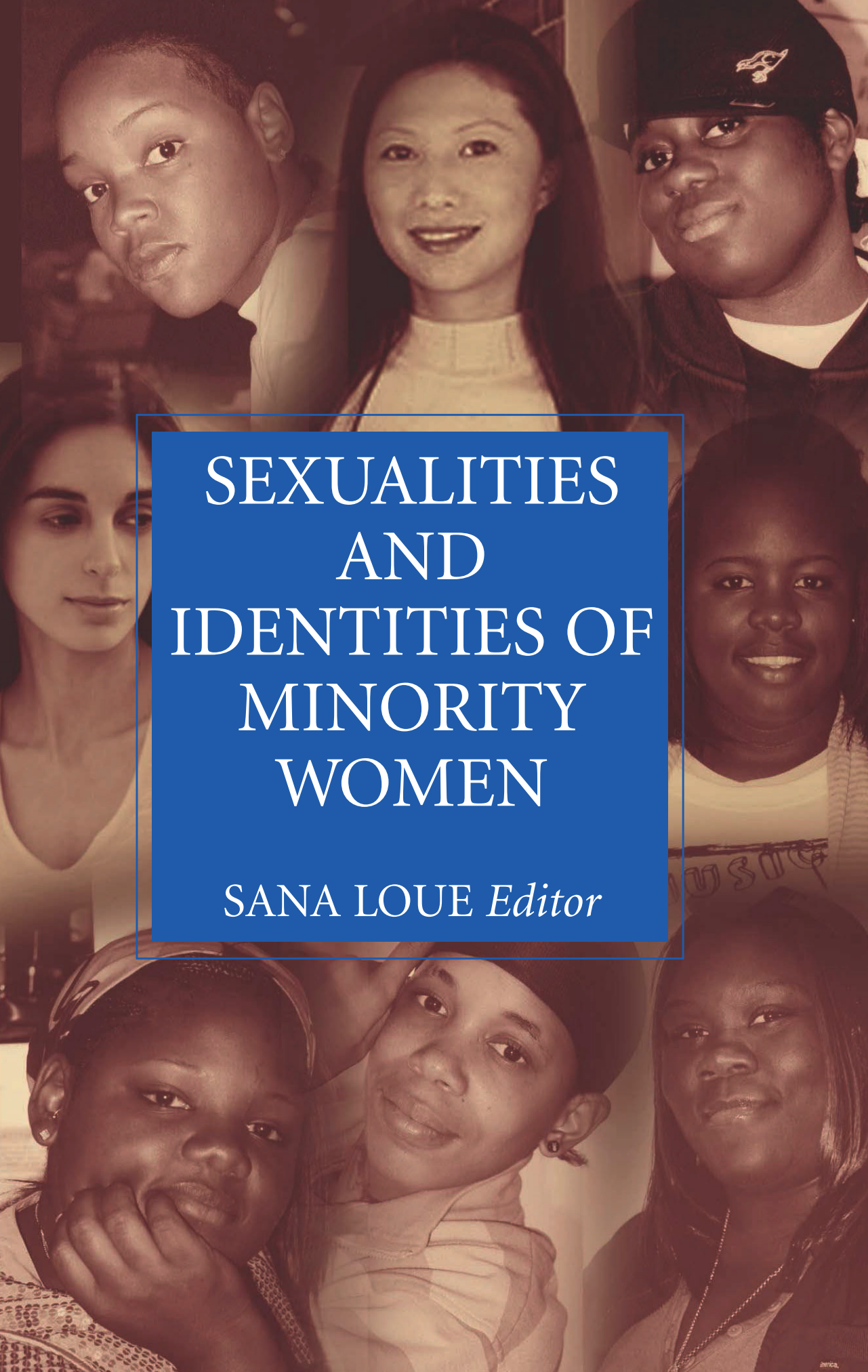

SEXUALITIES AND IDENTITIES OF MINORITY WOMEN

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Sexualities and Identities of Minority Women

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Preface

The concept for this book came about following the publication of the volume *Health Issues Confronting Minority Men Who Have Sex with Men*, published by Springer in 2008. Consistent with its title, that work focused on specific health issues identified by communities, researchers, and AIDS service providers that were and continue to be of concern . During the preparation of that volume, I received numerous telephone calls and e-mails from women in various parts of the country, asking why a book was not also being developed to address their often-neglected concerns.

Accordingly, the topics addressed in *Identities and Sexualities of Minority Women* were developed based on input from minority women who participated in focus groups conducted in diverse regions of the United States. These focus groups were held specifically to provide an opportunity for sexual minority women in minority communities to identify those issues that from their perspective are most salient and relevant to their lives. It is not surprising, in view of the variation in process by which the topics were identified, as well as the differences in perspective associated with differences in sex and gender, that this resulting compilation of topics departs substantially from the focus of the companion text addressing health issues of minority men who have sex with men.

The first two chapters of the text, authored by Viladrich and Loue and Loue, respectively, address issues related to minority identity development and the development of sexual identity. Together with the accompanying essay authored by Rembert, they underscore the difficulties that may confront women in their attempts to establish their identities at the intersection of minority statuses with respect to race or ethnicity, biological sex, and sexual orientation and, for some, religion and class as well. The challenges confronting women at the intersection of these identities are further developed in the chapters by Brooks and colleagues and Daniels, who discuss the challenges and difficulties encountered by minority sexual minority women in their interactions with both minority and sexual minority communities.

As each of these initial chapters makes clear, there has been and continues to be a relative lack of attention to the relevant developmental and relational issues. This lack of attention derives, in part, from ignorance of these issues but also to a large degree from prejudice and discrimination. These themes become even more apparent in the chapters authored by Mendéz, O'Shea, and Jones and Pike, in their

respective discussions of the lack of legal recognition and protection for female-partnered households, of nonheterosexual-identified women navigating through the health care system, and of nonheterosexual-identified women in the workforce and larger community. These issues are highlighted in a very real, personal sense in the interview with Natoya "Daddy" Cody that follows.

The concluding chapter by Loue, focusing on religion and spirituality, continues to reflect individuals' search for wholeness and acceptance, despite rejection and isolation even by religious communities. The volume concludes with an interview with Dominique, who through her faith in a higher power finds the strength to accept her own identity, even in the face of discrimination and rejection, and permits the future to be one of hope.

Acknowledgments

This book would not have been possible without the thoughtful discussions of the many unnamed women who participated in the focus groups that gave rise to this volume and its content. The individuals who contributed their photos to this volume have asked to remain anonymous; we honor that request, and thank them for their courage in making their identities known. Gary Edmunds is to be thanked for his assistance in locating library materials, transcribing interviews and focus groups, and proofreading.

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Chapter 1
Minority Identity Development

Anahí Viladrich and Sana Loue

Introduction

The term *minority* has been defined in any number of ways. Wirth (1945, p. 347) offered one of the earliest definitions of minority:

> We may define a minority as a group of people who, because of their physical or cultural characteristics, are singled out from the others in the society in which they live for differential and unequal treatment, and who therefore regard themselves as objects of collective discrimination. The existence of a minority in a society implies the existence of a corresponding dominant group enjoying higher social status and greater privileges.

A number of scholars have maintained that the central feature of a minority group is the power deficiency relative to that group (Blalock, 1960; Dworkin & Dworkin, 1982; Geschwender, 1978; Wilson, 1973) and the resulting oppression of one group by another. This imbalance of power may be manifested in the economic, political, and social domains of life (Ashmore, 1970; Barron, 1957; Howard, 1970; Kinloch, 1979; Ramaga, 1992; Wagley & Harris, 1958) through overt or more subtle forms of influence, exploitation, domination, oppression, and discrimination (Meyers, 1984; Ramaga, 1992). This power imbalance allows the establishment and maintenance of both control and dependency (Manderson, 1997). Within this paradigm, it is the relative power or lack of it that is determinative of minority group status rather than the numerical superiority or inferiority of a group (Meyers, 1984; Ramaga, 1992). The disempowerment and oppression of the black majority by a white minority in South Africa during the years of apartheid serves as such an example. Some writers, however, have refused to characterize a group as a minority if the group is larger in relative size within the population under discussion or if the group has no desire to preserve the characteristics that are believed to render it distinct (Anon, 2007; Schermerhorn, 1964).

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Characteristics that have been linked to minority group identity include sex, gender, sexual orientation, disability, ethnicity, nationality, race (without debating the validity of that concept), language, culture, and religion (Baron & Byrne, 1977; Barron, 1957; Hacker, 1951; Pap, 2003; Rose, 1964; Wagley & Harris, 1958), although religion has rarely been relied upon to define a minority in the United States (Minority, 2008). One scholar explained:

> Minorities are sub-groups within a culture which are distinguishable from the dominant group by reasons of differences in physiology, language, customs, or culture patterns (including any combination of these factors). Such sub-groups are regarded as inherently different and not belonging to the dominant groups; for this reason they are consciously or unconsciously excluded from full participation in the life of the culture. . . . Some minorities are physically different but culturally similar with respect to the majority . . . others are culturally different but physically similar . . . and still others are both culturally and physically different. . . . The cultural and/or physical differences between majority and minority actually may be so minute as to make it impossible to detect by simple observation who is a member of the minority and who is a member of the majority (Schermerhorn, 1949, p. 5).

