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How College Students Discuss Their Relationships

John Domenico

University of New Hampshire

Relationships and Healthcare

INTRODUCTION

Ten million men and women each year experience some level of abuse from their intimate partner (National Coalition Against Domestic Violence, 2018). Studies suggest that 1 in 4 men and 1 in 3 women will be a victim of domestic abuse by an intimate partner within their lifetime. Katie Edwards (2015), a psychological researcher, found that “sexual-minority students” experienced significantly higher rates of dating violence in a six-month period when compared to heterosexual counterparts. Individuals who identify as homosexual are substantially less likely to report experiences with intimate partner violence (IPV) as they oftentimes fear further discrimination or abuse (American Psychological Association, 2002). The Center for Disease Control (CDC) and other sources such as the National Coalition Against Domestic Violence (NCADV) report statistics regarding physical acts of IPV, such as domestic violence, and rape, but lack research on intimate partner violence that is solely emotional.

Abuse is a significant problem in society today, with individuals who identify as homosexual more likely to sustain abuse but less likely to report it. Despite the research the CDC has on physical abuse, there is failure to capture the importance of emotional IPV. The purpose of this study was to determine if college students who identify as homosexual report that their previous relationships with IPV, including emotional violence, and how they would describe and disclose that experience to their healthcare clinicians.

BACKGROUND

The CDC defines an intimate partner as a close relationship, involving but not limited to a person one is emotionally connected to, either with or without a definitive label or sexual intimacy (Center for Disease Control, 2017). Merriam-Webster’s offers two definitions of the

term, “homosexual.” For this research project, their second denotation will be used, “...involving sexual activity between persons of the same sex” (Merriam-Webster, 2018 pg. 1). Lastly, The CDC categorizes emotional abuse as “psychosocial aggression:” “...the use of verbal and non-verbal communication with the intent to harm another person mentally or emotionally ...” (Center for Disease Control, 2017), but still lack the research or statistics supporting its prevalence or relevance. They identify the major components of psychosocial aggression as: “...expressive aggression; coercive control; threats of physical or sexual violence; control of reproductive or sexual health; exploitation of victim’s vulnerability; exploitation of perpetrator’s vulnerability; and presenting false information to the victim with the intent of making them doubt their own memory or perception” (Center for Disease Control, 2017, pg. 1).

Research studies on emotional IPV in individuals who identify as homosexual are limited. A study of 64 men in 10 focus groups reported name-calling, control, power differentials, intense jealousy, and most saliently, internalized homophobia being reflected back onto them. They also reported that they felt emotional IPV left more scars than physical and identified PTSD and depression as long-term effects of their abuse, as well as stress regarding their own sexuality (Woodyatt & Stephenson 2016). Findings from research conducted on heterosexual relationships are similar. Researchers from a large university found that psychological abuse from an intimate partner made it more likely for the receiving partner to experience PTSD, depression, and anxiety (Começanha, Basto-Pereira, & Maia, 2017). Additionally, researchers from a local intimate partner violence program that aided in recuperating women found that those who had a history of frequent emotional abuse still felt depressed after the program (Estefan, Coulter, & Vandeweerd, 2016). Perhaps most salient is a research project conducted at a large university which examined suicidal ideation in comparison

to emotional abuse using tools such as the “Multi-Measure of Emotional Abuse” quiz and a “Revised Conflict Tactics Scale.” Researchers found that there was a positive relationship between dominance and hostility from a partner and the presence of suicidal ideation of the abused (Wolford-Clevenger, Grigorian, Brem, Florimbio, Elmquist, & Stuart, 2017).

Researchers have expressed the difficulty in how one measures emotional abuse. The CDC in partnership with the Department of Public Health at Clemson University in 2006 developed the *Measuring Intimate Partner Violence Victimization and Perpetration: A Compendium of Assessment Tools*. The tool offers several scales that measure emotional abuse. The tool asks questions pertaining to prevalence, length, and specific emotionally abusive or manipulative acts, types and levels of abuse, both from the victimization and perpetration point of view (Thompson, 2006). Similarly, in 1999, two women researchers developed their own scale to measure emotional abuse, using a 54 item, four domain tool to measure the severity of emotional abuse: hostile withdrawal, domination, denigration, and restrictive engulfment (Murphy & Hoover, 1999).

