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Persecution Experiences and Mental Health of LGBT Asylum Seekers

Rebecca A. Hopkinson, MD[a], Eva Keatley, MA[b], Elizabeth Glaeser, BS[c], Laura Erickson-Schroth, MD, MA[a], Omar Fattal, MD[a], and Melba Nicholson Sullivan, PhD[d]

[a]Department of Psychiatry, New York University School of Medicine, New York, New York, USA; [b]Department of Psychology, University of Windsor, Windsor, Ontario, Canada; [c]Department of Child and Adolescent Psychiatry, Child Study Center of NYU at NYU Langone Medical Center, New York, New York, USA; [d]NYU/Bellevue Program for Survivors of Torture, New York, New York, USA

ABSTRACT

Asylum seekers are a unique population, particularly those who have endured persecution for their sexual orientation or gender identity. Little data exist about the specific experiences and needs of asylum seekers persecuted due to lesbian, gay, bisexual, or transgender (LGBT) identity. Quantitative data were gathered regarding demographics, persecution histories, and mental health of 61 clients from a torture survivors program in New York City who reported persecution due to LGBT identity. Thirty-five clients persecuted due to their LGBT identity were matched by country of origin and sex with clients persecuted for other reasons to explore how persecution and symptoms may differ for LGBT clients. LGBT asylum seekers have a higher incidence of sexual violence, persecution occurring during childhood, persecution by family members, and suicidal ideation. Understanding the type of persecution experiences and how these influence mental health outcomes is an essential step toward designing and delivering effective treatments.

KEYWORDS

Asylum; bisexual; gay; lesbian; LGBT; posttraumatic stress disorder; refugee; survivor of torture; transgender; trauma

Asylum seekers[1] are often the victims of torture in their home countries (United Nations, 1984), with estimated rates of maltreatment ranging from 3%–35% (Office of Refugee Resettlement, 2012). Asylum seekers who have endured such harm are at higher risk than the general population for mental health disturbances including posttraumatic stress disorder (PTSD), major depression, loneliness and isolation, cultural bereavement, problems with acculturation, and feelings of guilt, shame, mistrust, and helplessness (Longacre, Silver-Highfield, Lama, & Grodin, 2012; Reading & Rubin, 2011; Steel et al., 2009).

For LGBT individuals, this relationship between early victimization and negative mental health outcomes may be more pronounced. The early life

CONTACT Rebecca A. Hopkinson rebecca.hopkinson@seattlechildrens.org M/S OA.5.154 PO Box 5371, Seattle, WA 98145-5005, USA.

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abuse, rejection, victimization, and internalized homophobia of United States–based LGBT individuals are associated with a myriad of mental health difficulties later in life (D'Augelli, Grossman, & Stark, 2006; Gold, Dickstein, Marx, & Lexington, 2009; Gold, Marx, & Lexington, 2007; McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012; Ryan, Huebner, Diaz, & Sanchez, 2009).

Many investigations in the United States have offered insight into the mental health experiences of LGBT individuals, who face victimization early in life, but little is known about the mental health and experience of LGBT asylum seekers coming into the United States. What we know comes from a few studies showing that pre-migration abuse can have greater consequences on adult mental health (Alessi, Kahn, & Chatterji, 2015; Briere, Kaltman, & Green, 2008; Cloitre et al., 2009; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

LGBT asylum seekers have unique early life experiences that are characterized by verbal, sexual, and physical abuse by parents and caregivers at home, peers and personnel at school, and in the larger community in their home countries. (Alessi, Kahn, & Chatterji, 2015; Reading & Rubin, 2011; Shidlo & Ahola, 2013; United Nations Human Rights Council, 2011). In these countries, LGBT individuals are often subject to threats and harassment, neglect, alienation, and restricted access to community or familial resources. These punishments for gender nonconformity or homosexuality often begin in childhood and can occur daily from multiple persecutors (Reading & Rubin, 2011; Shidlo & Ahola, 2013; United Nations Human Rights Council, 2011).