As a result, an individual who is a member of more than one defined minority group may be multiply stigmatized (Capitanio & Herek, 1999; Herek, 1999; Herek, 1999; McBride, 1998; Reidpath & Chan, 2005). For example, a woman who is a member of an ethnic minority and is nonheterosexual may be stigmatized because of her ethnicity, sexual orientation, and biological sex (Bowleg, Huang, Brooks, Black, & Burkholder, 2003). For the past two decades, the literature on racial disparities has focused on developing "intersectional theory" to depart from both traditional conceptions of race as biology, on the one hand, and from the influence of cultural or lifestyle behaviors, on the other (Mullings, 2002). Intersectional approaches, instead, underscore the interactive interweaving effect of the hierarchies of race/ethnicity, class, and gender on the lives of impoverished women (see Mulling, 2002; Schulz & Mullings, 2006; Sokoloff & Dupont, 2005). Rather than seen as additive, gender, race, and class are conceptualized as relational categories that have deep and enduring consequences for minority women's health and on their ability to successfully cope with everyday stressors (King, 1988). For instance, for the Harlem Birth Right Project (1993–1997), Mullings and her team developed a conceptual framework to examine the roots of African-American babies' low birthweight vis-à-vis the babies of white women from all socioeconomic levels. Findings showed that the intersecting effect of race, class, and gender creates unique stressors in the lives of black women which, in turn, lead them to delivering preterm low-birthweight babies. Based on research scientists' research (Wadhwa, Culhane, Rauh, & Barve, 2001), Mulling explains that ". . . hormones released during episodes of acute stress and chronic strain may stimulate spontaneous labor and preterm delivery" (Mullings, 2002: 35). This theoretical approach is coincident with what Geronimus (1992) refers to as the "weathering" effect or the chronic and enduring burden drawn from African-American women's continuous adaptations to structures of social inequality.

Lorde (1984, p. 120) discussed from the vantage point of an African-American lesbian the pressure on individuals having multiple stigmatized/oppressed identities of

> constantly being encouraged to pluck out one aspect of [your]self and present this as the meaningful whole, eclipsing or denying the other parts of self.

Also, an individual essentially inherits his/her status as a minority group member and cannot change that status unless the status of the group itself should change (Collins, 2008) or he/she denies group membership, something that is not possible in the case of skin color or biological sex (Harris, 1959).

Defining Ethnic Identity

The concept of minority, then, encompasses both racial and ethnic minorities, among other social identities, including sexual orientation. Although the classification of individuals and groups by race has met with significant scholarly criticism, the lived experience of individuals makes it clear that the construction of race continues to constitute a major factor in individual and group interactions. Scholarly literature has instead emphasized the concepts of ethnicity and culture in lieu of race in attempting to understand the context of individual and group behavior and processes.

Ethnicity is said to derive from "language, religion, culture, appearance, ancestry, or regionality" (Nagel, 1994, p. 153). Accordingly, an *ethnic group* has been defined as

> a reference group called upon by people who share a common history and culture, who may be identifiable because they share similar physical features and values and who, through the process of interacting with each other and establishing boundaries with others, identify themselves as being a member of that group (Smith, 1991, p. 181).

To a certain extent, ethnicity has become a malleable definition of race used to emphasize the social construction of the term, away from its biological (and inherently stable) connotations. Nevertheless, as other authors note (Phinney, 1990; Dressler, Oths, & Gravlee, 2005), explicit definitions of ethnicity and race in the literature are scarce, and quite often both terms are used interchangeably with none, or little, specifications regarding both their conceptual and methodological definitions (see Williams, 1994; Comstock, Castillo, & Lindsay, 2004). Dressler et al. (2005) define three main categories as constitutive of the term ethnicity: the cultural, the ancestral, and the referential. The first includes the shared belief systems (e.g., language, marriage rituals) and the more abstract aspect of life (the supernatural). By shared ancestry, Dressler and colleagues refer to the possession of a common history, kinship, and belonging to the same homeland. Finally, the referential category refers to the labeling of separate groups of people with regard to the ego (self-representation) and others (social recognition of difference).

In fact, individuals do not choose to be members of a specific ethnic group. Rather, membership is acquired through birth into a specific group, and the relationship with that group is forged through emotional and symbolic ties (Smith, 1991; Syed, Azmitia, & Phinney, 2007).

Ethnic identity has been variously defined as

> a complex and multidimensional construct that can encompass such factors as ethnic identity formation, ethnic identification, language, self-esteem, degree of ethnic consciousness, and the ethnic conscious, among others (Ruiz, 1990, p. 29).
>
> a dynamic, multidimensional construct that refers to one's identity. Or sense of self, in ethnic terms, that is in terms of a subgroup within a larger context that claims a common ancestry and shares one or more of the following elements: culture, race, religion, language, kinship, or place of origin (Phinney, 2000, p. 254).
>
> the sum total of group members' feelings about those values, symbols, and common history that identify them as a distinct group. . . . (Smith, 1991, p. 182).
>
> an individual's sense of self as a member of an ethnic group and the attitudes and behaviors associated with that sense (Phinney & Alipuria, 1987, p. 36).
>
> a clearly delineated self-definition, a self-definition comprised of those goals, values, and beliefs that the person finds personally expressive, and to which he or she is unequivocally committed (Waterman, 1985, p. 6).
>
> one's sense of belonging to an ethnic group and the part of one's thinking, perceptions, feelings, and behavior that is due to ethnic group membership (Rotheram & Phinney, 1987, p. 13).
>
> a form of self-conceptualization by a person which may be accepted or rejected by the social world around him. It may be forced on him by coercion and is of limited predictive value for his own ancestry or that of his descendants. It varies in meaning across persons and through history and is interchangeable with national identity (Bram, 1965, p. 242).
>
> the result of a dialectical process involving internal and external opinions and processes, as well as the individual's self-identification and outsiders' ethnic designations—i.e., what *you* think your ethnicity is, versus what *they* think your ethnicity is. Since ethnicity changes situationally, the individual carries a portfolio of ethnic identities that are more or less salient in various situations and vis-à-vis various audiences (Nagel, 1994, p. 154) (emphasis in original).

As noted by the sample of definitions above and as pointed out by Phinney (1990, p. 500), the array of definitions used to label ethnicity and ethnic identity is somehow indicative of disagreements about the topic. To a certain extent, part of this multiplicity of definitions is due to the diversity of the research questions scholars seek to answer. In any case, the socially constructed and changing nature of ethnic identity calls attention to the relational linkages between the ego and others that evolve through time and space. Historically, the United States has witnessed structural changes in the social representation of ethnic groups, as was the case with Italians, Polish, and Irish populations in the United States, who moved from being considered as "ethnic others" to becoming paradigmatic cases of the assimilation process known as "the melting pot." Indeed, much of the nativist attempts to marginalize and discriminate against newcomers in the nineteenth and early

twentieth centuries rested on the social construction of those immigrant groups as different from the white majority (Kraut, 1995).

Accordingly, ethnic identity can be seen both as a process and as an outcome (Brookins, 1996; Erikson, 1968; cf. Syed, 2007), a private and a social construction (Jenkins, 2003; Trimble, Helms, & Root, 2003), playing a critical role in the enactment of relationships, in conversation, and in the outcome of communication (Hecht, Ribeau, & Alberts, 1989; Larkey & Hecht, 1995). Ethnic identity is believed to be critical to self-concept and psychological functioning (Gurin & Epps, 1975; Maldonando, 1975).[1]

Evidence suggests that the process and outcome of ethnic identity development may vary across ethnic groups (Phinney, Romero, Nava, & Huang, 2001), as well as gender (cf. Leaper & Friedman, 2006), socioeconomic status (Phinney 2001), and immigrant generational status (Phinney, 2003). For example, research findings indicate that the strength of ethnic identity decreases between first- and second-generation immigrants (Phinney, 2003). New sorts of ethnic identity are present among second- and third-generation immigrants. For example, among some interracial groups, a sense of ethnic belonging to the white majority may be prevalent. The joining of "broader" ethnic aggregates may also be the case, as in the case of descendants from immigrants from different Latin-American countries (whose primary allegiance is to the country of origin) who, once in the United States, may consider themselves as "Latinos," a category that may be absent from the ethnic imaginary back in their countries of origin. An examination of all such variations and factors is beyond the scope of this chapter. We provide here an overview of various theories of racial/ethic minority identity development, which are potentially relevant to the identity development of nonheterosexual-identified minority women.

The Development of Ethnic/Racial Identity

Race and ethnicity can serve as the basis for the development of group identity. In general, however, they have been approached from different methodological and theoretical perspectives (Phinney, 1996). This discussion encompasses both to the extent that similarities exist.

Various theories have been advanced in an attempt to understand and explain the development of ethnic identity at both individual and group levels. These include social identity theory (Tajfel & Turner, 1986); social construction theory (Nagel, 1994); and a number of stage theories, akin to ego development theory (Yeh & Huang, 1996).

Social Identity Theory

Social identity theory views group identity as a critical component of self-concept (Tajfel & Turner, 1986) and, accordingly, views ethnic identity as a form of group identity that is key to the self-concept of minority group members. The theory

further posits that individuals attribute value to the group in which they are members and derive their self-esteem from their feelings of membership within that group.

In some cases, however, a particular group may be subject to discrimination or negative stereotyping, resulting in low self-esteem (Hogg, Abrams, & Patel, 1987; Ullah, 1985). In such instances, it is asserted, ethnic group members will engage in reaffirmation and revitalization efforts in an attempt to assert a more positive image of their group (Tajfel, 1978), reinterpret those characteristics perceived as inferior so as to transform the associated negative perception into one that is more positive (Bourhis, Giles, & Tajfel, 1973), and/or emphasize the group's distinct features (Hutnik, 1985). Individuals may also attempt to pass as members of the dominant ethnic group (Tajfel, 1978).

The Social Construction of Ethnic Identity

The constructionist perspective posits that ethnicity is socially constructed by individuals and groups through their negotiation, definition, and production of boundaries, identities, and culture (Nagel, 1994). As such, the content and boundaries of ethnicity are in continual flux in relation to context and are subject to redefinition and renegotiation by both members of the specific ethnic group and outsiders to that group.

