Lab, Principles and Techniques in Counseling

Supervisors: Lisa Goodman, Ph.D., Nettie Greenstein, Psy.D.

- Provided 10 hours of biweekly individual supervision with 8 Master's student advocates for low income women domestic violence survivors
- Prepared didactic instruction of community based advocacy and provided structure for developing counseling skills
- Facilitated process examination for students to gain a better understanding of their personal issues, perspectives, and experiences that impact their advocacy work

IDENTITY ABUSE

Guest Lectures

PY740 Psychology of Women, Spring 2012, Spring 2013

Topic: Working with Sexual Minority Women

PY230 Abnormal Psychology, Fall 2012

Topic: Personality Disorders

Cottey College Forensic Psychology, Fall 2014

Topic: Intimate partner violence

Teaching Assistant

PY348: Culture, Community and Change, Spring 2011

INVITED PRESENTATIONS

Katz-Wise, S., Mereish, E., & **Woulfe, J. M.** (2015) Associations Between Anti-Bisexual Prejudice and Physical Health Among Bisexual Adults Presented at the 33rd Gay and Lesbian Medical Association Conference, Portland, Oregon.

Fauci, J., & **Woulfe, J. M.** (2015). Using Community-Based Research to Connect Academia, Action, & Policy. Presented at the Society for the Psychological Study of Social Issues (SPSSI) Summer Conference.

Goodman, L. A., **Woulfe, J. M.**, Fauci, J., & Hiemal, D. (2014). The power of partnership: Building effective University-community partnerships to address domestic violence. Presented at the Eighteenth International Family Violence Research Conference, Portsmouth, New Hampshire.

Goodman, L. A., **Woulfe, J. M.** (2012). Bringing a network-oriented approach to domestic violence services: A focus group exploration of promising program practices. Presented at the Sixteenth International Family Violence Research Conference, Portsmouth, New Hampshire.

Woulfe, J. M., Escamilla, A., & Newman, J. (2011). LGBTQ Asylees. Presented to Boston Medical Center for Refugee Health and Human Rights, Boston, MA.

Woulfe, J. M., & Cooke, K. (2011). Intimate partner violence in the LGBTQ Community. Presented at the Grand Rounds for the Edith Norse Memorial Veterans Affairs, Bedford, MA.

Goodman, L. A., & **Woulfe, J. M.** (2011). A network-oriented approach to intimate partner violence prevention. Presented at the 121st Annual Convention of the American Psychological Association, Washington, DC.

IDENTITY ABUSE

Goodman, L. A., & **Woulfe, J. M.** (2011). Poverty and counseling psychology: Expanding the diversity umbrella. Presented at the 121st Annual Convention of the American Psychological Association, Washington, D.C.

Woulfe, J. M. (2005). Older Adolescents Facing a “Major” Decision: Cognitive Performance and Affective Response. Presented at the Annual Convention for the Society for Research in Child Development. Atlanta, GA.

PUBLICATIONS

Mereish, E., Katz-Wise, S., & **Woulfe, J. M.** (under review). Associations of anti-bisexual prejudice and health among bisexual adults.

Goodman, L. A., Banyard, V., **Woulfe, J. M.**, Ash, S., & Mattern, G. (2015). Bringing a network oriented approach to domestic violence services: A focus group exploration of promising practices. *Violence Against Women*, 1-26.

Goodman, L. A., Bennett Cattaneo, L., Thomas, K., **Woulfe, J. M.**, Chong, S. K., & Fels Smyth, K. (2014). Advancing domestic violence program evaluation: Development and validation of the measure of victim empowerment related to safety (MOVERS). *Psychology of Violence*.

Goodman, L. A., Liang, B., Tummala-Nara, U., Borges, A., Claudius, M., & **Woulfe, J. M.** (2014). Self-Awareness, Individual-level Advocacy, and Context Change: A model for integrating social justice roles into Counseling Psychology doctoral training. In Praeger Handbook of Social Justice and Psychology.

Goodman, L. A., Thomas, K., Cattaneo, L. B., Heimel, D., **Woulfe, J. M.**, & Chong, S. K. (2014) Survivor-defined practice in domestic violence work: Measure development and preliminary evidence of link to empowerment. *Journal of Interpersonal Violence*, 1-23.

Valdez, C., Chavez, T., & **Woulfe, J. M.** (2013). Emerging adults’ lived experience of formative family stress: The family’s lasting influence, *Qualitative Health Research*, 23(8), 1089-1102.

Woulfe, J. M., Oliver, T. R., Zahner, S. J., & Siemering, K. Q. (2010). Multi-sector partnerships in population health improvement. *Preventing chronic disease*, 7.

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PROFESSIONAL AFFILIATIONS

Society for the Psychological Study of Social Issues (SPSSI), Student Member

IDENTITY ABUSE
2013-present

American Psychological Association, Student Affiliate Member
2010-present

Division 44: Society for the Psychological Study of LGBT Issues 2012 –
present

Division 17: Society of Counseling Psychology 2010 –
present

MANUSCRIPT EDITING

Student Reviewer Sep 2010 –
Sep 2014

Duties: Reviewed manuscript peer-reviewed journals including: American Journal of Orthopsychiatry; Journal of Counseling Psychology; and, Violence Against Women