However, much of the research and recommendations regarding emotional abuse and IPV has focused upon heterosexual partners, with the bulk of work regarding violence against women by their male partners. Individuals who identify as homosexual may have very different experiences based upon their identity, the current sociopolitical climate, and their experiences of stigma. The experience of navigating homosexual adolescence, research on homosexual youth, and theories on homosexual development have numerous critiques, namely for their arbitrariness and generalizability. Vivienne Cass (1984) identified the six stage Model of Gay/Lesbian Identity Development. The six stages outline the process an individual who identifies as homosexual undertakes when coming to grips with their sexuality. Cass describes that

individuals are tasked with assimilating their previous life with their new homosexual identity. Similarly, Anthony D'Augelli (1994) drafted the six stage Homosexual Lifespan Development Model, which places emphasis on the process of coming out. D'Augelli identified that one must exit their heterosexual status in order to enter their homosexual status. This conceptualization that there is often an ongoing struggle with identity, a period of adaption and a need for belonging, created a part of the theoretical framework that guided the researchers.

Individuals who identify as homosexual may not reach out for assistance when experiencing abuse. Additionally, it is estimated only 34% of people injured by their intimate partner receive medical care (National Coalition Against Domestic Violence, 2018). With the legalization of gay marriage in June 2015, and recent social uptake of gay culture, homosexual couples will be encountered in healthcare. A portion of the fundamental and comprehensive head-to-toe assessment performed on every patient focus on home life, relationships, and the feeling of safety within those two domains. Nurses are on the front line of care and spend the most time with patients. Nurses must be hypervigilant and cognizant of the prevalence and relevance of intimate partner violence in the client who identifies as homosexual in order to best care for and protect their patient.

METHODS

Design

The design of this study was a descriptive, qualitative study utilizing narrative and thematic analysis techniques. As there is little research conducted on emotionally abusive intimate partner relationships between those individuals who identify as homosexual, a qualitative study asking participants to engage in a semi-structured interview and answer open ended questions was determined best. This was due to the fact that more thematic research involving homosexual

individuals in this domain must be performed and subjected to analysis and comparison to heterosexual counterparts prior to utilizing quantitative and systematic scales (Murphy & Hoover, 1999; Thompson, 2006; Wolford-Clevenger, Grigorian, Brem, Florimbio, Elmquist, & Stuart, 2017) that are largely based upon the heterosexual experience.

Setting

Interviews were conducted in a private setting agreed upon by participant and researcher in advance. Public locations, such as a coffee shop or library, were utilized, if requested. All interviews took place on or around a medium-sized, public university in the northern region of New England. The university is home to roughly 15,000 students.

Sample

Participants were recruited through distribution of a flyer outlining the nature of this research project. In an effort to protect participants from being outed, the flyer did not mention that the research was specifically investigating homosexual intimate partner relationships. Recruitment was done partly by advertising through a sexual health and rape prevention program that the university offered to staff and students. An Institutional Review Board (IRB) approved postcard was disseminated to specific groups on campus with large LGBT student participation. Students were encouraged to contact the researchers for further information regarding participation in the study. Confidentiality was maintained by establishing a separate email that interested participants could contact.

To be included in this study, participants had to be 18 years or older, be an undergraduate or graduate student, have been involved in a previous or current homosexual relationship, and be able to speak, read, and write in English. Potential participants were excluded if they were: under 18, not a student, had never been involved in a homosexual relationship, or were unable to speak,

read, and write in English. Of the seventeen that expressed interest in the study, thirteen were eliminated as they had disclosed they had not been in a previous homosexual relationship. Of the four individuals who reported having a prior homosexual relationship, three were selected to participate in this study (N=3). The potential fourth participant was not interviewed due to time constraints.

Procedures

Institutional Review Board approval was obtained through the university's IRB prior to initiation of this research project. Informed consent was obtained from all participants prior to participation. Each interview lasted approximately one-half hour. After consulting Tracy Birmingham, UNH Special Counsel, regarding mandatory reporting laws under Title IX, and for the protection of the identity of participants, only the student researcher had access to participant level data that had not been de-identified. Any participant level data that could be potentially identifiable was de-identified prior to sharing with any faculty or staff researchers. This allowed participants' data to remain anonymous and not trigger mandatory Title IX reporting. Any disclosure of child or elder abuse, or hazing, would have still triggered mandatory reporting laws.

