Beyond the Gay/Straight Binary: Gender and/or Sexually Diverse Male Survivors

Jim Struve, LCSW, Howard Fradkin, Ph.D., & Lee Beckstead, Ph.D.

Writing this chapter began as an effort to elaborate on the effects of sexual trauma for gay and bisexual males. But we were immediately captured by the inherent limitations of writing about this subject within the binary rules for sexuality and gender. Approaching this topic from a strict dualistic perspective (e.g., gay and bisexual male survivors as opposed to heterosexual male survivors) repeatedly constrained, blocked, or distorted the observations we wished to communicate. Sexual trauma furthermore introduces confusion and distress about matters of gender and sexuality. Therefore, we will begin with a discussion of terms and how they may be used to understand a range of experiences but also can be problematic in perpetuating marginalization. We hope this discussion will reduce stigma and expand options for healing.

Defining a Framework for Sexuality and Gender

One initial challenge in working with this population is determining appropriate definitions and labels. For instance, describing this population as "non-heterosexual" distinguishes individuals who experience some degree of same-sex sexual attractions from those who experience exclusively heterosexual attractions. However, the binary term "non-heterosexual" leaves this population defined against who they are not rather than describing who they are[1]. It also positions this population against the majority and reinforces a heterocentric

[1] This section was informed by a discussion on the American Psychological Association's Division 44 (Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender

privilege. This is similar to referring to everyone who is a person of color as non-White. It combines and reduces a diverse group of individuals and cultures into a "non" category by comparing them to the majority. It can be oppressive to be defined as a "not" and even more difficult to try and develop an identity based on being a "not."

Yet, minority identity development often includes periods of defining oneself as separate from the majority so the individual can examine experiences of stigmatization and find personal ways to adapt positively to a minority status. This type of separation and differentiation can help individuals develop self-acceptance and stop efforts to try to be who they are not (i.e., the majority).

All survivors of sexual trauma in general hold a minority status. They may feel ashamed of being different from the norm until they are able to meet peers with similar victimization experiences, which can help them feel less stigmatized and more empowered about their own life experiences.

The term "sexual and/or gender minority" is an inclusive term denoting the spectrum of sexual and gender identities. It recognizes that not everyone who experiences same-sex sexual attractions will identify as lesbian, gay, bisexual (LGB). This inclusiveness is important because recent population statistics suggest that there are more individuals who experience same-sex attractions who do not identify as LGB than there are who identify as LGB (Bailey et al., 2016). In addition, someone may have an asexual sexual orientation, experiencing little or no sexual desire but no erotic aversion. This does not represent a pathological condition, such as being

---

Issues) email list serve in March, 2016. We appreciate those who shared their views on these diversity issues.

afraid and avoidant of being sexual, but is another variant of human sexuality.

"Gender nonconforming" and “non-traditional gender” have been used to refer to transgender individuals; however, the first term applies only to gender expression and the second could apply to identity or to a person’s biological sex (e.g. intersex), each with a comparison to the norm. These terms can be misleading because someone who is transsexual (referring to those who changes their body to look more male or female, matching how they feel inside) may express their[2] gender in traditionally normative ways. Also, a person may be cisgender (referring to individuals whose gender identity is congruent with the sex they were assigned at birth), but have manners of dress and behavior that do not fit cultural norms of masculinity and femininity. Furthermore, transgender and transsexual individuals often identify as heterosexual.

Some individuals report experiencing erotic aversion, not just disinterest or social aversion, to being sexual with individuals of their non-preferred sex (Beckstead, 2012). Erotic aversion has not been extensively studied, but this physiological, emotional limit may distinguish those who are exclusively same-sex attracted or exclusive other-sex attracted from those who experience some capacity for erotic satisfaction with both women and men. Trauma may be intensified when violations occur between a person’s erotic-aversion limit and their abuse-relational dynamic (e.g., exclusively same-sex attracted male victim and female offender, exclusively other-sex attracted male victim and male offender).

Many still adopt the LGB labels because they imply belonging to a group with specific

[2] The third-person plural pronouns “they,” “them,” and “their” are sometimes used in this document as third person singular pronouns to avoid the use of gendered pronouns and include individuals who are gender non-binary.

norms, values, and behaviors. Historically, however, bisexual people have been left out of--or been invisible within--this LGB group membership, even though LGB includes bisexuality. Reasons some who experience same-sex attractions do not adopt the LGB label include that they do not pursue same-sex sexual relationships, may experience stronger other-sex attractions, may hold negative biases about being LGB, and/or do not see themselves reflected in that sociopolitical identity (Beckstead & Morrow, 2004; Vrangalova & Savin-Williams, 2013; Yarhouse, Tan, & Pawlowski, 2005). Therefore, their sexual orientation, behaviors, and public and personal identities may not always match. This is because the process of identity development depends upon cultural definitions and opportunities and how a person makes decisions about sexuality and behaviors.[3]

We recommend that readers make a conscious choice to avoid the use of "homosexual" or "homosexuality" to limit the historical pathological meaning attributed to these terms. They can be too simplistic, not encompassing the totality of someone's affectional, romantic, behavioral, relational, and cultural experience. Similarly, "heterosexual" can be misleading because it can refer to a person's orientation, behavior, and identity. However, this can lead to ambiguous assumptions; for example, not all heterosexually married individuals are heterosexual in orientation (Corley & Kort, 2006). "Gay," for some, simply means "being attracted to the same sex"; however, for others, it implies specific social norms of how a person lives out their orientation (e.g., "I have same-sex attractions, but I am not gay"). "Same-sex attracted" is descriptive but may also offend some as reducing their identity to only their attractions. Some

[3] Editor's note: See the chapter by Kort in this volume for discussion of sexual identity/orientation confusion.

may not adopt a bisexual identity because of bi-negative beliefs that bisexuals are promiscuous, can't make up their minds, or are too afraid to come out as gay, all of which do not match how they see their sexuality.

Each of these terms also implies that sexual and gender identities are fixed, ignoring how identity development can be fluid or in flux throughout life. Because of this potential for misunderstanding and bias, it is important to help survivors clarify the best terms to describe their sexuality and to understand how they came to label themselves this way. For these reasons, we encourage clinicians to prioritize two principles of ethical mental-health services: "Do no harm" and "Facilitate individual self-determination." This ensures that interventions are respectful and compassionate to the lived realities from all points on the spectrum, without dismissing any (Reconciliation and Growth Project, 2016).