The literature suggests that prolonged torture and abuse contributes to the development and severity of traumatic stress (Briere et al., 2008; Cloitre et al., 2009; Silove, 1999), as does rejection by family (Ryan et al., 2009). Additionally, early onset and longer duration of neglect, maltreatment, and physical and sexual abuse are associated with increased severity and variability of mental health symptoms (Cook, Blaustein, Spinazzola, & Van Der Kolk, 2003). These can include symptoms of PTSD, dissociation, somatization, relational and attachment conflicts, behavioral inhibition, depression, anxiety, and changes in personality (Briere et al., 2008; Bryer, Nelson, Miller, & Kroll, 1987; Cloitre et al., 2009; Cook et al., 2003; Herman, 1992; Maercker, Fehm, Becker, & Margaf, 2004; Shidlo & Ahola, 2013).

In particular, sexual trauma experienced by these individuals has been shown to be a strong predictor of PTSD (Cortina & Kubiak, 2006; Kessler et al., 1995; McCutcheon et al., 2010; Perkonigg, Kessler, & Wittchen, 2000). Evidence of higher rates of sexual trauma has been clinically and qualitatively uniquely observed in the LGBT asylum seeker community (Alessi, Kahn, & Chatterji, 2015; Reading & Rubin, 2011).

LGBT individuals often migrate to the United States with the expectation of improvement in their lives and mental health (Lewis, 2014). However, even after arriving in the United States, it is common for LGBT asylum seekers to experience feelings of isolation and alienation (Heller, 2009; Reading & Rubin, 2011). Although the majority of non-LGBT asylum seeker populations have the support of immediate family members, friends, or other members of their persecuted group, LGBT asylum seekers are often alone in their migration as a result of their LGBT identity. They struggle to relate to LGBT individuals from the United States due to cultural differences and shame about their history of persecution, yet their ethnic communities living in the United States continue to be a source of harassment and fear (Portman & Weyl, 2013; Shidlo & Ahola, 2013). Due to the involvement of family and community members in persecution, LGBT asylum seekers' ability to place trust in new support systems can be severely disrupted, increasing isolation (Herman, 1992; Shidlo & Ahola, 2013). In the absence of family and social support, asylum seekers are challenged with meeting basic needs prior to obtaining legal status in the United States. This contributes to additional psychological sequelae, as lack of social support after a traumatic event is a risk factor for PTSD (Brewin, Andrews, & Valentine, 2000).

Therefore, LGBT asylum seekers experience an accumulation of trauma, characterized by multiple events, in multiple areas of life, over time, which continue even after attempting escape to a new country. As described by Shidlo and Ahola (2013, p. 2), "the relentlessness, pervasiveness, and inescapable character of this type of persecution and discrimination [against LGBT individuals] leads to a potent cumulative effect of these traumatic events."

LGBT asylum seekers may face an even greater risk for negative outcomes without targeted intervention due to both the unique early life experiences of persistent and consistent trauma and post-migration factors. Given these unique early life experiences and general circumstances, LGBT asylum seekers present to service centers with needs that are different from the general asylum seeker population.

To date, there is no quantitative data to confirm that asylum seekers persecuted for their LGBT identity are more likely than other asylum seekers to have experienced sexual trauma, childhood trauma, interfamilial trauma, or specific mental health impacts of prolonged trauma.

This article focuses on a torture treatment program located in a large metropolitan area of the United States. This program works with individuals from around the world who have experienced torture and other human rights violations in their countries of origin. Many of these individuals seek asylum in the United States. Medical, mental health, social, and legal services are provided. A subset of these individuals have experienced persecution for their identity as lesbian, gay, bisexual, or gender non-conforming, and these individuals have described similar experiences as those described in Alessi and colleagues' 2015 paper (Alessi, Kahn, & Chatterji, 2015).