If a participant mentioned identifying information, this was removed or modified using a pseudonym from the interview transcripts that was used for data analysis. The data was collected through audio-recorded interview that then was transcribed by REV.com into word documents. These documents were stored online in Box. Box is a cloud-based storage of restricted and legally protected information. The documents were password protected, and the university IRB has approved Box.com for the storage of restricted information. All paper notes and audio recordings were destroyed following transcription. Data recorded and written was transferred

onto encrypted files and stored on Box. Per federal guidelines and pertinent to university requirements regarding ownership, management, and sharing of research data, data will be maintained until the student graduates from the university or three years after the publication of any data.

Each participant was made aware of the resources available to them to aide in mental or sexual health. Participants had complete control over what they choose to share in this interview. At the conclusion of each interview, participants were offered a document which consists of several local and national resources in regard to intimate partner violence.

Methods

Participants were asked several open-ended questions in a semi-structured interview, including, “Can you tell me about your intimate partner relationships you had as an adult? Can you give me an example of what you could consider an unhealthy partner relationship? Can you give me an example of what you would consider a healthy partner relationship? What characteristics make this unhealthy/healthy? How do you think you developed these ideas of healthy/unhealthy relationships? Tell me about your experiences sharing information about your intimate partner relationships with others? Have you shared your sexuality with your clinician?” And lastly, if participants expressed some form of intimate partner violence, “Have you shared that with your healthcare provider or clinician?” If the researcher deemed a subject the participant was describing was of particular importance, the researcher encouraged the participant to expand upon it.

Data Analysis

Data analysis was ongoing throughout the study. Interpretation and identification of themes helped guide the researcher’s understanding. Data interpretation occurred simultaneously with

analysis and subsequent interviewing. Interpretation began with analysis of each case and all forms of data within said case, including any journaling or notes and memos written by the researcher. Following analysis of a case, it was compared with the other cases to identify similarities and differences. Then, data was compared to previous research and theoretical models for reliability and applicability. All data is planned to be reported through an academic paper and poster presentation with identifying elements removed and participants identities kept entirely confidential. There is a potential for peer-reviewed publication to result from this research.

RESULTS

Interviews resulted in participants sharing rich and meaningful experiences with the researcher. Participants were easily able to identify aspects of what they would consider a “good” vs. “bad” relationship and were able to verbalize what they felt IPV and emotional violence would be in a partner relationship. However, they were not able to readily see that some of their prior experiences were scenarios involving IPV or emotional abuse and they were not totally comfortable sharing their sexual identity or partner relationship experiences freely with others, including their healthcare providers. With the concepts of Cass’s and D’Augelli’s theories as a framework for understanding the experiences of young adults who identify as homosexual, and a deep engagement in the data, it was noted that each of the participants was engaged in a process of protecting their true identity and that this impacted their relationships with others and their conversations with their healthcare providers. Thematic analysis of the data revealed that individuals who identify as homosexual felt the need to protect their “true selves,” or their queer identity. The four major themes, or variations of methodologies to protect one’s “true self,” are hiding the truth, staying closeted, internalizing homophobia, and becoming co-dependent.

Demographics

Due to the nature of this study, with the risk of being “outed,” as well as the disclosure of events that may involve sexualized violence, demographics were not collected in order to protect the participants in this study.

Inclusion criteria, and therefore the demographics that can be reported, are that each participant was between the age of 18-24, an undergraduate or graduate student at a medium-sized northern New England public university, identified as homosexual, had been involved in a past homosexual relationship, and could read and write English.

Protection of One’s “True Self”

Despite the cultural and societal shifts in the last twenty years, the legalization of gay marriage, and social upheaval that has taken place, young adults who identify as homosexual in a college setting still feel the need to protect their “true self,” i.e., their homosexual identity. Individuals do this because they do not feel physically or emotionally safe disclosing their sexuality. They do this primarily through (1) an internalization of homophobia, (2) staying closeted or acting different in differing situations, or (3) being co-dependent with other gay people in their lives because they can be their “true self,” or, lastly, (4) hiding the truth from themselves and others to protect themselves from shame, and to cope with intimate partner violence.