This dynamic, fluid process occurs at both individual and group levels. Because ethnicity and ethnic identity may be determined or designated situationally, depending on the larger context or audience, individuals maintain a portfolio of ethnic identities. The individual's choice of identity in any specific situation is dependent upon the utility of a particular identity with respect to the relevant political and social context and the audience. As an example, American Indians may choose to self-identify as members of a particular lineage, tribe, or region, or simply as Native American or American Indian (Cornell, 1988). Similarly, Latinos, Asian Pacific Islanders, and non-US-born Blacks may self-identify by national origin or may utilize the broader US census-defined designation, such as non-Hispanic Black (Gimenez, Lopez, & Munoz, 1992; Espiritu, 1992; Padilla, 1986; Waters, 1991).

As noted in ethnographic research, ethnic self-identification may change through individuals' life spans following mobile social trajectories through new environments and geographies. For instance, in her work with Argentine immigrants in New York City, Viladrich (2005) examined the participants' changing self-representations in terms of class, racial, and ethnic categories. Although many Argentines had considered themselves as members of the "white majority" in their country of origin, their self-perception changed in the United States, where they were more often labeled as members of the Latino minority, along with their perceived socioeconomic dislocation in mainstream America. And, just as ethnic identity changes, the content of the underlying culture to which an identity refers also changes, as it is reshaped and reinterpreted over time (Barth, 1969; Nagel, 1994).

Stage Theories

Table 1.1 provides an outline of various stage theories of ethnic/racial identity development. Each of these is discussed in greater detail below.

Atkinson et al. (1979) utilized a stage model to explain the developmental trajectory that an individual may undergo in developing an identity as a member of a minority group. Conformity, the first stage, was hypothesized as a period during which the individual is self-depreciating, minority group-depreciating, discriminatory toward members of other minority groups, and appreciative of the dominant racial/ethnic group. Dissonance, the second stage, reflects a growing internal conflict, characterized by both self- and group-depreciation and self- and minority

Table 1.1 Outline of various stage theories of ethnic identity development

Source	Stages	Application
Atkinson, Morten, & Sue (1979)	Minority Identity Development Model: conformity dissonance resistance and immersion introspection synergistic articulation	Latinos (Espín, 1987)
Cross (1971)	Pre-encounter encounter immersion-emersion internalization internalization-commitment	African Americans
Gay (1985)	Pre-encounter encounter post-encounter	
Phinney (1989, 1996)	diffuse foreclosed moratorium achieved	
Poston (1990)	personal identity choice of group categorization enmeshment/denial appreciation integration	biracial identity
Ruiz (1990)	causal cognitive consequence working through successful resolution	Latinos
Smith (1991)	preoccupation with self preoccupation with ethnic conflict resolution of conflict integration	

group-appreciation. The individual may continue to hold the dominant views of the minority hierarchy, while also feeling that experiences are shared. During the third stage, known as resistance and immersion, the individual develops an appreciation of himself/herself and him/her minority group, as well as a feeling of empathy for other minority experiences. He/she may also develop a culturocentric perspective, while simultaneously holding a deprecatory view of the dominant group.

The fourth stage, introspection, reflects increased questioning. During this stage, the individual seeks to understand the basis of self-appreciation and becomes increasingly concerned with the unequivocal appreciation of the minority group, the ethnocentric basis from which others are judged, and the depreciation of the dominant group. The fifth stage, termed synergistic articulation and awareness, finds the individual self-appreciating, appreciative of her own minority group and other minority groups, and selectively appreciating the dominant racial/ethnic group. The individual is able to evaluate the cultural values and accept/reject them based on their merit and/or the individual's own experiences. This model has been used as a basis for understanding Latino identity development and has been analogized to the identity development of Latino lesbians (Espín, 1987).

This hypothesized developmental trajectory is reflected in the musings of a lesbian woman who immigrated to the United States from Cuba. She reflected:

> As a child my self-definition was not conscious, since there was no need for awareness of ethnic identity while I lived in Cuba. Coming to the United States instantly brought to my awareness at the age of 10 what being Latina meant in this country. I would say that the need to assert that identity was strengthened by the racism in the U.S. In my teens I passed through a period of acculturation in which to some extent I internalized society's views of ethnic groups in a very subtle way. During college, I became active in political and community activities and went through a "militant" phase in which I came to understand the nature of racism and oppression more deeply. Presently, I consider myself to have a more universal or humanistic perspective and I am able to appreciate as well as critically analyze my cultural heritage (Quoted in Espín, 1987, p. 45).

Cross' (1971) model similarly views identity development from the perspective of minority oppression by and resistance to a dominant culture, but has been applied specifically to Black racial identity development. Cross postulated that individuals progress through five distinct phases: pre-encounter, encounter, immersion-emersion, internalization, and internalization-commitment. The pre-encounter stage is marked by the dominance of Euro-American values, a denigration of Blackness and of self, and the assessment of success and achievement against what are seen as White values. During the encounter stage, the individual is confronted by an incident or event that causes him/her to think about his/her ethnicity and to rethink previously held beliefs and values. In essence, the encounter serves to dislodge "individuals from their pre-liberation, pre-encounter, pre-conceptual 'ethnic innocence'". . . (Gay, 1985, p. 40).

The events of the encounter stage propel the individual toward the third stage of immersion-emersion, during which he/she experiences the feelings of ambivalence,

anger, and depression, while alternating between the rejection and embracing of other Blacks. It has been proposed that the adoption during the 1960s and 1970s of Afro-American cultural symbols, such as African-inspired clothing and names, constituted an immersion at the group and individual levels (Gay, 1985). Emersion occurs as a transitional link to internalization as the individual seeks a more balanced perspective. The final stages of internalization and internalization-commitment are characterized by a transformation of identity, as inner conflicts are resolved and more generalized anger against non-Black groups is directed toward fighting oppression. These stages have been variously referred to by scholars as transcendence (Thomas, 1971) and ethnic clarification (Banks, 1981).

Gay (1985) has re-tooled the Cross model (1971), compressing it into three phases: pre-encounter, analogous to Cross' pre-encounter stage; encounter, mirroring Cross' second stage; and postencounter, encompassing Cross' final three phases. Gay distinguished these developmental phases as follows:

> Whereas the overriding human behaviors of the pre-encounter stage are characterized by non-questioning conformity to externally determined roles and identities, those of the encounter stage are characterized by feelings of emotional turmoil and psychological traumas, and the predominant behavioral motivations of the post-encounter stage are self-determined ethnic identities, ethnic objectivity and rationality, and a genuine acceptance of the right to be ethnically different (Gay, 1982, p. 74).

Ruiz (1990), like Cross, focused on the development of ethnic identity, as it relates to a specific minority group. Ruiz' model of Latino ethnic identity development posits that individuals progress through five stages: causal, cognitive, consequence, working through, and successful resolution.

The first stage, causation, is characterized by messages that denigrate Latino culture and/or exalt the majority culture. Racism, ethnocentrism, and classism are implicit in these messages. During the subsequent cognitive stage, the individual is able to identify the erroneous beliefs that may have prevailed during the causation stage. As an example, this may include an erroneous belief that Latino ethnicity is inextricably linked to poverty and that total assimilation into the dominant culture represents the sole pathway to success. The third stage, consequence, reflects the individual's increasing fragmentation, as he/she perceives various ethnic traits or traditions as inferior or embarrassing. During this stage, individuals may isolate from their own ethnic group and even assume an alternate ethnic identity.

Ruiz suggests that as the individual enters the fourth stage of identity development, that of "working through," he/she experiences psychological distress. Through the exploration of relevant issues and reliance on a support system, the individual gradually de-assimilates, reconnects with his/her ethnic identity, and reintegrates those parts of himself/herself, which were discovered during earlier phases. The final stage of resolution finds the individual accepting of himself/herself and his/her ethnicity and culture (Ruiz, 1990).

Phinney (1989, 1996) has conceived of ethnic identity development as a process involving four phases. During the initial stage of diffusion, the individual has

engaged in little or no exploration of his/her ethnicity and has relatively little understanding of the salient issues. The stage of foreclosure is similarly characterized by relatively little exploration of ethnicity but, in contrast to the previous stage, the individual has greater clarity with respect to his/her own ethnicity. During this process, the individual may experience positive, negative, or neutral feelings toward other groups, depending on his/her previous experiences (Phinney, 1996). The third stage of moratorium reflects greater exploration, accompanied by confusion regarding the meaning of one's own ethnicity, increased awareness of racism, and possibly some anger toward Whites (Phinney, 1989, 1996). The final stage of achieved ethnic identity signifies the development of a sense of clarity and group membership and a more realistic assessment of one's own ethnic group.

Relatively few scholars have addressed biracial identity development. One such model is that of the Biracial Identity Development Model (Poston, 1990), consisting of five stages. The first stage, personal identity, is marked by children's identification difficulties resulting from the internalization of prejudices and values. Individuals are consequently pressured during the second stage, choice of group categorization, to choose an identity of one ethnic group. That choice may be premised on one or more of various factors, such as the status or degree or nature of social support. As a result of having made this choice, however, individuals may experience guilt and confusion because the choice does not reflect the sum total of their identity. Poston terms this third stage of development "enmeshment/denial." During the fourth stage, appreciation, individuals continue to identify with only one group but begin to develop an understanding of and appreciation for their multiple identities. The final stage of integration is characterized by a sense of integration and an appreciation of multiple identities.

In contrast to the many models that focus on the development of ethnic minority identity, whether applicable generally or to one ethnic group only, the Smith Ethnic Identity Development Model (Smith, 1991) examines ethnic identity development within the context of majority/minority status (for a discussion of majority, i.e., White, identity development, see Helms, 1990 and Rowe, Bennett, & Atkinson, 1994). This model consists of four phases: (1) preoccupation with self or the preservation of ethnic self-identity; (2) preoccupation with the ethnic conflict and with the salient ethnic outer boundary group; (3) resolution of ethnic conflict; and, ultimately, (4) integration. As Smith (1991, p. 183) explained, the

> model proposes that ethnic identity development is a lifelong process . . . Ethnic identity development is a process of differentiation and integration. One moves from a state of unawareness, from non-ethnic self-identification to ethnic self-identification, and from partial ethnic identifications to identity formation. Additionally, the process of ethnic identity development is affected by both contact and boundary-line drawing situations. . . .
>
> Ethnic identity development is a continual process of boundary-line drawing, of deciding what individuals and what groups are included in one's inner and outer boundary groups. . . . Broadening, narrowing, or crystallizing of ethnic boundaries is the basic process that directs one's ethnic identity development.