Likewise, biological sex is not binary. In reality, research reveals that between 1.7 to 4% of the world's population is intersex (Haas, 2004). "Intersex" refers to a medical condition for a person born with a reproductive or sexual anatomy not fitting typical definitions of female or male. It is the contemporary term that replaces the historically stigmatizing term "hermaphrodite." The existence of individuals who are intersex presents a conundrum for those subscribing to a binary view of gender (e.g., is it a heterosexual or same-sex marriage between a man and someone with an intersex condition?). In addition, the term "same-sex attractions" leaves out individuals not identifying with a binary gender.

Clearly, our language is evolving, finding terms that are more inclusive and accurate. We decided to use the term "gender and/or sexually diverse" (GSD) to refer to those who experience same-sex attractions and/or a gender expression that does not fit with cultural norms. However,

we recognize there is also a spectrum of sexuality and gender expression for cisgender, exclusively heterosexual individuals. That population of male survivors is beyond the scope of our attention here.

We also acknowledge the monumental changes rapidly impacting social justice for GSD individuals and allies. In many parts of the world, new freedoms for expressing sexuality and gender are emerging while historical sanctions based on discrimination and inequality are being lifted. The psychological effects of these changes on current and future generations are still unknown. We hope for more positive outcomes in the future, as people's lived experiences reflect the dynamics of lesser degrees of oppression of healthy sexual and gender expression.

Overall, clinicians who strive for cultural competence should consider the explosion of language among vast numbers of people whose lived realities reflect a spectrum of sexual and gender identities instead of binary identifications (van Anders, 2015). Even Facebook now acknowledges this spectrum by offering users 50 options for gender identification. Given the above complexities, we challenge three core concepts of the binary paradigm:

(1) Limiting sexuality and gender to the dual choices of male or female, masculine or feminine, "straight" or "gay," is unnatural and contrived. Sexuality and gender more realistically exist as spectrums of possibilities.

(2) Categorizing sexuality, gender, and culture as distinctly separate and independent features of human identity ignores the reality that these characteristics often overlap, intersect, and therefore affect each other.

(3) Prioritizing cisgender heterosexual masculinity as the gold standard by which all

expressions of sexuality and gender are judged potentially causes mental-health distress.

How Viewing Male Sexual Trauma Through a Binary Lens Causes Harm

Within a binary paradigm, options for sexuality and gender are either right or wrong, normal or pathological. Tolerance for expressions of diversity is narrow within families and cultures that adhere to binary perspectives about sexuality and gender. In these settings, victims in their healing process may struggle to feel normal, desiring to fit in with the majority. Viewing sexual trauma within a binary template may impose unnecessary expectations, perpetuate blind spots, neglect to challenge false beliefs, and therefore blur understanding of the trauma's complexity. These stereotypes and biases may contribute to the gross underreporting and the disproportionate muting of the effects of male sexual trauma as well as the unfortunate isolation of so many male survivors.

We can see how binary views impact our interpretations of sexual trauma through the different observations emerging when victims are female versus male. We know that a high proportion of sexual offenders are male, whether the victim is male or female. In situations of female victimization by a male, there is usually minimal or no suspicion about sexual orientation or gender identity. It is unlikely that the female survivor will fear she became heterosexual because of her male perpetrator. In contrast, for male survivors with a male offender, sexual orientation and gender are almost universally analyzed, with a disproportionate level of scrutiny.

Consider the example of a boy sexually assaulted by an older male. The assault represents an act of same-sex sexual aggression that both victim and society often interpret as "gay behavior." Often the perpetrator is believed to be gay rather than more attracted to underage

males, whether pre-pubescent or adolescent (pedophilic or hebephilic), than to adult males (androphilic). Although the sexual orientation of the victim cannot be assumed, usually this traumatic episode is infused with considerations about whether he is -- or will become -- gay. This fear, however, has no scientific basis; no scientific evidence exists that sexual abuse can change or create a person's orientation (LeVay, 2010; Stevenson, 2000; Xu & Zheng, 2015). If sexual trauma were to cause sexual orientation, then a higher percentage of the population would be LGB, given the rates of sexual abuse reported (Andersen & Blosnich, 2013).

Yet, a survivor is often left with residual struggles of untangling confusions and prejudice from sexual identity. Others may scrutinize him to assess his orientation and identity or otherwise explain whether his sexuality was tainted by his sexual trauma. In contrast, female victims (almost always) or male victims abused by a female (most often) do not face the same level of societal pressure to prove they are heterosexual.

Males sexually abused by males may come to feel negatively about same-sex sexuality and their own maleness/masculinity because of the association of same-sex trauma with being gay and male. False conceptions about same-sex sexuality and gender (e.g., equating victimization and passivity with being gay or transgender; equating same-sex sexual reenactments as signs of being gay) may interfere with survivors' ability to accept their sexual orientation and gender identity and deal effectively with the abuse (Gartner, 1999a). This is particularly problematic when bias leads to the survivor's sexual orientation or gender identity being pathologized, thereby diverting attention from traumatic aspects of sexual assault(s). Social bias may cause some survivors to invest in changing their attractions to prove they are not "weak" or shameful.

Sometimes, when the offender is female, the male survivor may reject being sexual with women due to a posttraumatic response and is left with only a gay or asexual identity, although this does not represent their core sexual orientation. But a binary paradigm sets up heterosexual survivors to be assumed to be gay when they do not initiate or are averse to heterosexual sexual activity due to a posttraumatic response.

Living in a world that operates by the rules of binary classifications, a male survivor may struggle to "pick a team" (i.e., straight or gay, masculine or feminine) in describing past, present, or future aspects of his sense of self. When treatment focuses on trying to change survivors' sexual orientation or gender identity to fit heterosexual norms, rather than providing them a safe space to discover their own sexuality and gender, it becomes a harmful reenactment of a victim submitting to a powerful other (cf. Brady, 2008; Morris & Balsam, 2003; Russell, Jones, Barclay, & Anderson, 2008).

For most people, racial and gender identity (e.g. being Black or female) is apparent to oneself and visible to the external world. However, sexual and gender identity are often unformed, disguised, or intentionally hidden. It is not unusual for GSD individuals to be deeply inculcated with sexual or gender prejudice before they realize their own GSD identity. Also, childhood sexual abuse occurs for many well before the average age of awareness of sexual feelings. Traumatic impact in such situations may be complicated if survivors are struggling to hide or deny their identity from themselves or the external world. This concealment can prevent a GSD survivor from developing necessary aspects of self.