Internalization of homophobia. *Internalization of homophobia, or, internalized homophobia,* is a defense or coping mechanism used by individuals who identify as homosexual. It is thought to be learned throughout the course of the individual’s life, as identifying as homosexual is a deviation from the norm, in this case, heterosexual, and that deviation

demarcates one as “othered.” This deviation from heterosexuality can cause feelings of shame, with these feelings of shame also occurring during intimate partner scenarios.

Participant A described their experience with sharing their sexuality and sexual encounters with their healthcare provider. Their own internalized shame of their sexuality created the inability to share with almost all heterosexual people they encountered for fear of judgment, misunderstanding, or belittlement.

When it comes to queer relationships... I don't [really] talk about them... I think it's probably a deep-seated issue... I'm afraid it will make people uncomfortable... I think there is a deep-seated insecurity.

Here, Participant A describes their experience in trying to share their experiences in homosexual relationships with those who identify as heterosexual, and the shame and issues they have with fully acknowledging both their own sexuality and their relationships.

Participant B described their first sexual encounter with a member of the same sex, at a party where they both had consumed a significant amount of alcohol to the point on inebriation. Their own shame related to their sexuality caused them to have a near panic attack after the encounter.

I wasn't sure if I was gay or not... I was crying profusely, and I didn't want anyone to find out... “Just keep quiet about it. No one has to say anything about this, and no one has to know about this...” He never spoke to me after about it...

Participant B explains that after their first same sex sexual encounter they feared being outed and begged their partner not to “out” them. They described the shame they had regarding the encounter and the fear they felt that other people would know they were homosexual identifying.

Participant C did not report direct internalized homophobia, rather they similarly describe a long-term causal relationship with an individual who would ingest copious amounts of alcohol prior to initiation of sexual acts, related to their partner's own internalized shame of identifying as homosexual.

I think he felt bad about being gay... most of his family didn't know... he'd come over and he'd drink a lot... I'd have one and he'd have three in the same amount of time...

Here, Participant C describes the ritual they would go through with their first boyfriend, who would drink to the point of inebriation prior to engaging in sexual intercourse, and the shame they observed regarding sexuality their boyfriend had.

Staying closeted. *Staying closeted* or attempting to conceal their queer or homosexual identity was a way for individuals to protect themselves in an effort to not be defined as "othered." This most often took place in early years, as all participants self-reported that despite knowing their sexual orientation in their early adolescent years during their high school education, all reported "coming out of the closet" around age 18, or after starting higher education (collegiate level.) Where one comes from may determine how they perceive themselves, their sexuality, or their partner and their sexuality. Participants also explained that even after "coming out of the closet" around the time they entered college, many remained "closeted: in different situations, not feeling comfortable always identifying as homosexual in all situations.

Participant A describes their experience in high school in one of the most liberal states in America. Despite knowing and understanding their sexuality in the latter half of the high school years, they knowingly kept their queer identity hidden, as they experienced and observed other acts of hate.

[I'm from] the most liberal state... but also the most racist city... it's a weird intersection... still having a lot of hate... I waited until college to come out, I think I came out to one or two people in high school. In college, no one really cared.

Participant A describes the idea of hate and hate coinciding- in this case, racism and homophobia. Their observation of systemic racism from their hometown made them fearful to "come out" until their entrance into college.

Participant C describes their experience of returning to their conservative hometown after attending a small liberal arts college where mainly all individuals on campus identified with some delineation from heterosexuality, and the impact that this branching out from their hometown had on members of their graduating high school class.

I wonder what high school would have been like if everyone who's out now was out then. There were... Oh, God. So out of our class, I think there's about 12 or 13 of us who've come out since then, and a couple more who identify as bisexual, but even everybody... most of the 13 moved away, you know, either New York City or Boston. A couple to California. The tendency is to go to a bigger city. So, the guys who get stuck there are just weird. They're the self-hating gays, you know? And I think it's okay for a hookup, but I don't know if that would be conducive for a relationship. Yeah, it just seems like people wanna leave.

Participant C points to both the importance of being in a place that feels safe when expressing your identity and in the deep-rooted shame about homosexuality that some can live with for years.