An examination of the foregoing theories suggests commonality with respect to various themes. The initial stage of each model consists of the acceptance of majority group values and standards and, often, the denigration of one's own ethnic/racial group. This initial stage is followed in almost all models by a period of exploration and clarification, often prompted by an encounter or conflict, culminating in the acceptance and integrations of one's own ethnicity. With the exception of Marcia's model, each of the foregoing models further presupposes that identity development is a progression through hierarchical stages, with each subsequent stage suggesting the successful achievement of the tasks of the preceding stages.

Unlike scholars who have conceived of minority ethnic identity development as a progressive movement through successive stages, Marcia (1966, 1980) postulated that ethnic minority individuals reflect one of four statuses: achievement, moratorium, foreclosure, and diffusion. Identity achievement reflects an individual's exploration of and commitment to an identity. In contrast, the moratorium status is characterized by the exploration of an identity, but the absence of a commitment. Individuals with a foreclosed status have ceased their exploratory process, while those with diffused status have been unable to reconsolidate the ego. Accordingly, each status is characterized by the presence or absence of a period of exploration and the presence or absence of a commitment to ego identity consolidation (St. Louis & Liem, 2005). This conceptualization of individuals as having statuses may be integrated with stage theories if one assumes that the individuals attain a particular status as they pass through successive stages. As an example, Ruiz' final stage of resolution may reflect the individual's attainment of Marcia's achievement.

The model of bicultural competence developed by LaFramboise, Coleman, & Gerton (1993) suggests the skills that comprise an integrated or achieved identity and that may be critical to one's effective functioning within two cultures without a loss of competence in or denigration of either. The acquisition of these six competencies occurs in a hierarchical manner: views of both groups' knowledge of the cultural beliefs and values of both groups; development of a belief in one's own efficacy; ability to communicate within both groups, a role repertoire appropriate for and within each group; and establishment of a social support system within each group.

Barriers to Successful Identity Integration

Significant potential barriers exist to the successful integration of ethnic minority identity. These occur at the individual, familial, and systemic levels. The inability and/or unwillingness of parents to address racial/ethnic issues with their children may present a barrier to successful ethnic identity integration (Spencer & Markstrom-Adams, 1990). As a result, the individuals may have no or limited access to role models who have been able to integrate ethnic identity successfully (Semaj, 1985; Spencer, 1983; cf. Spencer & Markstrom-Adams, 1990).

The "melting pot" perspective of assimilation has been identified as a major barrier to successful social integration (Ramirez & Castaneda, 1974). It has been suggested that this approach views the amalgamation of ethnic identities and the obliteration of individually identifiable groups as the ideal. The enactment of this perspective within the larger society may create conflict between the values presented at home and in the family, and those confronted in external spheres of daily living, such as the educational system and the workplace. Indeed, this perspective belies the reality of minority group members who may confront reminders of different-ness on a daily basis.

The imposition of societally stereotyped identities may also present a barrier. As an example, American Indian children raised in non-Indian environments may initially identify with European-American White culture (Westermeyer, 1979). As they become increasingly aware of discrimination, they may reject the dominant culture, but are unable to replace it with an American Indian identity, other than the external signs of Indian-ness, resulting in significant identity confusion. Similar difficulties have been noted among Latinos, Asians, and African Americans (Means, 1980). Nonheterosexually identified members of minority groups may face heightened difficulties as a result of their nonconformity with role expectations within their ethnic communities (Loiacano, 1989). Indeed, ethnic minority communities may even deny the existence of its nonheterosexual members, believing that same-sex orientation is a White phenomenon (Chan, 1989). Chapter 2, which follows, addresses models of sexual identity development and sexual identity in the context of intersecting identities.

Notes

1. The concept of ethnic identity has been used synonymously with that of acculturation, but the constructs are distinguishable. It is beyond the scope of this text to address the vast literature relating to this concept. It may be helpful to the reader, nevertheless, to have an initial understanding of the difference between the concepts of ethnic identity and acculturation. Acculturation has been defined as

> cultural change that is initiated by the conjunction of two or more autonomous cultural systems . . . Its dynamics can be seen as the selective adaptation of value systems, the process of integration and differentiation, the generation of developmental sequences and the operation of role determinants and personality factors (Social Science Research Council, 1954, p. 974).

As such, ethnic identity represents one component part of acculturation.

The process of acculturation has been described as a linear progression beginning with strong affinity to one's ethnic group culture, with relatively weak ties to the dominant culture, and culminating in weak ties to one's ethnic group culture and relatively stronger ties to the dominant culture (Andujo, 1988; Ullah, 1985). More recently, scholars have conceived of acculturation as a two-dimensional process, through which members of minority groups may maintain stronger or weaker ties either with their ethnic group culture and/or with their dominant culture, resulting in four possible outcomes: (1) assimilation: strong ties to the dominant culture and weak ties to one's own ethnic group culture; (2) separation/dissociation: weak ties to the dominant culture and

strong ties to one's ethnic group culture; (3) integration/biculturalism: strong ties to both dominant culture and one's ethnic group culture; and (4) marginalization: weak ties to both dominant culture and one's ethnic group culture (Berry, Trimble, & Olmedo, 1986).

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Chapter 2
Minority Nonheterosexual Women and the Formulation of Identity

Sana Loue

Introduction

This volume focuses on identities and sexualities of minority women. Who are minority women, and exactly what do we mean by identities and sexualities?

Identity refers to

> that which each woman tells herself about who she is when she is alone with herself. The term is also understood as that which each context to which she is field sensitive calls forth in a given moment (Espín, 1987, pp. 35–36).

Accordingly, the first portion of the chapter focuses on the process by which girls and women come to define who they are in terms of their identity and their sexuality. The emphasis is on the development of sexual and gender identity, although it is recognized that individuals may also undergo a process by which they come to self-identify as a "minority." Reference is made to racial and ethnic minority status to reflect the current usage of these terms; it is beyond the scope of this chapter to examine the validity of the concept of race or ethnicity.

It must be stated at the outset that the literature relating specifically to sexual identity development among racial/ethnic minority women is relatively limited, underscoring the need for more research in this area. This chapter does not address causal theories relating to sexual desire, orientation, or behavior, such as genetic influences (Bailey, 1995; Hamer, Hu, Magnuson, & Pattatucci, 1993; Hyde, 2005), neuroendocrine theories (e.g., Mustanski, Chivers, & Bailey, 2002; McFadden & Champlin, 2000; van Anders & Hampson, 2005), or family influences. Rather, the focus here is on how a female who is a member of a minority racial or ethnic group comes to know who she is with respect to her sexual desires, behaviors, and identities.

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Formulating Identity

Various theories have been advanced in an attempt to understand and explain the process by which an individual develops, recognizes, and acknowledges his/her identity. Three of the most widely discussed theories are discussed here: stage models of identity formation, symbolic interactionism, and social construction.

Stage Models of Identity Formation

Developmental Theory

The formulation of one's identity can be conceived of as an internal process, by which an individual develops a sense of himself/herself in the context of his/her environment. Erikson, one of the foremost theorists with respect to identity development, hypothesized that psychosocial growth and development occurs in stages, each of which is associated with a psychosocial crisis (Erikson, 1997). In this context, a "crisis" is conceived of as "a turning point for better or worse" (Erikson, 1964, p. 139) to which the individual can respond either adaptively or maladaptively. The extent to which an individual is able to successfully resolve each such crisis depends upon his/her experiences during earlier stages of development. Accordingly, each stage marks the development of a different facet of the individual's identity in relation to the external social world; the component parts of the individual ultimately give rise to the whole individual (known as epigenetic theory). The successful resolution of the crisis at a particular stage of development results in the development of a basic psychological strength or virtue at that stage, as follows.

Stage 1: Infancy. During infancy, the extent to which the child's caregivers, such as parents, meet the child's physical and psychological needs and the manner in which it is accomplished will determine the extent to which the child develops trust or mistrust in the surrounding world and the people in it. Those children who develop a sense of trust will acquire the virtue of hope.

Stage 2: Early childhood. Erikson characterized the psychosocial conflict during this stage as autonomy versus shame and doubt. The adaptive emergence from this stage produces the psychological strength of will. The response of the child's caregivers, such as parents, to the child's growing abilities and need to do things for himself/herself will determine whether the child will demonstrate self-sufficiency or self-doubt.

Stage 3: Play age. The psychosocial crisis presented during this stage of development is that of initiative versus guilt. Children who are provided with the opportunity to initiate motor and intellectual skills will acquire the psychological strength or virtue of purpose. The ability to play, which is acquired during this stage, will become the basis in later years for a sense

of humor. Those who are not provided with such supportive opportunities will develop a sense of guilt.

Stage 4: School age. This period of development is marked by a conflict between industry and inferiority. An adaptive child learns to love to learn and to play in a manner consistent with what Erikson has called the "ethos of production" (Erikson, 1997, p. 75) and develops a sense of competence. Maladaptation is characterized by excessive competition or the development of a sense of inferiority.