The current study aims to take these qualitative and clinical observations further and examine the unique experiences of LGBT asylum seekers compared with matched controls. The authors attempt to establish a baseline of data on LGBT-heterosexual differentials in mental health outcomes, specifically PTSD and suicidality. The authors sought to examine: (1) Are the rates of sexual trauma, identity of persecutors, and age of onset of trauma significantly different between LGBT asylum seekers and non-LGBT asylum seekers? (2) Are these variables related to trauma symptom severity? The authors hypothesized that asylum seekers persecuted for LGBT identity have higher incidences of sexual violence and familial trauma, earlier age of onset of traumatic events, greater PTSD symptom severity, and higher rates of suicidality than other asylum seeker populations. Currently, no other quantitative studies exist on this topic.

Method

Participants

Participants are clients who completed an intake assessment between January 1, 2008 and April 30, 2013. During this time, the program accepted 839 new clients. Of these, 61 (7.27%) reported persecution due to LGBT identity. These clients emigrated from 29 countries in Eastern Europe, Africa, the Americas, Central Asia, and the Middle East. Most clients (82.0%) identified as Christian or Muslim, with a minority identifying as Jewish, Not Religious, or Other. These groups were collapsed to de-identify participants. Further demographic data are reported in Table 1.

Of the 61 clients persecuted for LGBT identity, 35 (57.37%) had matched-counterparts who were clients of the same sex and country of origin but who were persecuted for reasons not related to their perceived sexual orientation or gender identity. Previous research has suggested that female sex is a risk factor for developing PTSD (Ai, Peterson, & Ubelhor, 2002; Brewin et al., 2000) and that women are particularly vulnerable to sexual violence in the absence of social

Table 1. Demographics of clients persecuted due to perceived-LGBT status (N = 61).

Demographics	*n*	%	Demographics	*n*	%
Sex (Male)	38	62.29	**Immigration Status**		
Age *M* (SD)	28.79 (6.99)		Undocumented	27	44.26
Region of Origin			Temporary Visa	5	8.19
Eastern Europe	26		Asylum application pending	21	34.42
West Africa	13		Asylee/Refugee	4	6.56
South America	7		Missing	4	6.56
Central Asia/Middle East	5		**Education Level**		
Central/North Africa	5		At least some primary	4	6.56
Caribbean	5		At least some secondary	11	18.03
			Post-Secondary	37	60.66
Functional English	49	80.32	Graduate degree	6	9.84
Months in the U.S. *M* (*SD*)	31.9 (31.6)		Missing	3	4.92

structures (Hynes & Cardozo, 2000). For these reasons it was important to limit any variability in sex between the LGBT and matched case groups. Clients were matched on country of origin to isolate the impact of LGBT status on persecution history within a sociopolitical context. Twenty-six LGBT clients (46.6%) were not included in the comparative analyses because no match with the same sex and country of origin was available. These omitted LGBT clients did not differ significantly from other LGBT clients with respect to sex, age, functional English, immigration status at intake, religious affiliation, highest level of education, rate of childhood persecution, history of sexual violence, incidence of head injury, past or present suicidal ideation, or identity of persecutors. The omitted clients, however, experienced a trend toward greater PTSD symptom severity at intake (M 2.9, SD .5) than those with match cases (M 2.7, SD .5; $t(55) = 1.9$, $p = .07$), lived in the United States for a significantly longer number of years (M 3.9, SD 3.0 vs. M 1.7, SD 1.8; $t(35) = 3.2$, $p < .01$), and originated from countries where the majority of, if not all, clients enrolled in the program were persecuted due to their LGBT identity. Of note, we were not aware of any transgender individuals in our sample. However, we referred to clients as LGBT rather than perceived LGB, as we are aware from the work of Shidlo and Ahola (2013) that identities may shift over time.

Measures

Intake and 6-month assessments

Data for this study were drawn from client records. Intake assessments are conducted by supervised trainees in the mental health fields and by licensed clinical staff. The intake assessment is conducted under the supervision of a licensed mental health professional. During the interview, the limits of confidentiality are reviewed and participants have the right to discontinue the interview at any time. They are informed that these data are used to understand their needs and to determine appropriate service recommendations. The intake interview protocol includes a risk assessment for harm to self and others, emotional support to manage distressing affect connected to sharing clients' experiences, and an outline of the next steps in the process. For clients who endorse a moderate to high level of risk to self or others, collaborative safety planning is implemented, and, when needed, clients are escorted to the nearest hospital emergency room for further evaluation.