Co-dependency. *Co-dependency* in this research meant the reliance on those people in the participants lives that also held a queer identity, identified as homosexual, or *quasi-*

homosexual, meaning they had some form of a homosexual relationship either with the participant or with other members of the same sex. This co-dependency developed because the person was used to concealing their identity and internalizing the shame that came with that identity, these individuals allowed the participants to fully be themselves, queer identity included.

Participant A described their experience with dating members of the same sex, the pressure from that person to commit, and, lastly, their experience with observing their queer friend's relationships as moving markedly faster than their friends who identify as heterosexual.

I think she assumed we were going to date, because it was one of those situations where you're the only two gay people in an area, so everyone's like "Oh my goodness, you're both gay. That means you're gonna get married." It was one of those situations. She broke up with her girlfriend, assuming that we would end up dating... It's like you get [a first] date and a U-Haul. Yeah. It moves that fast. I know a queer couple, two women, and a heterosexual couple. The heterosexual couple met three months earlier [than the queer couple.] We're all in the same friend group... They've been dating for two or three years, and the queer couple is married. They met the same year, the same summer, and one of them is married. No one really takes the partner's [heterosexual couples'] relationship as seriously. If the heterosexual couple broke up, we'd all be like, "Oh, that's tragic, but Monica will move on." I feel like if the queer couple broke up, we'd all be ruined, because they're lesbians. No one was like "Why are they getting married so fast?" It was like, "Oh my god, that's so great, they're getting married." I feel like even though it's been more years, if the heterosexual couple got married, we'd all be like, "That's a

mistake. That's way too fast. They're way too young. That's a mistake." They're the same age, met at the same time. I've always seen that as a pattern.

Participant A describes both their experience with women trying to become codependent on them as well as her own observation of homosexual relationships that move markedly faster than a heterosexual relationship, to the point that it should alarm others, but does not.

Participant C described falling in love for the first time with their roommate, who they would inevitably come out to during their freshman year of college. Their roommate was the first person they came out to, and both the participant and the roommate would rely on each other: the participant for validation through sexual encounters despite the roommate's heterosexuality, and the roommate relying on the participant throughout their battle with depression.

I fell for my roommate freshman year... He was curious... I had feelings for him, and he would flirt with me... we made out a couple times at parties when we were drunk, and I just got very close to him. And he struggled with depression, so after a while he would tell me about all that and it seemed like his mom, his sister, and I were the only people he would talk to about that. I was pretty much in love with him. [I felt] Kind of like I wanted to protect him in a way. [It] honestly kind of fucked me up a little bit... Cause everybody else that I had hooked up with, I'm like, "Well, you're nice, and I would date you, but you're not him." He was kind of standard. Everybody else kind of filtered through that, but that was the first time I've ever been like, in love with someone.

Participant C here describes their experience with being an emotional support for their questioning roommate who was battling depression. This codependence on each other would inevitably become too toxic, and leave the participant feeling damaged, and made it difficult for them to establish other meaningful connections.

Hiding the truth from themselves and others. Participants *hid the truth from themselves and others* regarding their intimate partner relationships. Despite not being directly asked to reflect upon a particularly negative relationship or encounter, all participants chose to divulge negative experiences that were borderline emotionally violent. Participants were asked to describe their own relationships, and when asked to describe what they themselves considered an unhealthy partner relationship, all three brought up characteristics that were apparent in their previous narrative. Despite this, not one connected their own negative relationship to their description, and all three reported not including these situations in conversations with their healthcare provider. There is a level of shame (internalized homophobia) involved in being a homosexual, and an added level of shame when in an abusive intimate partner relationship. If participants, do not acknowledge their own relationships as abusive or unhealthy, despite having formed a definition of such a relationship, it can be seen as another internalization and deflection in order to protect themselves.

Participant A describes that their homosexual intimate partner relationships are typically short-term, what they describe as “flings,” with heavy codependence on either side and emotional manipulation. They describe the death of a close friend that left them reeling and emotionally unavailable to their partner.