Stage 5: Adolescence. Adolescence reflects the conflict between identity and role confusion. During this stage of development, the individual must selectively integrate experiences of childhood and the various images that the individual may have of himself/herself. Individuals must engage in a certain amount of role repudiation in order to accomplish this integration of self; some roles may actually jeopardize the synthesis of the individual's identity and must therefore be discarded. Successful integration will yield the psychological strength or virtue of fidelity, which is related to both infantile trust and adult faith. In contrast, individuals who do not pass through this stage of development may engage in more global role repudiation, potentially leading to systematic defiance or the development of a negative identity consisting of socially unacceptable behaviors and traits.

Stage 6: Young adulthood. During young adulthood, individuals must develop the capacity to become intimate with and care about others. The challenge is to be able to commit oneself in a relationship that may require compromise and sacrifice. The antithesis to this intimacy is isolation, which may be associated with a fear of losing one's identity in a relationship. Individuals who successfully resolve this conflict acquire the ability to love and exhibit healthy patterns of cooperation and competition in their relations with others.

Stage 7: Adulthood. The seventh stage reflects the crisis of generativity versus self-absorption and stagnation. Generativity encompasses procreativity, productivity, and creativity, ushering in new beings (children) as well as new ideas and products. In contrast, those who stagnate remain focused on their own wants and desires, resulting in what Erikson has called "generative frustration" (Erikson, 1997, p. 68). The virtue or strength that is derived from successful resolution of this conflict is "care," meaning a broader commitment to care for persons, products, and ideas. The virtue or strength of care may extend to the idea of universal care, such as care for the welfare of all children.

Stage 8: Old age. Erikson hypothesized that the final stage of life is characterized by the conflict between integrity and despair (Erikson, 1997). During this stage, the individual will look back over his/her life. They may view their life as having been satisfying and meaningful (integrity) or as deeply unsatisfying (despair). The former response implies an acceptance of death and a philosophical perspective, while the latter suggests a fear of death and "the feeling that time is now short, too short for the attempt to start another

life and to try out alternate roads . . .” (Erikson, 1951, p. 269). Those who are able to pass through this stage successfully will have developed wisdom.

Stage 9: Gerotranscendence. Erik Erikson’s original stage model of psychosocial development comprised only eight stages of development. However, a ninth stage was later added to this model to reflect the conflict that arises during the very latest years of life (Erikson, 1997). This ninth stage of development, corresponding to the 80s and 90s in life, is often characterized by a pervasive sense of loss—of one’s physical senses, such as the ability to hear and to see; of friends and family members who have predeceased the elder; and of recognition by others as a source of knowledge and wisdom.

As noted in Chapter 1, stage models have frequently been utilized to describe the developmental trajectory of minority identity; they have also provided a basis for understanding the development of sexual identity. Espín (1987, p. 39) has remarked upon the similarities between stage models of minority identity development and of sexual identity development, noting that the process of development

> must be undertaken by people who must embrace negative or stigmatized identities. This process moves gradually from a rejected and denied self-image to the embracing of an identity that is finally accepted as positive. Both models describe one or several stages of intense confusion and at least one stage of separatism from and rejection of the dominant society. The final stage for both models implies the acceptance of one’s own identity, a committed attitude against oppression, and an ability to synthesize the best values of both perspectives and to communicate with members of the dominant groups.

Stage Models of Sexual Identity Development

Stage Models of Lesbian Identity Development

In developing his stage model of gay identity formation, Coleman (1982), like Erikson, hypothesized that in each of his five enumerated stages the individual would focus on the accomplishment of specified tasks. However, an individual could move on to the subsequent stage without necessarily completing the tasks designated in the previous stage, i.e., an individual could attend to the tasks of several stages simultaneously. Coleman believed that, during each stage, the individual would develop an ever-increasing awareness of his/her same-sex attraction. These stages are as follows.

Stage 1: Predisclosure (coming out). During this first stage, the individual senses a “differentness” from other people. The individual may try to avoid dealing with the underlying issue and may develop low self-esteem. Successful resolution of this conflict would promote the individual into the second stage, whereas a failure to resolve it could lead to depression and self-harm.

Stage 2: Disclosure to self and others. During this stage, the individual gains self-acceptance and discloses to others. The formation of a positive self-concept during this stage is necessary for progression to the next. The functions of this stage appear to be similar to those identified by Erikson as being critical to adolescence. The individual must selectively integrate experiences and images of himself/herself and discard those that jeopardize a synthesis of the person.

Stage 3: Exploration. This stage may be characterized by experiences with sex and drugs, although the substance use may be a mechanism to cope with the stress that the individual experiences as he/she attempts to discover what it means to have a homosexual/lesbian identity. Coleman asserted that many other behaviors that would be seen as age-inappropriate are, in fact, understandable because individuals in this stage are attempting to resolve issues that heterosexuals would have confronted during their adolescence. This suggests that Coleman's conceptualization of this stage may occur chronologically during what Erikson would term the period of young adulthood.

Stage 4: First relationship. Although the individual now wants a stronger connection with a partner, the first relationships may be doomed because of internalized homophobia, inadequately developed social skills, and a lack of empathy with others. It is not unusual for individuals in this stage to move back to the previous stage.

Stage 5: Integration. The final stage reflects the individual's integration of the public self and the private self. It does not, however, signify that all of the work required during the previous stages has been completed; in fact, there may be numerous tasks still requiring attention. And, although this stage is highly stressful, the consolidation of the private and public selves allows for the possibility of more successful and stable relationships. This stage may mirror, in some respects, Erikson's stages of young adulthood and adulthood, during which the individual may develop more intimate relationships and increased productivity and creativity.

Other scholars have formulated alternative stage models to explain the development of a nonheterosexual identity, although some have focused their work entirely or in large part on gay men (e.g., Isaacs & McKendrick, 1992; Plummer, 1975). Briefly, those who have addressed nonheterosexual identity development specifically among women include the following.

Ponse's (1978) model of development was derived from interviews with 75 lesbian women. This model consists of five stages: a subjective feeling of being different as a result of sexual and/or emotional desire for women, the interpretation of these feelings as "lesbian", the assumption of a lesbian identity, a search for companionship with lesbian women, and participation in an emotional and/or sexual lesbian relationship. One of the strengths of this model is the emphasis on the individual's *interpretation* of his/her feelings as "lesbian," an element that is absent from many other models. This particular element is critical because different individuals may have similar experiences, but may interpret their experiences and

associated emotions quite differently, selecting from among them those that they believe are relevant to their sexual identity. As an example, two different women may engage in sexual-romantic relationships with both men and women. One individual may conclude from these experiences and her associated feelings that she prefers the company of women and is lesbian, while the other may conclude that she is equally attracted to both men and women and assume a bisexual identity.

The models of identity developed somewhat later by Sophie (1985/1986), Chapman & Brannock (1987), and McCarn and Fassinger (1996) also derive from interviews with lesbian women. Sophie's interviews with 14 lesbian women resulted in a four-stage model: an initial awareness of one's feelings, a period of testing and exploration, acceptance of one's identity, and, finally, the integration of one's identity. The 197 interviews with lesbian women conducted by Chapman and Brannock (1987) produced a five-stage model that commences with the awareness of one's same-sex orientation and progresses through a recognition of the incongruity between one's orientation and expectations; periods of self-questioning and identification; and culminates in a choice of lifestyle. Similarly, McCarn and Fassinger (1996), whose interviews included 38 lesbians, identified a new awareness as the initial stage of development of a nonheterosexual identity. This first stage was followed by periods of exploration and a deepening of commitment, culminating in a synthesis of one's identity, analogous to the integration stage postulated by Sophie (1985/1986).

McClanahan's (1994) survey study with 154 self-identified lesbian women suggests that if sexual identity develops in stages, individuals may not experience all stages or may move through various stages at quite different points in their lives. Almost one-half of the study participants reported an early awareness of their sexual difference. Others, however, indicated that their desire for women had evolved slowly over time and that they had not felt different when they were younger. These findings may also challenge the primary essentialist assumption underlying stage models of sexual identity development, i.e., that sexual orientation is a "real" thing, rather than a construct and that the developmental trajectory must necessarily culminate in same-sex identity synthesis (Stein, 1998 Yarhouse & Jones, 1997).

Stage Models of Development and Bisexuality

Most of the models of sexual identity development assume that the individual will at some point in time accept her identity as a lesbian and make that identity known to others; a failure to do so signifies an inability to achieve integration of the person. This ignores the experience of individuals who are bisexual in terms of their attraction, orientation, behavior, and/or self-identity.

Although bisexuality is often perceived as a willingness to have romantic/sexual relations with men and women, it may be more accurate to view bisexuality as a refusal to exclude either men or women from consideration as potential partners (Berenson, 2002). One bisexual activist explained that

> what distinguishes it [bisexuality] from heterosexuality or homosexuality is that for a person who is either homosexual or heterosexual, the gender of their partners is of primary importance to them. For a bisexual person, it's not the most important criterion, it's one of the criterion [sic] (Berenson, 2002, p. 13, quoting Domino).

As such, bisexuality stands as a rejection of the heterosexuality/homosexuality dichotomy and the conceptualization of bisexuality either as a refusal to choose between these two options or as a transitional phase of development (Bower, Gurevich, & Mathieson, 2002; Queen, 2002). Further, an unwillingness to exclude either males or females from consideration as potential partners is not synonymous with nonmonogamy (Shuster, 1987).

According to at least one scholar, the diversity of individuals' experiences and trajectories of bisexual identity development mitigates against a generalization of this process (Shuster, 1987). It has been asserted that because bisexuals consider all people to be potential friends and lovers regardless of their biological sex, they define themselves "as much by their constellation of committed friendships as by their sexual relationships" (Shuster, 1987, p. 63). Other scholars, however, have delineated stage models for the development of bisexuality that parallel those relating to lesbian identity.

As an example, Weinberg, Williams, and Pryor (1994) identified four stages of bisexual identity development based on a series of interviews that they conducted. According to their model, the developmental trajectory encompasses initial confusion, resulting from sexual feelings for individuals of both sexes; finding and applying a label (bisexual) that could explain their desires and behaviors; settling into the identity, a period occurring years after an individual's first attractions to or sexual involvement with males and females; and continued uncertainty, often stemming from a lack of social validation and pressure to label themselves as either heterosexual or lesbian.