The intake includes standardized measures and a semistructured interview used to elicit information regarding demographics, social and legal concerns, trauma history, psychiatric symptoms, and physical complaints. Following the intake, interviewers produce a narrative report reflecting the aforementioned areas in addition to DSM-IV diagnoses and recommendations. Six months following the intake assessment, clients are invited to participate in an interview

that includes standardized measures and semistructured questions about the domains of functioning assessed during the intake interview.

Posttraumatic stress disorder

The Harvard Trauma Questionnaire (HTQ) is a self-report instrument that assesses PTSD symptoms (Mollica et al., 1992). Sixteen items on the measure focus on symptoms of posttraumatic stress that are scored on a 4-point Likert scale (from *not at all* = 1 to *extremely* = 4) for intensity in the past week. The HTQ is used widely in research and clinical settings with refugee populations and has been shown to have strong validity, sensitivity, and specificity based on PTSD as defined by the DSM-III-R (Mollica et al., 1992).

Suicidal ideation

Interviewers obtained information regarding clients' past and present suicidal ideation. History of suicidal ideation was recorded by the interviewer on the interview form. For this study, a binomial variable of present and/or past suicidal ideation was used (i.e., yes/no).

Trauma history

Interviewers obtained specific details of the clients' trauma histories including reasons for persecution, identity of the persecutors, age of first persecution, types of persecution acts endured, and whether or not the persecution involved sexual violence. These key indicators were elicited during the unstructured portion of the interview, allowing for patients to report their trauma history in narrative format.

LGBT status

The intake interview form did not include specific questions regarding LGBT status. For the purposes of this study, patients were categorized as LGBT if they spontaneously reported during their intake interview that they were persecuted due to being lesbian, gay, bisexual, or transgender.

Sexual violence

During the intake interview patients were asked, "Have you ever been assaulted or harmed sexually?" The interviewer recorded the patient's response as "yes" or "no." This broad variable relied on patients' and interviewers' interpretations of the definition of sexual assault. Due to the interpretative nature of this field, the variable was further validated by a qualitative review of the intake narrative reports by the research team. Incidents of sexual violence were identified and recorded in three groups as outlined by the Centers for Disease Control: sex act, abusive sexual contact, or non-contact sexual abuse (Basile & Saltzman, 2002).

Identity of persecutors

Based on the clients' narratives, interviewers had the option to select up to two types of persecutors from a list of possible identities, including government authorities, paramilitary group, rebel group, other country's forces, organized crime/street gang, religious organization, family members, and "other." Emergent coding of the intake narrative reports was conducted to record any additional information about persecutors. This coding generated an additional persecutor identity variable of community members (neighbors, classmates, teachers, or a stranger living in the same place).

Data analysis

Descriptive data are provided for demographics, persecution experiences, and mental health variables for all clients persecuted for LGBT status (N = 61). Independent sample t-tests and chi-square analyses were used to determine if history of sexual violence and age of first persecution were associated with higher HTQ scores or suicidal ideation, as suggested by previous research (Cook et al., 2003; Cortina & Kubiak, 2006; Kessler et al., 1995; McCutcheon et al., 2010; Perkonigg et al., 2000). Independent t-tests were used to analyze how identity of persecutors was associated with HTQ scores.

Comparative analyses were conducted with the matched cases (N = 35); univariate analyses were used to determine if survivors of persecution due to LGBT identity experienced trauma events distinct from their counterparts. Chi-square analyses were conducted to determine if asylum seekers persecuted for LGBT identity were significantly different from matched cases in religious affiliation, immigration status, education level, functional English, identities of persecutors, childhood persecution, history of sexual trauma, history of head injuries, presence of physical injuries from abuse, or rates of suicidal ideation. Independent sample t-tests were used to determine if LGBT clients were significantly different than matched cases in age at intake, intake HTQ scores, follow-up HTQ scores, or longest period of detention.