Given the harm that sexual abuse can inflict on identity development, conducting a comprehensive assessment of developmental dynamics for sexuality and gender is a prerequisite to clinician competency in working with GSD male survivors. Clinicians must understand that

the internal realities of the GSD male survivor may or may not be congruent with external presentation. More precisely, self-awareness, self-acceptance, identity, and expressions of sexuality and gender may not be synonymous. Perceptions, cognitions, behaviors, and emotional experiences may be vastly different depending on where in the developmental process of sexuality and gender a survivor was at the time of victimization as well as when he seeks help for healing.

Consider the spectrum of developmental variation (i.e., age, stage of developmental awareness, and context) within which sexual trauma may have occurred and the differing implications for how the GSD male victim might process his experience:

1. A male assigned at birth who is the victim of sexual trauma before he understands he is GSD;

2. A male assigned at birth who is the victim of sexual trauma who understands at the time of the trauma that he is GSD;

3. A male assigned at birth who was confused about his sexual orientation at the time he was the victim of sexual trauma and who later considers himself neither gay nor straight;

4. A male assigned at birth who experiences same-sex attractions but does not identify as gay, bisexual, or a sexual/gender minority, perhaps due to cultural, religious, or ideological reasons;

5. A male assigned at birth who identifies as heterosexually male but is targeted as a victim of sexual trauma because he displays “feminine” or “unmasculine” gender traits;

6. A female assigned at birth who identifies as male (or closer to male than female), who may be attracted to men, women, or both, and who is a victim of sexual trauma(s) in which the perpetrator(s) perceived the individual as female and/or whose assault targeted the individual's gender expression and perceived sexual orientation.

In any of these scenarios, who decides whether or when a male survivor is gay, bisexual, traditionally masculine, or somewhere else on the GSD spectrum? Clinicians must exercise care to avoid making assumptions and interpretations about developmental stages of awareness and identity.

5 Guiding Principles for Clinical Work with a Male Survivor who is Gender and/or Sexually Diverse
-Sexuality and gender are represented by a spectrum of identities vs. being limited to the binary choices of straight-gay, male-female, masculine-feminine.
-Sexuality and gender sometimes overlap or intersect; therefore, they are not necessarily bifurcated and exclusionary.
-Awareness, identity, and expression about sexuality and gender are distinct stages of development, perhaps evolving at different rates.
-The impact of sexual trauma may be vastly different depending upon the victim's stage of development regarding awareness, identity, and expression about sexuality and gender.
-There may be a dual layering of trauma when sexual assault occurs within the context of sexual/gender minority distress.

Understanding the Impact of Sexual and Gender Prejudice

GSD men have much in common with male sexual abuse survivors; many GSD men experience common concerns, whether or not they are sexual abuse survivors. Also, numerous

factors exist for most male sexual abuse survivors, whatever their sexual orientation. Ironically, many of these factors are the same for survivors and GSD men. For example, both survivors and GSD individuals may struggle with telling others about their stigmatized identity. Survivors who are GSD, therefore, may struggle with a "double layered" impact of these factors. Many of these factors and their influence may be culture-based, so their specific impact is not inherently universal in nature. The box below represents some similarities between sexual abuse survivors and GSD males.

	Sexual Abuse Survivor	GSD Male
Isolation	Abusers are masterful in enrolling their victim in a web of secrecy, often leading the victim to isolate himself from critical members of his support system.	GSD men commonly separate themselves from the dominant heterosexual culture, constructing a lifestyle dominated by secrecy & isolation.
Secrecy	Abused individuals learn that secrecy is linked to loyalty; violating the ground rules of secrecy may result in abandonment or further abuse.	Oppressive cultural norms create a context in which GSD men who are open and non-secretive are frequently judged as "flaunting" their sexual orientation; therefore, many GSD men choose secrecy rather than risking judgment, rejection, or loss.
Disclosure	Victims of abuse frequently become targets of blame or are ostracized after accidental or intentional disclosure.	Accidental or intentional disclosure of stigmatized minority sexuality may precipitate a "big explosion" and/or result in negative repercussions in a GSD man's life.
Hypervigilance	Abused men are normally intensely hypervigilant about others' behavioral and mood changes, always watchful for potential abusers.	GSD men often rely on a finely-tuned "gaydar" as a guide in searching for friends and foes as they negotiate life in a less-than-safe world.
Control	Many survivors feel insecure or fearful when they do not or cannot exercise control.	Feeling powerless to affect the larger world, GSD men often seek to control people and situations within their inner circle of relationships.
Shame	Most survivors feel shame about	GSD men often learn to hate their

	being victimized; shame is devastating to self-esteem and results in highly negative self-images for most survivors.	sexuality before discovering their own membership in this sexual minority; self-hatred is a fertile breeding ground for shame.
Vulnerability	Children are inherently dependent on adult guardians to provide for safety and protection. Innocence and dependency sometimes create circumstances where children become the vulnerable prey of adult sexual offenders.	Because transphobia, bi-phobia, and homophobia are generally accepted as the normal, acceptable social order, GSD men usually normalize their vulnerability to myriad aspects of life in a precarious world.
Intimacy	Intimacy may trigger survivors' responses that are defensive or undermine relationship; closeness may be perceived as a dangerous precursor of abuse.	Culturally, GSD men need to learn about relationships under cover of secrecy; a lack of familial or community support often creates stressors that interfere with GSD men's efforts to achieve intimacy in primary relationships.
Dissociation	By "tuning out," "numbing out," or "diverting attention from reality," victims of abuse are able to tolerate what might otherwise be intolerable life circumstances.	Dissociation is a predictable survival strategy for GSD men who consciously acknowledge they live in a dominant culture that unapologetically rejects them.
Sexuality	Many abuse survivors struggle to disentangle sexual feelings and behaviors natural to their core personality from learned or conditioned responses to abuse.	Heterosexuality is the cultural norm for "healthy" sexuality; a GSD man frequently struggles to gain acceptance of his sexuality without the filter of oppressive judgments.