Among self-identified bisexual women, desire and behavior may vary significantly. Some may experience sexual and/or romantic feelings for and engage in sexual activities equally frequently with men and women. Others may tend to prefer either men or women with respect to sexual feelings, sexual behavior, and/or romantic feelings (Weinberg et al., 1994).

Evaluation of Stage Models

Clearly, stage models have been formulated without considering the heterogeneity of minority groups and the various intersecting realities that may impact on an individual's identity development. These include, but are not limited to, socioeconomic status, educational level, migration history, and religious and spiritual traditions. They have also conceived of the developmental process as hierarchical or linear in nature, commencing with the individual's awareness of a same-sex attraction and culminating in self-acceptance (Parks, Hughes, & Matthews, 2004). However, despite these deficiencies, they provide a foundation for the further examination of the developmental trajectory.

Symbolic Interactionism

Many, if not most, individuals formulate their identity, at least in part, on the basis of their interactions and relationships with others. For instance, a female may function simultaneously as: a girl or woman; a mother; a daughter; an employee; someone who is sexually attracted to males or females or both or neither; a member of a specific cultural, religious, and/or racial or ethnic group; a friend; a neighbor; a volunteer, and so forth. Each of these interactions potentially leads to the imposition by others of labels and meanings on that individual, which she may then integrate into her self-definition. Although Erikson emphasized the internal process of identity development, he recognized the interactional element, stating that "part of identity must be accounted for in that communality within which an individual finds himself" and there may be

> fragments that the individual had to submerge in himself as undesirable or irreconcilable or which his group has taught him to perceive as the mark of fatal "difference" in sex role or race in class or religion (Erikson, 1975, pp. 19–20).

As an example, an individual may frame his/her sexual identity in response to societal oppression; in this context, a lesbian identity may also be a political identity. The existence of societal oppression based on sexual orientation may not, however, be consistent across all time periods and all locales; accordingly, a lesbian identity may not constitute a political response in such a context. Researchers investigating the meaning of being a lesbian reported that 35% of their respondents indicated that loving a woman or having sex with women was a part of their core personality (Eliason & Morgan, 1998). However, 65% believed that being a lesbian meant having a worldview that encompassed feminism or civil rights issues (Eliason & Morgan, 1998), lending credence to the idea that one's identity is, at least in part, a function of one's interaction with others and one's larger environment.

The concept of symbolic interactionism bears a relation to that of labeling, whereby individuals who are perceived to be outside the norm, or whose behaviors are perceived to be outside the norm, are deemed to in some way be deviant (Scheff, 1984). The attribution of deviance and a corresponding label to these individuals and/or their behavior may evoke a response that reinforces the notion of their deviance. The relationships between these two concepts are illustrated well by examining the language used to describe nonheterosexual nongender-conforming Native American individuals.

Various terms have been used in an attempt to describe the fluid gender and sexual expressions among indigenous peoples (Farrer, 1997). Walters, Evans-Campbell, Simoni, Ronquillo, and Bhuyan (2006, p. 127) explained the deficits inherent in these efforts:

> The label of *third gender* . . . is based on the Western binary system of gender and diminishes the complexity of multi-gendered statuses and expressions. The term *berdache* is offensive because of its colonial origins and purely sexual connotations: it is a non-Native word of Arabic origin (i.e., *berdaj*), which refers to male slaves who served as anally receptive

> prostitutes. . . . More contemporary anthropologists created the terms *women–men* and *men–women*, which are similarly deficient.

The use of these labels to refer to indigenous persons with fluid sexual and/or gender identity evoked feelings of shame among individuals to whom these terms were applied.

Ultimately, Native activists adopted in 1990 the term *two-spirit*, from the Northern Algonquin word *mizh manitoag*, referring to the inclusion of both masculine and feminine elements within the same individual. It was felt that the adoption of this term would allow individuals

> to reconnect with tribal traditions related to sexuality and gender identity; to transcend the Eurocentric binary categorizations of homosexual vs. heterosexual or male vs. female; to signal the fluidity and non-linearity of identity processes; and to counteract heterosexism in Native communities and racism in LGBT communities (Walters et al., 2006, p. 133).

Further, this reclaiming of language and identity to which it refers was felt to counter the shame that had been inculcated through the negative interactions and labeling associated with colonization and Christianization (cf. Tinker, 1993) and to serve as a unifying construct in struggles against "racism, heterosexism, and internalized oppression" (Walters et al., 2006, p. 133).

Social Constructionism

The social constructionist perspective asserts that homosexual behavior, i.e., sexual relations between members of the same sex, has occurred throughout history. However, the identities and lifestyles of the individuals who are attracted to members of their own sex have varied across historical eras, locations, and cultures. Accordingly, social constructionists understand the categories of "heterosexual," "homosexual," "lesbian," etc., to reflect society's current interpretation of the meaning of same-sex desires and behaviors (Epstein, 1987; Rust, 1993). One scholar explained that categories

> are human mental constructs . . . they are intellectual boundaries we put on the world in order to help us apprehend it and live in an orderly way . . . [N]ature doesn't have categories; people do (Stone, 1988, p. 307).

How women feel and behave sexually has been shaped, they claim, by cultural and societal messages that have constrained both their awareness of themselves and their choices (Baumeister & Twenge, 2002; Tolman & Diamond, 2001).

It should not be surprising, then, that some women who define themselves as not heterosexual may not self-identify as lesbian. The term "lesbian" has been rejected by some Black women as too Eurocentric (Mason-John & Khambatta, 1993). Some older women prefer to self-identify as "gay women" (Deevy, 1990), while still

others refer to themselves as "queer" (Stein, 1997). Even the use of the term "lesbian" has been subject to debate:

> Arriving at a working definition of "lesbian" is fraught with difficulty and contradiction, there is no consensus about what defines or even what characterizes a lesbian. The word is variously understood and positioned within a multiplicity of paradigms: the moral, the mystical/religious, the juridical, the scientific, the medical, the political, and the social. "Lesbianism" can mean immoral behavior, a sin, a crime, a sexual perversion, a pathological state, a site of or metaphor for resistance, a form of deviance, or a social role/lifestyle. Among lesbians ourselves there is profound dissensus about lesbian identity, with essentialistic and constructionist theories of varying kinds and degrees giving rise to contradictory and often competing performances of "lesbian" . . . lesbian-ness is a product of the shifting relationships among individual subjectivity, the body and the social (including kinship networks, sub-cultural groups, etc.), and of meanings constituted by/within those relationships. Such relationships are characterized by activity and rapid change, with the result that "lesbian" is a word in constant flux (Wilton, 1995, pp. 29–30).

The concept of homosexuality/lesbianism as a socially constructed category has met with vigorous opposition from various writers. The perspective has been interpreted by some to suggest that, if homosexuality is "constructed,"

> then conceivably a homosexual public school teacher might seduce a student and socially "construct/recruit" a homosexual out of an innocent heterosexual adolescent (Warner, 2002, p. 289, quoting Hanks, 1990, pp. 3–4).

This pronouncement misconstrues the nature of the social constructionist perspective by confusing the meaning attributed to behavior with the behavior itself.

Sexual Identity in the Context of Intersecting Identities

It is evident from this brief review that, in general, models of identity development that have been formulated to date generally fail to consider the heterogeneity of the populations to which they refer. Many of the models of sexual identity development were derived exclusively or primarily on the basis of research conducted with White women and men. As a consequence, their relevance to non-White/ethnic minority populations is uncertain (Speight, Myers, Cox, & Highlen, 1991). Similarly, the models of minority identity development have failed to consider the impact of an individual's nonheterosexual desires and/or behavior on his/her minority identity.

Indeed, ethnic/racial minority individuals may confront numerous circumstances not encountered by their nonminority counterparts that may affect their ability and willingness to divulge their sexual minority status. These include discrimination and oppression because of their ethnicity/race, particularly if they are biracial; discrimination within their ethnic/racial community against nonheterosexual individuals; discrimination by sexual minority persons because of their race/ethnicity; and the absence of healthy role models (Akerlund & Cheung, 2000; Espín, 1987; Walters et al., 2006). For Latina women, for instance, "coming out" may jeopardize strong family ties and the ability to live and work within one's community, while disclosing one's nonheterosexuality represents a denial of that part of identity associated with the most intimate relationships (Espín, 1984). As a result, nonheterosexual

minority women may receive significantly less social support than their nonminority counterparts due to experiences involving mistrust, rejection, and racism (Hall & Rose, 1996; Mays, Cochran, & Rhue, 1993).

Ohnishi, Ibrahim, & Grzegorek (2006) have noted that individuals' acceptance of their own sexual identity may or may not occur parallel to their acceptance of their racial/ethnic/cultural identity. They may embrace both identities; deny or struggle to accept both identities, experiencing significant marginalization and a high level of stress; or embrace either their racial/ethnic/cultural identity or their sexual identity while struggling to accept the other. The extent to which an individual accepts his/her racial/ethnic/cultural identity is often dependent upon

- the impact of one or more ethnic groups on the individual during critical periods of development,
- the individual's (im)migration status,
- the perception by the larger society of the individual's particular racial/ethnic/cultural group,
- the extent to which the individual is aware of his/her group's history and his/her feelings about that history,
- the individual's educational level and that of his/her parents,
- the individual's language abilities in English and other languages,
- the individual's religious and spiritual beliefs and practices,
- the birth order within the individual's family and his/her rank in that birth order,
- the individual's sex, gender, and sexual orientation and the perception and meanings attributed to them by members of the relevant racial/ethnic/cultural groups,
- the individual's chronological age and stage of life and the meaning attributed to them by members of the relevant racial/ethnic/cultural groups, and
- the individual's disability status (Ibrahim, 1999).