Results

Demographics, persecution histories, and mental health of LGBT Clients

Sixty-one clients reported persecution for LGBT identity. Details of demographic information are provided in Table 1.

The most common trauma experience was sexual violence, which is further described in Table 2. Clients also experienced high rates of beatings (n = 36, 59.0%); threats (n = 18, 29.5%); slapping, kicking, and punching (n = 14, 23.0%); and blows with heavy objects (n = 12, 19.7%).

Table 2. Trauma events experienced by asylum seekers perceived as LGBT (N = 61).

	n	%		*n*	%
Identity of persecutors (N = 57)			**Any sexual violence** (N = 58)	38	65.52
Family members	26	45.61	Completed sexual act	26	44.83
Government authorities	37	64.91	Abusive sexual contact	15	25.86
Organized Crime/Gang	11	19.30	Non-contact sexual abuse	18	31.03
Religious group	2	3.50	**First persecution during childhood (<18 years)** (N = 52)	36	69.23
Community members	34	59.65	<5 years old	7	14.46
			5–13 years old	13	25.00
			14–17 years old	16	30.77

Clients reported having suffered persecution at the hands of one or more types of perpetrators, including family members. Many experienced their first persecutions before the age of 18 years, with some experiencing violence prior to 5 years of age. See Table 2 for details of age, perpetrators, and sexual violence.

Average HTQ scores at intake were above the clinical cutoff for PTSD (N = 57; M 2.8, SD .5) and were just below the cutoff at the 6-month follow-up (N = 34; M 2.4, SD .64). Forty-four (72.1%) clients reported current or past suicidal ideation.

History of sexual violence was associated with higher HTQ scores at intake ($t(52) = -2.3$, $p = .03$) but not higher rates of suicidal ideation ($\chi^2 = 1.4$, $p = .2$). Age of first persecution was not significantly associated with either HTQ scores at intake or presence of suicidal ideation. Persecution by specific groups (i.e., family members, government authorities, organized crime/street gangs, religious group, and community members) was not associated with higher HTQ scores at intake or presence of suicidal ideation.

Comparing LGBT and non-LGBT clients

With regard to religious affiliation, immigration status, education level, proficiency in English, time since arrival in the United States, and age, there were no significant differences identified between the 35 clients who were persecuted for LGBT identity and 35 matched cases persecuted for reasons other than LGBT identity (e.g., ethnic minority status, religious affiliation, political affiliation). The client groups differed significantly in their persecution experiences (Table 3)—specifically, rates of sexual violence, age of first trauma, and identities of persecutors. They did not differ in rates of physical violence or length of detention.

LGBT clients endorsed significantly higher rates of past or present suicidal ideation (n = 29, 82.9%) than their matched cases (n = 19, 54.3%; $\chi^2(1) = 6.6$, p = .01). Intake and 6-month follow-up HTQ scores were not significantly different between the LGBT clients (Intake: M = 2.6, SD = .5; 6-month follow-up: M = 2.2, SD = .5) and their matched cases (Intake: M = 2.8, SD = .6; 6-month follow-up: M = 2.1, SD = .5).

Table 3. Trauma events experienced by asylum seekers perceived as LGBT compared to their controls.

	LGBT Group (N = 35)		Non-LGBT Group (N = 35)				
Identity of persecutors	n	%	n	%	df	χ^2 or t	p
Family members	13	37.14	0	0	1	16.62	<.01
Government authorities	25	71.43	26	74.29	1	0.01	.95
Paramilitary/Rebel/Other country forces	0	0	3	8.57	1	3.05	.08
Organized Crime/Gangs	7	20.00	6	17.14	1	0.14	.71
Religious group	1	2.86	1	2.86	1	0.00	.98
Community members	8	22.85	4	11.43	1	1.77	.18
First persecution during childhood (<18 years)	22	62.86	13	37.14	1	4.43	.04
History of any sexual violence[a]	22	66.67	8	23.53	1	12.60	<.01
Completed sexual act	13	39.39	4	11.76	1	6.75	.01
Abusive sexual contact	4	12.12	3	8.82	1	0.20	.66
Non-contact sexual abuse	11	33.33	3	8.82	1	6.09	.01
Self-report head injury	28	80.00	30	85.71	1	2.72	.10
Any physical injury from abuse	29	82.86	29	82.85	1	0.00	1.0
Months detained in persecution	12.85 (25.42)		24.71 (82.73)		55	t = .70	0.49

Note. [a]LGBT N = 33, Controls N = 34.