GSD male survivors are commonly alert to threats of rejection and violence. Repercussions of sexual and gender prejudice/violence are one plausible explanation for why GSD males face higher risks for sexual trauma (Xu & Zheng, 2015). Data from the past 20 years indicate that LGB individuals report higher rates of childhood sexual abuse than heterosexuals (Roberts, Rosario, Koenen, & Austin, 2012), with gay men reporting rates close to levels reported by heterosexual women (Rothman, Exner, & Baughman, 2011). A 2001 nonclinical study (Tomeo, Templer, Anderson, & Kotler) revealed that whereas only 7% of heterosexual men in their sample reported same-sex molestation during childhood, 46% of gay men

acknowledged childhood sexual trauma. Data from the 2010 National Intimate Partner & Sexual Violence Survey (Center for Disease Control, 2013) revealed that 26% of gay men and 37% of bisexual men experienced rape, physical violence, and/or stalking by an intimate partner at some point in their lifetime. That same survey reported that 40% of gay men and nearly 50% of bisexual men had experienced sexual violence other than rape in their lifetime, compared to 21% of heterosexual men. It is important to note a caution in how we interpret data comparing risk factors for males who identify as GSD vs. heterosexual, as it is possible that heterosexual males are less likely than GSD males to acknowledge having been victims of sexual trauma. More research is needed to clarify how sexual and gender prejudice affects heterosexual male survivors.

Unfortunately, sexual, gender, and racial prejudice is woven into many of the primary institutions that govern society (e.g., laws and traditionally religious doctrines). This creates a context for the sanctioned marginalization and abuse of minorities: Vives (2002) found that 75% of a sample of 445 gay and bisexual males had experienced verbal harassment and 33% confirmed physical violence related to sexual orientation. Data from another survey found that nearly 50% of gay and bisexual adults experienced verbal abuse and 20% experienced physical violence or property crimes because of their sexual orientation (Herek, 2009). A study of Latino men who have sex with men revealed they had a higher incident rate of childhood sexual abuse compared to Caucasian men who have sex with men (Arreola, Neilands, & Diaz, 2009). Grant et al. (2011) interviewed 6450 transgender or gender non-conforming adults. Results indicated that 15% of respondents reported being sexually assaulted while in prison and 22% of respondents reported being sexually assaulted by residents or staff while in homeless shelters.

The character of sexual trauma that results from discrimination is quite different from incestuous abuse because of the added dimension of revulsion and prejudice against the minority identity itself (Gartner, 1999a, 1999b). Hate crimes are frequently perpetrated with the intent to disgrace or obliterate the personal and cultural identity of the victim(s). The resulting impact of "identity trauma" may utterly overshadow the sexual components of the attack (Kira et al., 2011). Victims of this kind of sexual violence characteristically exhibit features of complex trauma resulting from being the target of hate intermixed with sexual violation (Courtois & Ford, 2013).

Research shows higher rates of posttraumatic stress disorder for sexual abuse survivors who were gender non-conforming compared to survivors who were gender conforming (Roberts, et al, 2012). Brooks (2001) asserted that violence is a customary tool used against gender atypical males and that acts of aggression may be used to reprimand "misbehavior" and to instill the "rules" for socially acceptable male behavior. As one GSD male survivor described:

> *In college the sexual assault that I experienced at 18 was definitely associated with being not masculine enough. My abuser wanted to prove that I was gay to his friends by having me perform oral sex on him while they watched and then by anally penetrating me to prove to them I liked it as he had me masturbate while he penetrated me. So the "proof" that I liked it and that I was gay was the fact that I came while he was anally penetrating me.* (Jason)[4]

[4] Jim Struve and Howard Fradkin are co-chairs for the MaleSurvivor Weekends of Recovery (WOR) program, which provides 3-day experiential workshops for male survivors. We have included throughout the remainder of this chapter selected quotes from a survey of WOR alumni, which Jim and Howard conducted in 2015. Real names are not used in any of these quotes.

Sexual and gender prejudice is also carefully intertwined within hazing rituals, a phenomenon that seems to be more characteristic of masculinized environments (e.g., fraternal organizations, sports teams, the military, social clubs, etc.). Within these rituals, sexuality and gender are routinely manipulated, distorted, or completely denied for some overarching purpose (e.g., gaining entry into a group, enforcing compliance and loyalty, testing someone's personal fortitude). The environments within which these hazing rituals occur and the longstanding traditions that may encase their implementation often sanction, disguise, or dismiss any responsibility for the effects of sexual trauma that belong to the offenders, yet may be internalized by the recipient. One complication in addressing sexual trauma that occurs under the guise of this socially sanctioned discrimination is that the victim may not recognize the experience as being a sexual violation. Furthermore, institutional tradition may lead victims to accept trauma as the price they agreed to pay by submitting to the hazing, or may stifle bystanders from intervening to stop such harmful behavior.

Unfortunately, investigators of hate crimes and subsequent treatment providers often miss uncovering dynamics of this complex trauma. A contributing factor is that GSD survivors will frequently not disclose sexual details of their assault. There are a variety of reasons this may occur, including that they (a) may have internalized the assault as expected discrimination or customary punishment, (b) may not identify as a sexual or gender minority and thereby do not perceive the assault as a hate crime, (c) may have dissociated the sexual aspects of the assault for fear of harmful repercussions – internal or external - that might result if they acknowledged or disclosed them, and/or (d) may fear disclosure that they have a body that does not look entirely male if they are someone with intersex anatomy or if they were assigned a female sex at birth

and have transitioned to express a male identity and appearance. To complicate treatment further, professionals helping the victim may not inquire about any of these aspects of the assault.

GSD male survivors who experience sexual trauma before they are fully aware of their sexual or gender identity or during a period when they are questioning or confused about their identity may be averse to disclosing their victim status due to fears that doing so will imply they are other than heterosexual masculine males (Cassese, 2000). This can be especially complex for the transgender male survivor who may have been sexually assaulted while identifying and living as a male but targeted because of his female anatomy:

> *I didn't think anybody would believe me. I thought, "Who's going to believe that a guy would rape a 'woman' who looks like a prepubescent boy? I'm hideous!" In addition, I was worried what the implications would be on my gender identity. I feared that if I let a man overpower me, if I was raped vaginally, I could never become the man I knew I was.* (Gerald)

In some cases – for instance, male survivors living in a country with harsh laws against sexual nonconformity or in an isolated cult – being assumed to be a GSD male can result in monstrous physical harm or even death. For them, remaining silent about sexual trauma is an appropriately wise and protective strategy to avoid harsh punishment reflecting judgment about a GSD identity.