The extent to which an individual discloses his/her nonheterosexual identity may be similarly dependent on such factors. Research findings suggest that lesbians of color may not only delay self-identification as lesbians in comparison with White women, but may also be less likely than White lesbians to disclose their sexual orientation to nonfamily members (Parks et al., 2004).

Identity, Attraction, and Behavior

Identity and Attraction

Our current understanding indicates that one's self-identity may not be congruent with one's sexual attractions, orientation, or relationships (Golden, 1987). Findings from psychophysiological research indicate that both women who self-identify as lesbians and those who self-identify as heterosexual show genital arousal in response to both same-sex and opposite-sex visual sexual stimuli (Chivers, Rieger, Latty, & Bailey, 2004). In one study of adult women, two-thirds of those who self-identified as heterosexual reported having had romantic or sexual attractions

to members of the same sex, and almost one-half of those who self-identified as lesbian reported feeling attracted to members of the opposite sex (Pattatucci & Hamer, 1995). Individuals may continue to think of themselves as lesbian even though they periodically experience attraction to men, as long as they do not act on that attraction (Rust, 1992).

A girl may experience same-sex attraction but not self-identify as lesbian until a significant amount of time has elapsed (Savin-Williams, 2005). Individuals' willingness to self-identify as other than heterosexual may be delayed depending upon their cultural context and the potential repercussions of such a disclosure (Savin-Williams, 1996). It has been asserted, for instance, that Latinas may be more likely to self-identify as bisexual rather than lesbian due to perceptions of the lesbian/gay community as White (Morales, 1989). A bisexual identity may also allow individuals to maintain a multidimensional image of themselves rather than a monocultural identity as either Latina or lesbian and to avoid the political connotations associated with the label of lesbian (Chan, D'Augelli, & Patterson, 1995). Those females who have a greater proportion of same-sex attractions initially, compared to opposite-sex attractions, have been found to be more likely to later self-identify as lesbian (Diamond, 2000, 2003a, 2003b).

Also, how a woman self-identifies may change over time. Diamond (1998, 2000, 2003a) found from her prospective study of sexual identity among same-sex attracted women that although study participants' attraction to women remained consistent over time, their sexual identification was fluid over the course of their lives. An 8-year cohort study of 79 nonheterosexual women, 15% of whom were members of racial/ethnic minority groups, found that over the 8-year period, 22.8% of the women consistently self-identified as lesbian (stable lesbians), 31.7% self-identified as both lesbian and nonlesbian at different points in time (fluid lesbians), and 45.6% self-identified as bisexual or unlabeled (stable nonlesbians) (Diamond, 2005). Fluid lesbians were found to have more same-sex attractions, contact, and romantic relationships in comparison with nonlesbians, but less than those who were stable lesbians, providing yet additional evidence of the fluidity and plasticity of women's sexuality. A bisexual identity may signify concurrent identities, historical identities, or sequential identities during the life course (Fox, 1996).

Several scholars, however, have disputed the notion of sexual fluidity among women. Hyde and Durik (2000) have argued that women's apparent fluidity is a function of social and cultural factors. In a somewhat similar vein, others have asserted that many women are unaware of their true sexual identities as a result of cultural and societal oppression (Tolman & Diamond, 2001; Ussher, 1993).

Identity and Behavior

Behavior, as well as attraction, may not be congruent with self-identity. For example, some women may be celibate as a function of choice or due to their circumstances, but continue to identify as lesbian or bisexual, despite the absence of sexual activity (Esterberg, 1997). Indeed, one scholar has argued that sexual orientation need not be

continuously performed to be proved (Whitney, 2002). One would not expect such continuous "evidence" in the context of heterosexuality.

Among adolescents and young adults, many who engage in same-sex sexual relationships may identify as heterosexual and, of those who self-identify as lesbian, many are heterosexually experienced (Remafedi, Resnick, Blum, & Harris, 1992; Savin-Williams, 2005). Individuals who have identified themselves as lesbian but have relationships with men may continue to think of themselves as lesbian (Diamond, 2000; Near, 1990). Research similarly suggests that women who identify as heterosexual may experience sexual desire for and have sexual relations with a woman in the presence of "unusually intense emotional bonds [that] spill over into authentic, albeit temporary, same-sex sexual desire" (Diamond, & Savin-Williams, 2000, p. 301). Although it is commonly argued that any same-sex sexual activity is dispositive of a homosexual/lesbian orientation (Whitney, 2002),

> the notion that "one drop of homosexuality indicates latent homosexuality in a straight" theory sounds suspiciously like "one drop of black blood makes you black and you can't go to our schools" racist attitude (Hutchins & Kaahumanu, 1991, p. 8).

Given the fluidity of sexual identity and sexual behavior, it should not be surprising that two women involved in an intimate relationship with each other might self-identify quite differently. The term "mixed orientation" is often used to refer to such relationships in which each partner's self-identity may appear to be incongruent with the sex or identity of their partner (Rodríguez Rust, 2000). The term "heterogenous" has also been used (Bozett, 1982; Hays & Samuels, 1989).

Gender, Sexual Orientation, and Identity

Just as among heterosexual women, tremendous gender diversity exists among nonheterosexual minority and nonminority women. Gender refers to the roles, mannerisms, speech, etc., traditionally associated with a particular biological sex. It is to be distinguished from sex, a concept rooted in biology and encompassing male, female, intersex, and transsexual (Connell, 2005; Institute of Medicine, 2001; Roscoe, 1994).

The idea of the femme-butch dichotomy appears to have been adopted by lesbian communities by World War II (Gibson & Meem, 2002). The term "butch" was used, and is still used, to refer to women who dress and act in ways generally attributed to and reserved for men. In contrast, "femme" refers to a "womanly woman" (Gibson & Meem, 2002). This dichotimization of roles was, however, relatively short-lived, giving way in the 1970s to a rejection of what was perceived as traditional heterosexual gender roles (Butler, 1990) and the embracing of "an androgynous feminist aesthetic and nongendered social interaction" (Levitt & Horne, 2002, p. 26).

Lesbian-feminism perceived masculinity as both inextricably linked to biological men and the source of women's oppression (Maltry & Tucker, 2002). Butch lesbians were pressured to eliminate their masculine indicators, and femme lesbians were urged to discard their high heels as instruments to bind feet, their lipstick as

a reflection of excessive consumerism, and their tight clothing as an enticement for men.

Later, in the 1990s, some lesbian communities reclaimed the butch-femme expressions and identity, but have permitted a greater complexity within roles than had been accepted previously. For instance, appearance may range from that of "soft butch," signifying a softer masculine look, to that of "stone butch," a lesbian woman who is clearly masculine in appearance and who refuses to be made love to as a woman in order to guard against a loss of masculinity (Halberstam, 1998). Butch identity signifies masculinity, but it is masculinity as embodied in a female body (Butler, 1990). Inness and Lloyd (1996, p. 19) explained:

> [B]y virtue of her female body, the butch will have different life experiences and expectations from a man's. For example, a man does not experience the social pressure to be feminine that a butch does. Men are not worried about being raped the way women, even butches, are. As women, butches are still often considered less intelligent and capable than their male co-workers. In sum, butches are raised to be women, are treated like women, and suffer the stigma of not looking and acting the way women are expected to.

The femme identity is not synonymous with that of a "lipstick lesbian." Both identities reflect various aspects of traditional femininity. Unlike the femme, the lipstick lesbian is seen as "straight acting" (Maltry & Tucker, 2002, p. 96).

Not all lesbians are comfortable, however, with these categorizations and expectations. Research suggests that, although larger size is more accepted in lesbian and bisexual communities compared to heterosexual groups, a significant proportion of women may experience negative effects from perceived pressure to conform to stereotyped appearance standards for lesbians (Taub, 2003). This may be particularly true for bisexual women who find that they are "unrecognizable" to lesbian women if they do not conform to such norms (Bower et al., 2002) and for racial/ethnic minority women whose ways of being, becoming, and expressing may not be recognizable to or consistent with the dominant lesbian politics (Espín, 1987; Walters et al., 2006). Under such circumstances, bisexual women may attempt to "pass" as lesbians in order to connect with the lesbian community and experience a sense of acceptance. These efforts, however, may also result in a profound sense of loss and estrangement from one's racial/ethnic community (Espín, 1987; Walters et al., 2006).

Implications for Research and Clinical Practice

The research findings discussed in this chapter have significant implication in both the research and clinical contexts. In conducting research, it is critical that investigators consider in formulating their research questions, their hypotheses, and their recruitment strategies self-definitions and the multiple domains of attraction, behavior, and self-identity. Recruitment of a sample of lesbian women, for instance, may result in a sample of women who self-identify as lesbian, but whose sexual desires and behaviors may encompass not only women, but men, intersex individuals,

and/or transgender/transsexual individuals. It is clear that women's self-identity may differ at differing points in time and that identity, desire, and behavior need not appear or be congruent.

It is equally important to recall in the clinical context that behavior is not identity and to refrain from casting judgment when a client's self-identity appears to be at odds with the therapist's conceptualization of what that identity "should" signify in terms of associated behaviors. Therapy will be most helpful to the client if the therapist is able to recognize the complexities inherent in the client's identity development; accompany the client where he/she is in his/her process of development; respect the choices that the client has made in expressing who he/she is and the value that he/she has placed on those choices; and assist the client in making thoughtful choices about where, when, and to whom he/she will reveal the various dimensions of his/her sexuality and identity.

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Portrait 1
The Woman I Am!

Denise Rembert

I knew when I was eight that I was different from everyone else around me, my family, my friends, everyone. When I was eight years old my father caught me and my childhood best friend in somewhat of a compromising position. After being disciplined by both him and my mom and having it pounded into my head that this was not what young ladies do with one another and being ridiculed by my dad, my brothers, and my sister, I think I must have put those emotions away for years before they became too much to ignore.