Discussion

Our results suggest that asylum seekers persecuted due to their LGBT identity may experience higher rates of sexual violence, earlier age of first trauma, higher incidence of persecution at the hands of family members, and higher rates of suicidality than asylum seekers persecuted for other reasons (e.g., religious, political, or ethnic affiliation). These differences underscore the unique experiences of this population and the need for specific mental health treatment.

Among the 61 LGBT asylum seekers identified, 66% had experienced sexual violence as part of their persecution history. Consistent with previous research, these clients had greater PTSD symptom severity than LGBT clients without a history of sexual violence. In addition, when compared to matched cases, LGBT asylum seekers had a higher incidence of rape (i.e., completed sexual act) and non-contact sexual harassment. Previous research has suggested that sexual violence is more commonly experienced by women and LGBT-identified individuals (Balsam, Rothblum, & Beauchaine, 2005) and is predictive of suicide attempts and of worse psychological outcomes, with symptoms increasing with greater exposure (Cortina & Kubiak, 2006; Keller et al., 2006; Kessler et al., 1995; McCutcheon et al., 2010; Perkonigg et al., 2000; Rees et al., 2011). In one all-female sample, Keller et al. (2006) found that rape was one of the few predictors of higher PTSD symptom severity. Although the literature regarding female victims of sexual assault is more robust, there is a body of literature that suggests that factors related to the LGBT experience—specifically, internalized homophobia—may increase the negative effects of sexual assault (Gold et al., 2009, 2007). The findings from this study, along with

previous research, highlight the need to address sexual trauma and the unique sociopolitical context in which it occurs when treating LGBT asylum seekers.

Of note, 46% of LGBT asylum seekers experienced persecution at the hands of their family members. In stark contrast, not one of the 35 matched cases did. This finding suggests that LGBT asylum seekers may be at a greater risk for persecution by family members than asylum seekers of similar demographic backgrounds who are persecuted for other reasons. Asylum seekers that are persecuted for their ethnic or religious group membership often share that membership with their family. In contrast, it is reasonable to assume that family members of persons persecuted for LGBT status do not identify or feel affiliated with that group. As such, LGBT persons may be particularly vulnerable not only within the community but also within their family structure. Family-inflicted trauma may reflect the rejection of LGBT family member(s), which research has demonstrated predicts negative health outcomes, including depression and suicidality (Ryan et al., 2009).

As predicted, LGBT asylum seekers had a higher incidence of childhood persecution, with 69.2% reporting incidents of persecution before the age of 18. This is a common experience for sexual minority youth (Schneeberger, Dietl, Muenzenmaier, Huber, & Lang, 2014) and may be related to gender non-conforming physical characteristics, mannerisms, or preferences. Gender non-conforming attributes are related to victimization in U.S. youth populations (D'Augelli, Grossman, & Stark, 2006). Although childhood victimization was not significantly associated with either PTSD symptom severity or suicidal ideation in this study, childhood trauma is known to have negative consequences on adult mental health (Briere et al., 2008; Cloitre et al., 2009; Kessler et al., 1995). In a study of 582 women, Cloitre and colleagues (2009) found that trauma-related symptoms such as dissociation, social avoidance, and difficulty with anger management, also termed "complex" symptoms, were strongly associated with the number of childhood traumatic events and not significantly correlated with increased number of such events in adulthood. Similarly, Briere and colleagues (2008) found that increased complex symptoms are correlated with cumulative traumatic events during childhood, most significantly childhood rape and physical abuse. The lack of significant associations between age of persecution and mental health outcomes in this study may be the result of methodological limitations due the archival nature of the data. Despite these findings, the high incidence of childhood persecution in this population demands attention, and the mental health outcomes must be explored in future research.