Although not a hate crime, some offenders use aspects of sanctioned social bias to manipulate or control GSD male victims. For example, a male victim may internalize his offender's blaming messages of "If you didn't like the sex, why did you get an erection?" and/or "If you didn't like the sex, why didn't you stop it?" For the survivor who knows they are or

suspects they may be GSD males, those messages can be very destabilizing and can interfere with the processing of their trauma. Not understanding the physiology whereby sexual responsiveness may occur even during traumatic encounters, GSD male victims may internalize their body response as proof of consent – a factor that many manipulative offenders will maliciously use to control their victim. The following quote is an example of how sexual messages and trauma dynamics can interfere with processing confusion about body physiology and identity.

> *I feel like a straight man trapped in a gay man's body. I feel I was born to be a straight man but that the abuse conditioned my body and arousal template to understand sex as being submissive to an aggressive ... man, which is still the primary interest of my body's sexuality even as my primary self is disgusted by what my body compels me to do.* (Jamaal)

This can be particularly tricky when GSD male survivors and/or their allies subscribe to deeply held convictions that any degree of GSD identity or expression is pathological, religiously apostate, or otherwise rejected. There may be faith-based or ideological prohibitions that prevent GSD male survivors from honest disclosure or engagement in unrestricted discussions of same-sex aspects of their sexual trauma. The GSD male survivor may be overwhelmed by the dissonance between the norms of their support environments (e.g., family, faith, peers) and their internal aspirations for identity and expression. GSD male survivors who are caught in these real-life cultural dilemmas commonly develop highly refined skills for dissociating sexual aspects of whatever trauma they experienced.

This application of dissociation may provide a necessary degree of protective refuge, whereby others in the survivor's life may exhibit greater acceptance when the survivor remains shrouded in silent conformity or an identity of confusion. For many GSD male survivors, identity dissociation and trauma dissociation may become intertwined in complex ways. The task for the clinician is to provide safety that allows the survivor to bring those considerations back into consciousness.

Risky Sexual Behavior

Sexual abuse can interrupt sexual identity development and therefore a survivor's chance for sexual health. As previously mentioned, GSD male survivors may exhibit a number of health and behavior issues whose origin can be linked to the residual impact of sexual minority stress. An important issue to explore is the prevalence of risky sexual behaviors among GSD male survivors. There are two viewpoints to this issue: First, many GSD males are at greater risk for sexual trauma prior to any assault. Second, many GSD male survivors engage in intensified risky sexual behavior after being assaulted. Regardless of sexual identity, men who are abused are more likely to report engaging in high risk sexual behavior compared to their non-abused counterparts (Jinich et al., 1998; Kalichman, Gore-Felton, Benotsch, Cage, & Rompa, 2004).

A first pathway to risky sexual behavior originates in real or perceived obstacles to equal and open access to other GSD male peers. Sexual and gender prejudice is again a preexisting factor in this discussion. For instance, GSD children may isolate themselves for fear of being different or may be isolated due to not fitting in. This seclusion may leave them vulnerable to predators, especially if the youth displays gender traits setting them apart from the norm (Roberts et al., 2012; Sandfort, Melendez, & Diaz, 2007).

Identification as GSD has historically been shrouded in secrecy and marginalization. Expressions of identity that do not conform to the expectations of non-traditional heterosexual masculinity are often viewed with suspicion and may even be subject to punitive repercussions that are grounded in legal or faith-based prohibitions. For this reason, GSD or questioning youth tend to be restricted in opportunities and locations where they can explore their sexuality safely.

Lacking permissible access to male peers who share their sensibilities, prepubescent and adolescent GSD males may search for like-minded others and put themselves in situations (e.g., public sex environments, internet chatrooms) where there is an increased risk of being sexually abused (Balsam, Rothblum, & Beauchaine, 2005) or seek inclusion in all-male environments such as sporting activities, Scouting, extracurricular youth groups, etc. Close physical contact in these settings with older males may be particularly comforting. However, inexperienced GSD males are therefore more vulnerable to influences of older males who may invite, manipulate, or coerce them into sexual contact(s) before they learn the rules and skills of consent. The context of this sexual contact may be further complicated if the young male was secretly desiring an opportunity for same-sex sexual expression and connection of a non-exploitative nature.

Recognition of the inappropriateness of this kind of sexual contact may be muted by internalized self-blame when GSD males believe they were complicit in instigating the sexual contact or if the experience was justified as "sexual initiation." A GSD male who has this historical scenario may need input from an outside observer – clinician or ally - to help them decipher how a lack of opportunities to express their attractions safely created a vulnerable pathway to victimization.

I had experienced same-sex attraction and wanted to seek out others who identified as gay. For this reason, I had gone online to speak with what I hoped

> *would be older gay role models and a community but instead found men who wanted to sexually exploit me. My family was highly homophobic and I was scared to come forward about the abuse because I was more afraid of getting in trouble with them than with preventing what was happening.* (Ben)

The second pathway to risky sexual behavior is an outgrowth of having been subjected to traumatic sexual experiences. Depending upon the vulnerability of the survivor, the perpetrator's abusive behaviors may become internalized and create an unsafe template for how to express sexual feelings (see Ben's comments above). "Risky" behaviors include but are not limited to having unprotected sex with one or more anonymous partners; exchanging sex for drugs or money; having unprotected sex with an intravenous drug user; and engaging in non-consensual bondage, dominance/discipline, sadism/submission, and masochism (BDSM).

A 1994 study of 1001 men in three American cities (Chicago, Denver, and San Francisco) reported that men who also disclosed a history of sexual trauma were more likely to have participated at least once in unprotected anal intercourse during the four-month pre-study period (Cassese, 2000). Another study (Kalichman et al., 2004) reported a higher risk for HIV/AIDS among gay men - especially gay men of color - who also acknowledged a history of childhood trauma (including sexual trauma). Gay and bisexual Latino men who perceived their sexual assault to be coerced reported more consumption of alcohol, a greater number of sexual partners, and a greater frequency of unprotected anal sex (Dolezal, 2002).