I’ve never seriously dated another woman. I tend to get into little flings and be like “Okay, goodbye.” I have a tendency to be emotionally unavailable to a lot of romantic interests. It takes me a while to trust people... I don’t like talking about my exact emotions when they’re happening, because then I don’t have to face them... She broke up with her girlfriend, assuming we would end up dating, and then I just have a big fear of commitment. I was adamantly fighting that expectation [that we would date] and

adamantly not wanting to be the stereotype... [Then] There was a two week- period that we didn't talk at all. After that, I couldn't deal with any of my emotions, classically, so I just shut down, and I didn't really talk to her for a few weeks.

When asked to examine what they considered a healthy and unhealthy intimate partner relationship, they described it as one that fostered open communication, respect, and validity of emotions, versus a relationship where a partner or themselves feels as if they are not being heard or afraid of having their voice heard.

...communication, respect, validating emotions, just spending appropriate amounts of time together... Sometimes I worry how do you still have your independence, what happens if this ends, will you be able to pick up. Then I think not being heard and being afraid having your voice heard, being afraid of the repercussions.

Despite during the description of their previous relationships and the researcher's linkage of their descriptions to their own definition of what they considered unhealthy, when asked to describe their experience in sharing their negative experiences with a healthcare clinician, they reported never sharing.

They've been unhealthy... but I've never been hit... it could be so much worse... it's something that would never need to be "mandatedly" reported.

Participant A outlines their own experiences with relationships, where they would reject their own emotions and "gaslight" their partners. They then go on to explain that they believe a relationship involves communication, respect, and the validating of each other's emotions. When asked if they had shared their negative partner experiences, they declined, saying they felt that despite describing their relationship, and it coinciding with their own definition of unhealthy, it was not so unhealthy that it needed to be reported.

Participant B describes their relationships as infrequent, clandestine sexual encounters that can be either short or long term with a variety of different men. During and in-between their frequent sexual trysts, when attempting to begin a relationship, most of the men were uninterested and ashamed of the sexual acts that had transpired, leaving the participant feeling empty and ashamed of themselves.

It has gotten to a point where I would leave the situation sad... I definitely cried after some of them because of the fact that I just felt like I wasn't good enough for an actual relationship with an actual other individual, like a boyfriend, because of the fact that I had hooked up with so many men, and that I was basically just being used, in a way, for sex, but- I would definitely say that I have left a lot of situations sad because I feel like nothing happens afterwards. You're just there for that time being, and then it's just done. It kinda gets old after a while, I would say, just like hooking up. It just felt like a void in a way, like nothing was there.

When asked to describe a healthy and unhealthy intimate partner relationship, they described a relationship with open and honest communication about how one feels, and on the opposite side of that, described a relationship where the partner wants nothing to do with them when sex is not involved.

...connection and communication. If there's something bothering you, you should be able to tell them right off the bat, [there] shouldn't be anything you need to hide... involve[s] abuse, not just physical but also mental abuse. [Someone who] brings you down, who never wants to see you, who doesn't give you the time of day.

Again, when the researcher made the connection between the description of their intimate relationships and their description of an unhealthy relationship, the participant reported not sharing with their provider.

I have not because I just never felt the need to because it's kinda one of those things where it's your problem, not really theirs, and at the end of the day, they can't really change how you feel...

Participant B describes their experience with their partners gaslighting them, using them for sex, and ignoring them during the day, when sober. Then, the participant describes an unhealthy relationship as one where your partner ignores you, and one where you feel unsafe telling your partner how you feel. When asked to describe their experience in relating and disclosing this information to their healthcare provider, the participant explained that they did not feel it was necessary, as the provider would be unable to change much of what had happened to them, and so disclosing this information was arbitrary.

DISCUSSION

This study is among the few studies that have attempted to understand the impact of emotional intimate partner violence in individuals who identify as homosexual. This study may be one of the first to analyze the relationship between IPV and a lack of reporting of said events in healthcare settings. Researchers are beginning to understand the unique differences between intimate partner violence in homosexual couples versus heterosexual couples, such as the presence of internalized homophobia, the use of "outing," and sexual orientation identity crises (Woodyatt & Stephenson 2016). This study suggests that overall, individuals who identify as homosexual still feel the need to protect their "true (homosexual) self," because they do not feel physically or emotionally safe.