Interestingly, while LGBT individuals did have a higher incidence of persecution factors thought to contribute to worse mental health outcomes (history of sexual violence, childhood persecution, and persecution by family members), this group did not differ from their matched cases in PTSD symptom severity. This finding is inconsistent with our understanding of sexual violence as a

predictor for poor mental health outcomes in U.S. samples (Cortina & Kubiak, 2006; Kessler et al., 1995; McCutcheon et al., 2010; Perkonigg et al., 2000; Rees et al., 2011). However, it may be that these factors hold different weight in an asylum seeker population, which has a multitude of current and past severe stressors. Recent research has found that post-migration stressors are equally important to psychological distress among asylum seekers as pre-migration traumatic events (Schweitzer, Melville, Steel, & Lacherez, 2006; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997). Post-migration factors such as social support, financial independence, and access to basic needs are critical for the mental health of all asylum seekers and should be addressed in any interventions developed for LGBT asylum seekers.

An additional explanation for this difference from previous studies may be that the decision to seek asylum reflects asylum seekers' resilience (Lewis, 2014.) For example, U.S.-based asylum seekers are a group of clients that decided to flee their home countries by accessing internal and external resources. Unlike refugees, asylum seekers do not enter into the United States with access to social resources that address their basic needs like housing, health insurance, and work authorization. Their ability to access these resources and overcome linguistic, cultural, physical, and psychological constraints reflects resilience and other protective factors.

In the present study, LGBT asylum seekers reported significantly higher incidence of suicidality than their matched cases. Although suicidality is also increased in the United States LGBT population, (Haas et al., 2011; Marshal et al., 2011), this finding is of particular interest given that PTSD symptom severity was not significantly different between these groups. There were limited data on other psychiatric symptoms, such as depression and anxiety, which could affect suicidality. It is important to consider factors such as sexual trauma, internalized homophobia, or stressors connected to being members of an oppressed group. Previous research in the LGBT population found that suicidality was directly linked to victimization, and this relationship was influenced by family support, connectedness, and community support (Duncan & Hatzenbeuler, 2013; Eisenberg & Resnick, 2006; Hershberger & D'Augelli, 1995). The complex relationship between suicidality, victimization, and family and community support may be a key aspect of the unique experience of LGBT asylum seekers and the mental health symptoms from which they suffer.

Limitations

Important limitations to this study exist due to the archival nature of the dataset. First, the only symptom-based measure in the study focused on posttraumatic stress. Consequently, there is a wide range of common psychiatric morbidity that may have been missed, particularly given the presence of suicidal ideation.

The impact of mood and the presence of psychotic symptoms or anxiety that may be affecting the mental health of this population cannot be assessed.

It is also worth considering whether the PTSD symptoms assessed by the HTQ are the most relevant for this population, given the literature on child maltreatment, which suggests that exposure to trauma is expressed in other ways when the onset is early in life. Common symptoms include dissociation, sexual concerns, difficulties with self-concept, interpersonal problems, and behavioral and emotional dysregulation (Briere et al., 2008; Cloitre et al., 2009; Maercker et al., 2004). Future research and assessment measures should evaluate these difficulties in more detail.

Sample selection is also a limitation to this study. As a retrospective case-control paper, all data are gathered from chart review of clients from a program in a major U.S. metropolitan area. The program has criteria for admission including a history of torture or other human rights violations. Moreover, most clients find the program through their social support networks (e.g., attorneys, community center, friends or family). Thus this support-seeking sample may not be generalized to all asylum seeker populations. Another artifact of participants coming from one treatment program is the program's explicit focus on survivors of torture and human rights abuses. Specifically, the United States and United Nations definitions of torture require the active persecution and/or acquiescence of government officials. This contributes to the high incidence of persecution by government officials in both groups. Thus it is a reflection of the broader sociopolitical context in which torture and other human rights abuses occur.