In our clinical experience, many GSD survivors' risky sexual conduct reflects either reenactment behaviors or repetition compulsion patterns, as one GSD male survivor described:

> *I have come to realize that the past and current type of pornography that I watch resembles to a great degree the behaviors, positions, and language that was used*

as part of my sexual victimization. I see a clear pattern of repeating my sexual trauma. (Kaleem)

We observe three factors that may exacerbate the interaction of sexual trauma and risky sexual behaviors for GSD male survivors:

(1) Premature imprinting of "learned homoerotic response patterns" may be a powerful residue for GSD males who are sexually victimized at a young age by an older male (Brady, 2008; Gartner, 1999a; Gilgun & Reiser, 1990; King, 2000). The offender's sexual dynamics may eclipse the victim's ability to experience his own, leaving the victim developmentally frozen, bonded to the sexual practices of his trauma, and repetitively engaging in sexual behaviors that are familiar. The GSD survivor may believe his only value is in being a good sex object. Lacking self-awareness, education about healthy sex, appropriate outlets, and assertiveness skills, these GSD male survivors may habitually seek out partners in ways that cross the boundaries into risky and unfulfilling sexual encounters. This may reflect chronic sexual behaviors that are essentially reenactments of their sexual trauma, as this GSD survivor surmised:

The history of risky sexual behaviors IS the sexual trauma. (Jose).

(2) Some males who engage in sex with other males struggle with intense denial of their non-heterosexual feelings. These survivors may feel compelled to avoid any associations with their authentic sexual self, no matter where they reside on the spectrum of sexuality. They may manage real or anticipated triggering by avoidance, and struggle with guilt and shame if they "surrender" to their desires

for same-sex intimacy. Therefore, if they succumb to same-sex desires, their denial may put them at risk of engaging in unsafe sexual practices (Rosario, Schrimshaw, & Hunter, 2006). Often, such a same-sex sexual encounter will occur impulsively, with a greater risk that their sexual behavior is reenacting an abuse scenario. Taking steps to be safe may require them to acknowledge the reality of their behavior, thereby making the sexual encounter(s) too real. The dissociative dimensions of denial and minimization create the perfect context for avoiding considerations of safety. One GSD male survivor described it this way:

> *My sexuality is compartmentalized. On one side, I have a loving heterosexual relationship with my wife. On the other is this part of me that wants a man to hurt and abuse me for his sexual pleasure. I do not classify myself as bisexual.* (Henri)

(3) Shame is an overriding emotional dynamic for many GSD male survivors. Therefore, resulting issues of self-hatred and low self-esteem often contribute to avoiding safe sexual practices. Engaging in risky sexual encounters may be a way to inflict self-punishment, treat themselves as they were treated, and/or reinforce internalized beliefs that they are unworthy of safety and protection. If the GSD male survivor is struggling to accept non-heterosexual emotions and behaviors, intense shame may further reinforce the tendency to avoid considerations of risk management and safety. Sadly, sometimes GSD male survivors seek out exposure to HIV as a way to validate feelings of negative self-worth.

> *I normally have unprotected sex every time unless my partner asks for it. Very, very, very few do. I probably currently average 2-3 casual sexual encounters per*

> *month. If I'm honest with myself I realize that this self-destructive behavior just feeds my self-hatred and feelings of worthlessness.*
>
> (Alejandro)

While any one of these factors may fuel risky sexual behavior for the GSD male survivor, there may also be a cascading process whereby multiple levels of these factors interplay with each other. Wright (2001) refers to this dynamic as a "spiral of risk," wherein GSD male survivors seek high-risk behavior in their quest to belong or to avoid abandonment. As one GSD male survivor related,

> *In my case, I think the connection is clear. Violent abuse that my body responded to strongly correlates with the yearning for violent sexual contact with men as an adult.* (Steven)

Promoting Healthy Sexual and Gender Identities

It is essential to co-create sufficient safety with GSD male survivors to allow them to access and reveal their authentic self, in their own words and at their self-determined pace of disclosure. There is, predictably, a natural fluidity about exploration, awareness, examination, acceptance, identity, and expression; however, the clinician must avoid *a priori* assumptions based on judgments of linear progress between these developmental stages. Maintaining safety can nurture a GSD male survivor's ability to be accurate and authentic in his communications about his trauma experience(s) and define what he needs for his healing journey.

The risk for disconnection is always possible when survivor, ally, and/or clinician do not share the same assumptions about sexual and gender diversity. To some degree, almost everyone

in our culture is vulnerable to false notions of sexuality and gender and the cultural myths that sometimes overshadow substantiated truths about diversity issues and sexual trauma. The following are some common myth-truth distortions that may impact GSD male survivors, allies, and professional caregivers alike:

1. Being gay is contagious; a male is at risk for becoming gay, bisexual, or some other presentation of GSD if he is sexually assaulted.
2. A male victim must be gay if they did not stop their sexual assault; any degree of genital arousal confirms they must not be fully heterosexual.
3. GSD males are known to be promiscuous, so the victim was probably somehow complicit in seeking out the sexual encounter.
4. The survivor's same-sex sexual reenactment behavior constitutes "gay" behavior. Thus, prejudice gets reinforced by pairing a gay or bisexual identity only to reenacting their sexual trauma. When the client and clinician are misled by this prejudice, then assessment and treatment options are limited.
5. "Man Up" is a common adage that differentiates "real men" (who can simply dismiss sexual trauma and move on with life) from GSD males (who are perceived to be lower on the hierarchy of manhood, thereby stigmatized as weak and unable to get over negative reactions from whatever sexual contact occurred). Unfortunately, heterosexual males who do not display the norms of "manning up" are frequently assumed to be GSD, thereby being similarly stigmatized.

The presence of myth-truth and bias is like having a window blind that shutters out truth or reinforces patterns of dissociation that block realities of sexual trauma. For the GSD male survivor who experiences overt or covert prejudice or myth-truth dilemmas, this additional

dimension of the assault(s) may overshadow or intensify the experience of the sexual trauma(s) and complicate the process of healing (King, 2000).

Helping GSD male survivors free themselves of the effects of sexual trauma may require support from the clinician about ways to challenge these myth-truth dilemmas and examine biases that interfere with the GSD male survivor's authenticity (Martell, Safren, & Prince, 2004). For many, it is critical to find a peaceful resolution to perplexing questions about sexuality and gender, including:

"Was I targeted for sexual assault because of my GSD traits?"

"Did my sexual trauma make me a GSD male?"

"How do I know what is my authentic sexual and gender identity?"

"If I wanted sexual contact with another man, does that mean the sexual assault was my fault?"

Therapeutic safety provides the opportunity for GSD male survivors to identify and examine vulnerabilities, questions, shame, and confusion about sexuality and gender. Empowering GSD male survivors with skills to challenge these myth-truth distortions if they exist in their support systems may be another essential task of successful healing. Within this environment of safety and freedom to make choices, the GSD survivor may more authentically articulate a fluidity or blending of distinctly different aspects of identity. None of this work can be accomplished, however, if clinicians working with this population have not deconstructed these myth-truth dilemmas and biases for themselves.