Participants in this study each described different instances where they or their partner internalize their shame regarding their sexuality. This took place during a relationship, in communication with heterosexual individuals, or during healthcare visits. This report corroborated reports from Woodyatt and Stephenson (2016) whose study illuminated the idea that emotional abuse in a homosexual relationship can involve internalized aggression regarding one's sexuality. This aggression could transcend into utilizing one's sexuality as a token of power, i.e. threat of outing, belittling one for one's sexuality (despite existing within a homosexual partnership).

This finding relates to the first stage of Cass's and the first and second stage D'Augelli's model. Cass (1984) describes feelings of shame regarding who one is internally, and D'Augelli (1994) identifies the divergence from what society deems normal, in this case, heterosexuality and personal acceptance of homosexuality. These stages involve shame, identity confusion, and denial. It could be argued that this shame is learned, and as D'Augelli suggests, there is a separation from what society, and inherently oneself, deems as normal. As we live in a "heteronormative" society, meaning a society where heterosexuality is the norm, we as people learn from birth that heterosexuality is the "end goal." As adolescents diverge from this, they stray from what society has deemed normal, and subsequently what they have internalized as normal. This stray can involve great shame that transcends beyond the intimate partner relationship, and into the relationship between clinician and patient.

Individuals in this study also reported their use of staying closeted to protect themselves. Despite report of understanding and the acknowledgement of their sexuality in later adolescent years prior to graduation from secondary school, all denied "coming out" until entering college.

These findings relate to the fourth stage of Cass's (1984) model as well as the third and fourth stage of D'Augelli's model. Cass outlines "identity acceptance," regarding the selective disclosure of their sexuality, while D'Augelli denotes the process of coming out to loved ones and friends. Cass describes the "compartmentalization" of "gay-life," and the attempt to "fit in and not make waves." Participants internally felt this formerly mentioned shame, and with that felt it necessary to conceal their identity, only disclosing to select individuals with whom they felt most safe. This became most notably relevant in regard to the participants hometown and where they originated from. Even those living in areas of the country that are considered less conservative chose to withhold their sexuality from those around them due to the context and prevalence of hate or the internalized homophobia of the individuals who identified as homosexual they witnessed. This provides support for the concept that where you come from may determine how you view your own sexuality and your partner's sexuality.

Thirdly, participants reported the dependency or the observations of co-dependency they felt or saw upon those individuals in their life who identified as homosexual. Reports included observations of homosexual relationships which moved quicker than their heterosexual counterparts, the pressure from others to commit in gay relationships, and the reliance on those who were in the LGBT+ community, as they felt they could be most themselves. These reports are parallel to Cass's fifth stage, "identity pride," where the individual who identifies as homosexual renounces heterosexuality and immerses themselves fully into gay culture. This immersion coincides with a dependency on those who are in the homosexual community, as it is felt that these fellow homosexuals may be the only people who can or will understand them (Cass, 1984).

Lastly, all three participants reported some level of IPV. These incidences may be viewed by some as minor transgressions, such as manipulation (using individual as experimentation), gaslighting (rejecting partner when sober or during the day, and calling for their partner when inebriated or “nobody was around; withholding or refusing to share emotions to establish control), co-dependency (feeling pressure or strong reliance from partner on the individual to commit, despite clear boundaries drawn,), to sexual assault (coerced sexual interaction when inebriated).

Each participant was not informed of the research project and researcher’s interest in analyzing IPV, though each, when asked to discuss their previous homosexual relationships, all chose to reflect upon negative experiences. This could support Edwards’ (2015) previous findings that homosexual adolescents are statistically more likely to experience intimate partner violence when dating- or this could simply be coincidence. One must not forget that these individuals chose to participate in this research study for a reason, and that the nature of qualitative research and informal interviews could be therapeutic in nature and a way for participants to divulge their stories in a setting where they would not receive judgment or repercussions. It must be considered that, as previously mentioned, there may not be such an outlet for them to do so, as there is potential for these participants to still be in the earlier stages of Cass or D’Augelli’s models, and as such, their feelings of conflict and “othering” need a safe place to be expressed.

Saliently, one must consider that in relation to the shame individuals who identify as homosexual feel, there may be further shame in regard to reporting IPV. Though all reported some level of IPV, each participant also chose to share that they did not inform their healthcare clinician of this information. As there is inherent shame, as suggested by Cass (1984) and a

“hurdle” of exiting the heterosexual identity as D’Augelli (1994) suggests, there is the possibility that there may be the added hurdle of discussing the presence of IPV. There may be also be a subconscious choice to rationalize the actions of the individuals’ partner and a decision to hide the truth.