The data consist of self-reported trauma narratives. Self-reported retrospective data are inherently affected by a person's perception and memory of events. This challenge in gathering information is compounded by the realities of working with torture victims: due to discomfort and difficulty with trust, they may not fully disclose all traumatic events during the first interview with a new provider or organization, and, as part of their symptom cluster, they may not recall all aspects of the traumatic events.

LGBT status was not determined by directly asking all clients. A person's sexuality and gender identity was known only if the client described being persecuted for their identity as LGBT, as part of the trauma narrative. Therefore, we do not have information about the sexual orientation or gender identity of clients who were persecuted for other reasons. Because of the archival nature of the data, there was no way of verifying this information. This may be a confounding variable, as many aspects of minority stress specific to the LGBT population are still present, even if the individual was not tortured for this reason.

We also are unaware of transgender individuals in our sample. However, we recognize from the work of Shidlo and Ahola (2013) that it is possible for our clients' identities to shift to include a transgender identity. We believe that a number of the challenges faced by LGB individuals may also be true

for transgender individuals, and that excluding the possibility of this demographic would be limiting without increasing precision in the study results.

We attempted to control for sex differences by matching case-control by sex. However, it is not known how the gay experience may differ from the lesbian experience for asylum seekers. This question is beyond the scope of this article and should be further explored in future research.

Some of the literature that was reviewed for this article is based on studies done in Western countries. Even though findings in these studies such as patterns of suicidality and effects of sexual trauma in childhood might not generalize to individuals who come from non-Western cultures, we are forced to rely on this literature due to the lack of studies conducted in the specific countries where our asylum seekers come from.

Conclusions and implications

Survivors of persecution for LGBT status experience a higher incidence of childhood persecution, persecution by family members, sexual violence, and suicidal ideation. Given the changing legal climate in the United States toward LGBT rights and the contrary in other parts of the world, we can expect that more individuals in this demographic will seek asylum in this country. Results suggest that LGBT asylum seeker populations present with unique trauma histories and symptoms. Further research regarding the traumatic events LGBT asylum seekers experience prior to seeking asylum and the unique post-migration stressors they encounter once resettled will contribute to specialized assessment, intervention, and policies that address their needs.

These data suggest that LGBT asylum seekers are survivors of childhood trauma. For individual therapy, clinicians are encouraged to incorporate the robust body of research regarding the diagnosis and treatment of traumatic reactions to violence perpetrated during critical developmental time periods by caregivers and community (e.g., Foster, 2013). To address the intersection of the nonverbal aspects of trauma, particularly child trauma, and the needs of English language learners, nonverbal (e.g., eye movement desensitization and reprocessing; Shapiro, 2001) and body-based approaches (e.g. Levine, 1997; Ogden, Pain, & Minton, 2006), art or music therapy may be more appropriate than models rooted in verbal expression (e.g. narrative exposure therapy; Schauer, Neuner, & Elbert, 2011). Moreover, group therapy models focused on rebuilding and healing relationships with self, others, and community, such as dialectical behavior therapy (Linehan, 1993) and mindfulness-based stress reduction (Kabat-Zinn, 2013), may best leverage the unique resilience and address the nuanced vulnerabilities of LGBT asylum seekers. Several torture treatment programs facilitate capacity building with United States Customs and Immigration Services (e.g., asylum officers). The capacity-building efforts include specific mandated trainings for refugee and asylum officers on the

experiences of survivors of torture, particularly LGBT survivors and unaccompanied minors. This work begins to address the organizational and policy gaps in the United States and the social justice aspects of LGBT asylum seekers, experience.

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Note

1. In this article, "asylum seeker" refers to immigrants who have fled their home country due to fear of persecution and are seeking safety in the United States without the grant of legal status and the public benefits (e.g., Social Security, work authorization, housing) accorded to refugees by the United Nations and United States prior to entering the country. They may or may not have applied for asylum or have a valid visa; thus they may or may not be documented.

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