Providing therapeutic guidance to help GSD male survivors develop authentic identity and healthy self-expression is core to congruent healing. Identity and expression are subjective. Therefore, the clinician must carefully balance when to validate the survivor's alternative values

and behavioral choices and when and how to challenge decisions that seem unhealthy. This clinical task can be very complicated when the choices being made by the GSD male survivor stir biases about life choice options within the clinician.

Just as we earlier challenged the binary paradigm as it pertains to discovery and assessment, we also approach healing from the perspective of spectrum. Reminding GSD male survivors of the continuum of options for sexual and gender identity and expression can relieve many aspects of distress. The clinician needs to honor the possibility that the GSD male survivor is not now – nor perhaps ever was – a member of either the straight or the gay "team." A first order task may be to educate the survivor – and perhaps his allies – about the validity of spectrum.

The following questions may help GSD survivors articulate their own gender and sexual diversity:

1. How do you define your sexual and gender identity currently?
2. Were you aware of your sexual feelings and identity prior to the trauma?
3. Did you have any concerns about your gender expression or sexual attractions prior to the sexual trauma?
4. Did the offender assign or imply a sexual identity to you during your sexual victimization?
5. How did you define your sexual and gender identity after the victimization?
6. Were there specific ways the offender used your gender expression or sexuality as a feature of your sexual victimization? Do you feel any specific aspects of your gender or sexuality contributed to being targeted?

7. Do you currently feel unsettled or conflicted about your gender expression or sexuality in any way that relates to your sexual trauma?
8. Do you have a history of engaging in risky sexual behaviors? If so, how are they similar and different from your original sexual trauma?
9. How do cultural values, bias, minority stress, and social privilege affect your sexual and gender identity development?

A second order task may be helping survivors differentiate the perpetrator(s)' dynamics from their own sexual orientation, values, and needs. One way to do this is inviting survivors to draw two overlapping circles and identify in one circle what represents for them healthy sexuality and indicate in the other circle what represents traumatic sexuality. This differentiation is important for self-direction and de-linking the survivor's physical and emotional desires from his sexual trauma. This process may also help acknowledge the benign overlaps between healthy and traumatic sexuality (e.g., smells, sounds, body parts, power dynamics, gender). As the survivor can learn to tolerate and accept the naturalness of sexual desires that are not linked to trauma, he acquires the capacity to know more about his inner self, discover possibilities for healthy intimacy, and thereby access his authentic sexual orientation.

Other overlapping circles can be added to this Venn diagram to indicate other characteristics (e.g., racial/ethnic, religious, LGBT identities) so the survivor can decide which of those communities' norms and values indicate healthy sexuality and which do not apply to the survivor personally. This process may help them accept and attend to what promotes safety, health, and connection, and therefore correct damage done by the abuse and societal discrimination.

It is complicated for the GSD male survivor to decipher - through the residual overlays from sexual trauma - which aspects of their sexuality and gender are core to their identity. Either attractions or aversions can possibly be symptomatic of unresolved trauma. Transgender survivors may have the most difficulty differentiating between the gender dysphoria they feel about their genitals from the posttraumatic stress responses they feel about being sexual. As with a compass that has been juggled, careful and patient observation allows the needle to eventually find its way back to pointing north. This metaphor, when applied as a real clinical intervention, can assist GSD male survivors to find their authentic orientation. Careful excavation of residual eroticized debris, pursued with patience over time, can be successful in discovering features of attraction and/or aversion that seem genuine.

External values or prohibitions may frequently be sources of disturbance. If so, therapeutic interventions that reduce shame and anxiety associated with same-sex desires and/or a diverse gender expression may calm any compulsivity in pursuing those interests. With this therapy outcome, the GSD survivor becomes more empowered and capable of making informed decisions about sexuality, gender, and other related social circumstances.

As with most therapeutic endeavors, the goal is not to achieve a definitive ending. Rather, successful healing allows the GSD male survivor to realize an ongoing process of homeostasis, a stable balance in which the survivor can continue to grow and thrive. Developing healthy sexuality and a positive sense of gender are key components to a life of equilibrium. Clinicians working with GSD male survivors on developing this equilibrium will need to enhance their own capacity to address social justice issues so they can counter the trauma done by sexual and gender prejudice.

References

Andersen, J. P., & Blosnich, J. (2013). Disparities in adverse childhood experiences among sexual minority and heterosexual adults: Results from a multi-state probability-based sample. *PLoS ONE*, *8*, e54691.

Arreola, S. G., Neilands, T. B., & Dıaz, R. (2009). Childhood sexual abuse and the sociocultural context of sexual risk among adult Latino gay and bisexual men. *American Journal of Public Health*, *99*, 432–438.

Bailey, J. M., Vasey, P. L., Diamond, L. M., Breedlove, S. M., Vilain, E., & Epprecht, M. (2016). Sexual orientation, controversy, and science. *Psychological Science in the Public Interest, 17*(2) 45–101.

Balsam, K. F., Rothblum, E. D., & Beauchaine, T. P. (2005). Victimization over the life span: A comparison of lesbian, gay, bisexual, and heterosexual siblings. *Journal of Consulting and Clinical Psychology*, *73*, 477-487.

Beckstead, A. L. (2012). Can we change sexual orientation? *Archives of Sexual Behavior, 41,* 121-134.

Beckstead, A. L., & Morrow, S. L. (2004). Mormon clients' experiences of conversion therapy: The need for a new treatment approach. *The Counseling Psychologist, 32*, 651-690.

Brady, S. (2008). The impact of sexual abuse on sexual identity formation in gay men. *Journal of Child Sexual Abuse*, *17*(3–4), 359-376.

Brooks, F. (2001). Beneath contempt: The mistreatment of non-traditional/gender atypical boys. In J. Cassese (Ed.), *Gay men and childhood sexual trauma: Integrating the shattered self* (pp. 1 – 17). Binghamton, NY: Haworth.

Cassese, J. (Ed). (2000). *Gay men & childhood sexual trauma: Integrating the shattered self.*

Binghamton, NY: Haworth.

Center for Disease Control & Prevention (2013). *The National Intimate Partner and Sexual Violence Survey: 2010 Findings on Victimization by Sexual Orientation*. Atlanta, GA: National Center for Injury Prevention and Control.

Corley, M. D., & Kort, J. (2006). The sex addicted mixed-orientation marriage: Examining attachment styles, internalized homophobia and viability of marriage after disclosure. *Sexual Addiction & Compulsivity*, *13*(2-3), 167-193.