Implications for Nursing Research

As suggested by Woodyatt and Stephenson (2016) there is a need for further research that examines the innate differences between emotional IPV in heterosexual versus homosexual relationships in terms of conceptualization and manifestation. The findings of this research study support this suggestion, as this research perpetuated the concept of internalized homophobia being a pillar in homosexual adolescent development and homosexual relationships.

With further research on the homosexual experience in IPV situations, one could conduct a broader, quantitative research project utilizing evidence-based scoring tools (Thompson, 2006; (Murphy & Hoover, 1999) and adding scenarios and scales specific to the homosexual experience (internalized homophobia, outing, questions regarding “the closet.”)

Additionally, this research did not examine why, but suggests that college aged individuals who identify as homosexual still do not feel safe being their “true selves,” including in healthcare scenarios. Further research could divulge further into the societal heteronormative culture and mechanisms that are established that create an unsafe environment for individuals who identify as homosexual.

Implications for Practice

This study, in conjunction with previous studies from Edwards (2015) and Woodyatt and Stephenson (2016) suggest that individuals who identify as homosexual are highly likely to experience some level of IPV but are less likely to report it. Nurses, as previously mentioned, are

on the frontlines of patient care, and spend the most time out of all healthcare disciplines with patients. It will be imperative for nurses working with the client who identifies as homosexual to understand the prevalence of IPV. With that, nurses, too, must understand the innate reaction of the individual who identifies as homosexual to protect themselves and their “true self.” It will be important for nurses to adopt adequate techniques when assessing for home and relationship safety, i.e., in private, non-judgmental, matter of fact statements, and fostering an environment that is conducive to an open dialogue.

Limitations

Researchers utilized a convenience sample of individuals located around a medium sized university in the northern part of New England. No saturation of results were obtained with this small group of 18-24-year-old, college educated individuals. The difficulty in recruiting because of the IRB restrictions may have contributed to the feasibility of obtaining a robust sample size. Additionally, time and resources served as a hinderance to this study. The limited time frame to research, gather, and analyze data, and lack of extraneous time for subsequent research and deeper analysis could have hindered or skewed results. With such a small sample size and limited time, although all participants expressed similar themes, it is not possible to be certain if any data saturation occurred. This too, must be considered.

Strengths

Strengths of this project included the comprehensive and dedicated teamwork of the researchers and the corroboration of previous research studies. The team of researchers worked diligently on the project over an extended period of time and allowed for a significant portion of time with the data to deeply analyze and compare data to previous research studies and theoretical models. Additionally, the findings of this study in relation to other studies, such as

Woodyatt (2016) argue that there is relevance, importance, and applicability when considering this research study.

CONCLUSION

There is a high likelihood of IPV in the client who identifies as homosexual. Additionally, this study suggests that those who identify as homosexual still do not feel safe disclosing their sexuality, and thus their true selves both in public and in private settings, such as with their healthcare clinician. Our findings suggest that despite the societal shift that has taken place and the overarching “acceptance” of homosexuality, there is still a fear of revealing one’s “true (homosexual) self” in certain scenarios, and because of this, individuals who identify as homosexual internalize the homophobia they receive and observe, they stay closeted for longer or stay closeted in certain situations, they become co-dependent on those individuals in their life who identify as homosexual, and lastly, they hide the truth of their relationships from others, and most saliently, themselves. Future research should continue to focus on the differences between heterosexual and homosexual relationships that involve IPV. Nurses must understand and acknowledge that this process of protecting oneself is taking place when working with the client who identifies as homosexual, and as such, be vigilant in their assessment skills. It is through this vigilance in assessment and acknowledgement of the high incidence of IPV in clients who identify as homosexual that conversations can be lead to better identification of young adults in need of additional support services. In addition, through the recognition that there are a range of possible experiences for all individuals, society can shift from one that is heteronormative (where heterosexuality is the norm) to a more expansive view of sexuality. This expansion and development could potentially allow for those who identify as homosexual to feel safer, and not

like they need to protect their true selves, thus decreasing their feelings of shame and improving their health care communication with their friends, families, and health care providers.

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