Courtois, C. A., & Ford, J. (Eds.) (2013). *Treatment of complex trauma: A sequenced, relationship-based approach.* New York: Guilford.

Dolezal, C. (2002). Childhood sexual experiences and the perception of abuse among Latino men who have sex with men. *Journal of Sex Research*, *39,* 165–173.

Gartner, R. B. (1999a). *Betrayed as boys: Psychodynamic treatment of sexually abused men.* New York, NY: Guilford.

Gartner, R. B. (1999b). Sexual victimization of boys by men. *Journal of Gay & Lesbian Psychotherapy*, *3* (2), 1-33.

Gilgun, J. F., & Reiser, E. (1990). The development of sexual identity among men sexually abused as children. *Families in Society, 71*(9), 515-523.

Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., & Keisling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey*. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force. Retrieved from http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf

Haas, K. (2004). Who will make room for the intersexed? *American Journal of Law & Medicine*, *30*(1), 41-68.

Herek, G. M. (2009). Hate crimes and stigma-related experiences among sexual minority adults in the United States: Prevalence estimates from a national probability sample. *Journal of Interpersonal Violence*, *24*(1), 54-74.

Intersex Society of North America. (2016). What is Intersex? Retrieved from http://www.isna.org/faq/what_is_intersex

Jinich, S., Paul, J., Stall, R., Acree, M., Kegeles, S., Hoff, C., Coates, T. (1998). Childhood sexual abuse in HIV risk taking behavior among gay and bisexual men. *AIDS and Behavior*, *2*(1), 41–51.

Kalichman, S., Gore-Felton, C., Benotsch, E., Cage, M., & Rompa, D. (2004). Trauma symptoms, sexual behaviors and substance abuse: Correlates of childhood sexual abuse and HIV risk among men who have sex with men. *Journal of Child Sexual Abuse*, *13*(1), 1–15.

King, N. (2000). Childhood sexual trauma in gay men: Social context and the imprinted arousal pattern. In J. Cassese (Ed.), *Gay men and childhood sexual trauma: Integrating the shattered self* (pp. 19-36). New York, NY: Routledge.

Kira, I.A., Templin, T., Lewandowski, L., Ramaswamy, V., Ozcan, B. Abou-Mediane, S., et al. (2011). Cumulative tertiary appraisal of traumatic events across cultures: Two Studies. *Journal of Loss and Trauma: International Perspectives on Stress and Coping*, 16, 43-66.

LeVay, S. (2011). *Gay, straight, and the reason why: The science of sexual orientation*. New York, NY: Oxford University Press.

Martell, C. R., Safren, S. A., & Prince, S. E. (2004). *Cognitive-behavioral therapies with lesbian, gay, and bisexual clients*. New York, NY: Guilford.

Morris, J. F., & Balsam, K. F. (2003). Lesbian and bisexual women's experiences of victimization: Mental health, revictimization, and sexual identity development. *Journal of Lesbian Studies, 7*, 67–85.

Reconciliation and Growth Project (2016). *10 Ethical Principles to Promote Health When Helping Those Distressed by Sexual Orientation and Gender Identity.* Retrieved July 14, 2016 from http://media.wix.com/ugd/ec16e9_739a6ca82a204e3e8db5e9435bf1413c.pdf

Roberts, A. L., Rosario, M., Koenen, K. C., Austin, S. B. (2012). Elevated risk of posttraumatic stress in sexual minority youths: Mediation by childhood abuse and gender nonconformity. *American Journal of Public Health*, *102* (8), 1587-1593.

Rosario, M., Schrimshaw, E. W., & Hunter, J. (2006). A model of sexual risk behaviors among young gay and bisexual men: Longitudinal associations of mental health, substance abuse, sexual abuse, and the coming-out process. *AIDS Education and Prevention, 18*(5), 444-460.

Rothman, E. F., Exner, D., & Baughman, A. L. (2011). The prevalence of sexual assault against people who identify as gay, lesbian, or bisexual in the United States: A systematic review. *Trauma, Violence, & Abuse, 12*(2), 55-66.

Russell, J. D., Jones, R. A., Barclay, K., & Anderson, M. (2008). Managing transference and countertransference in the treatment of gay, lesbian and bisexual survivors of childhood sexual abuse. *Journal of Gay & Lesbian Mental Health*, *12* (3), 227-243.

Sandfort, T. G., Melendez, R. M., & Diaz, R. M. (2007). Gender nonconformity, homophobia, and mental distress in Latino gay and bisexual men. *Journal of Sex Research*, *44*, 181-

189.

Savin-Williams, R. C., & Vrangalova, Z. (2013). Mostly heterosexual as a distinct sexual orientation group: A systematic review of the empirical evidence. *Developmental Review, 33*(1), 58-88.

Stevenson, M. R. (2000). Public policy, homosexuality, and the sexual coercion of children. *Journal of Psychology & Human Sexuality, 12* (4), 1-19.

Struve, J., & Fradkin, H. R. (2015). *Survey of GBT MaleSurvivor Weekend of Recovery Alumni*. Unpublished raw data.

Tomeo, M., Templer, D., Anderson, S., & Kotler, D. (2001). Comparative data of childhood and adolescence molestation in heterosexual and homosexual persons. *Archives of Sexual Behavior*, 30, 535–541.

van Anders, S. M. (2015). Beyond sexual orientation: Integrating gender/sex and diverse sexualities via sexual configurations theory. *Archives of Sexual Behavior, 44*(5), 1177-1213.

Vives, A. (2002). The psychological sequelae of victimization based on sexual orientation: A structural equation model of predicting suicidality among lesbian and gay young adults. *Dissertation Abstracts International*, 62(12-B), 5983B, (UMI No. 95012210).

Wright, D. (2001). Illusions of intimacy. In J. Cassese (Ed.), *Gay men and childhood sexual trauma: Integrating the shattered self* (pp. 117–126). Binghamton, NY: Haworth.

Xu, Y., & Zheng, Y. (2015). Prevalence of childhood sexual abuse among lesbian, gay, and bisexual people: A meta-analysis. *Journal of Child Sexual Abuse, 24*(3), 315-331.

Yarhouse, M. A, Tan, E. S. N., & Pawlowski, L. M. (2005). Sexual identity development and

synthesis among LGB-identified and LGB dis-identified persons. *Journal of Psychology and Theology, 33*(1), 3-16.