There were moments when I dreamed of being involved sexually with a woman and waking up feeling like I was destined for hell and that there was nothing that I could do to save my soul. I remember going to church and feeling an extreme amount of shame and embarrassment for me and my family because I had thoughts and dreams of being romantically and sexually with a woman. Again, I fought off all of those emotions for the benefit of my family. For a while it was fairly easy to do so because after years of my dad being extremely abusive to my mother, he decided to choose drugs, alcohol, and other women over his wife of 20 or more years and his children. A lot of my energy went into being there for my mom and hating my dad for making her unhappy during the time he was with her and then because he left us.

My mother made us go to church every Sunday and it was where I saw most of her pain and suffering show through. I think she was able to pray and gather her strength to let the love she had for my father go because he was so absent from our lives while we were growing up and when he was there everyone walked on eggshells for fear of when he would snap on her or one of us. It was best that he left when he did because my brothers were not getting smaller. That being said, I felt like prayer worked because I witnessed it firsthand with my mom, so I prayed a lot for my love for women to go away. I asked God to remove these feelings from me if they were not meant to be.

Those feelings are still here. So this has allowed me to believe that this is the life I am supposed to live. So spiritually I feel good about the woman that I am. However, I have not always felt this way. I can remember being 15 and really fighting within myself to be heterosexual. I used to try and figure out ways to do away with my feelings of being with a woman. There were times when cutting myself made me feel ok. Somehow, seeing the blood made me feel as though I was cutting

away the issues that I had with my sexuality. Also, I needed to feel this pain as a means of suffering because at the time I felt as though I was destined for hell. I was living my own personal nightmare, and I continued to cut myself for at least two years.

Being away from home at 17 was the worst time for me. I was depressed for a long time as I look back and I never got any help for my pain and emotional distress. Typically in college most students drink their share of alcohol and possibly do their share of drugs. But if you look at someone who is depressed and placed in that type of environment, you will most likely see someone who may consume double the average college students' alcohol and drugs. My college years were some of the most fun, exciting, and awesome times for me. I had some good days in college, living on campus and playing basketball on scholarship, but internally I was a wreck. There were so many times that I wanted to tell my family and some of my friends who I really was, but I was afraid that my family would disown me. So I bottled all of those feelings and emotions up again and did not say anything to anyone about the real Denise Rembert.

Living this way made my college years become the worst time in my life. My excessive alcohol and drug consumption made it very hard for me to play basketball, stay healthy, and stay focused on school work. Therefore I did not graduate on time. I made a lot of horrible decisions; some I pay for still today and some only I know about that internally haunt me. I had sex with men to try and find whatever it was I needed to help me get rid of these sinful emotions. I took pills to just stop thinking about it at all. There were times when I thought about killing myself, and times when I actually tried. Sometimes it would be that I just did not want to feel anything, so I would drink and smoke marijuana until I couldn't and I would be so sick from all that I consumed that I was not able to function for days at a time. By the grace of God I am still here and currently still dealing with some of those issues that seem to continue to linger, but I am at this point capable of helping another young person with the same struggle so that maybe their teenage and young adult years won't be as chaotic as mine were. I know too well that if not properly dealt with early on, you bring some of it into your adult years and it will continue to be rough for you.

I came out to my mother on the phone, not by choice, but by force from an ex-girlfriend of mine who felt like I needed to stop lying to my mom. So, here I am in Cleveland, Ohio and my mom is in Selma, Alabama; why would I tell her over the phone? I wouldn't under normal circumstances, but in this relationship nothing was really normal. We are at an event at my girlfriend's family's house, and she is upset with me because I am continuously forgiving her for her indiscretions. So, she decides to call my mom and scream out things like "Tell her you're a lesbian, and you live with me and we are lovers! Tell her or I will"! I am totally at a loss for words and my mom and sister are on the other end hearing everything and very concerned at this point. There are a couple of things that trouble me at this point. One of them is clearly that I have to come out to my mother over the phone right now. Second, clearly there is something wrong with my girlfriend.

So I dealt with my mother and sister first. Coming out was initially the most embarrassing and hurtful thing I had to do. Afterwards, it seemed very uplifting. I felt as if a ton of bricks had been lifted from my shoulders and relieved that she now knows. Of course, she thought I was psychotic and that I needed to see someone about my illness. After that my mom and I spoke briefly on the phone every now and then. But it was not the same; she was very withdrawn in her conversations with me and she did not offer any input into my life for at least 2 years and when she did it was always about an ex-boyfriend. At first it was extremely annoying, but I had to understand the changes that she was going through around this. We have gotten past all of that and I know she still wishes for grandchildren from me. I love my mother and I hope that she will one day understand that I did not choose to be this way; I was born this way.

I always think if I did not have the faith that I have, the spiritual grounding that I have, then where would I be? Lord knows my soul has been bruised and my psyche has been injured almost beyond repair. If it was not for the love. . . .

Chapter 3
Minority Sexual Status Among Minorities

Kelly D. Brooks, Lisa Bowleg, and Kathryn Quina

> *I am like halfway in and halfway out [of the Black community] because as soon as you bring up the gay piece and there's, you know, not a gay person to support you, it's always like. . . 'Have you ever been abused? Have you ever been raped? Is that why you're with a woman?'*
>
> Ayana, 29-year-old Black lesbian

> *Maybe it's not necessarily the issues, but the way [members of the White gay and lesbian community] approach them. They see everything in terms of sexuality defining themselves, and sort of like, leave everything out. They don't necessarily include issues like race, and class, and sometimes not even gender in terms of their mix, the way they look at things. So, I don't necessarily feel completely home in terms of the gay community.*
>
> Sherice, 36-year-old Black bisexual woman

As illustrated above, lesbian and bisexual women of color often find themselves at the margins of the racial, gender, and sexual orientation groups to which they belong. As members of multiple stigmatized groups, they face stigma and discrimination on multiple fronts, yet their experiences and needs are rarely fully understood or addressed in social movements and communities that focus on identity-based oppression. This lack of attention is mirrored in social science research and theory concerning marginalized social groups. Social categories such as race/ethnicity, gender, and sexual orientation are often treated singly as if they operated independent of one another; for a large part, separate theories and bodies of research address racial identity, gendered identities, and sexual identity, as well as racism, sexism, and heterosexism (Bowleg, 2008; Fukuyama & Ferguson, 2000; Greene, 2000; Stanley, 2004). By focusing on one identity at a time, such approaches tend to assume majority group status on other identities, representing, for example, the experiences of lesbian, gay, and bisexual (LGB) persons who are White and African Americans who are heterosexual. As a result, the experiences of women of color who are sexual minorities are neglected (Greene, 1994).

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This highlights the need to approach the study of oppression from an intersectional perspective – emphasizing that race, ethnicity, gender, class, sexual orientation, ability, and other social statuses intersect and mutually construct one another (Collins, 1991, 2000; Crenshaw, 1994; Weber & Parra-Medina, 2003). Such a view acknowledges that people contain multiple group memberships, resulting in some of their identities being privileged in society and others being marginalized. Thus, it is necessary to examine how these multiple identities are experienced simultaneously and how they interact with each other (Croteau, Talbot, Lance, & Evans, 2002). It is not a matter of adding up the number of marginalized identities a person has, but rather systems of oppression (e.g., racism, sexism, heterosexism) are viewed as interlocking.

This chapter focuses on the stigma and discrimination that lesbian and bisexual women of color experience due to the intersection of race, gender, sexual orientation, and class in their lives. We examine the literature regarding sexual stigma and highlight what is known about how this stigma operates for women of color. In addition, findings from a qualitative study with Black lesbian and bisexual women will be presented to illustrate how intersections can occur. Unfortunately, space limitations prevent a detailed discussion of every racial and ethnic group; therefore, we present concepts and issues that may be of relevance to many women of color, but we focus on Black women (women of African or African-Caribbean descent) most closely. Clearly, it is a mistake to treat women of color as a monolithic group with shared characteristics and experiences; even within a particular ethnic group, much variation exists. In addition, other statuses, such as dis/ability, religion, and immigration intersect with other identities and can shape women of color's experiences in important ways, but they are addressed only partly or not at all in this chapter. Pseudonyms are used for the interviewees mentioned in this chapter in order to safeguard their privacy.

Sexual Stigma

According to Herek (2004, 2007; Herek, 2007), sexual stigma represents "society's shared belief system through which homosexuality is denigrated, discredited, and constructed as invalid relative to heterosexuality" (Herek, Chopp, & Strohl, 2007, p. 171). This stigma encompasses nonheterosexual behaviors, identities, relationships, and communities, and it operates at both the structural and individual levels. On the structural level, societal devaluation of homosexuality becomes enshrined in and perpetuated by social institutions, such as religion and law. On the individual level, heterosexuals internalize the negative belief system toward sexual minorities, leading to sexual prejudice. Finally, sexual stigma becomes enacted in the harassment, discrimination, and victimization individuals perpetrate against sexual minorities.

Sexual Prejudice in the General Population

Although attitudes about homosexuality in the general public have become increasingly positive, prejudice against sexual minorities persists (Fernald, 1995; Yang, 1999). A nationally representative poll conducted in 2000 found that half of the respondents still believed homosexuality was morally wrong (Kaiser Family Foundation, 2001). In addition, Americans continue to oppose gay marriage at a rate of approximately 55–36%, with people who report a high level of religious commitment opposing it by a wider margin (73–21%; Pew Research Center, 2007). Because explicit attitudes, those that are aware of and are able to report to researchers, can be subject to social desirability biases, implicit (unconscious) attitudes may provide a more honest assessment of prejudice levels. Steffens (2005) measured both explicit and implicit attitudes toward homosexuality, finding that implicit attitudes were more negative than explicit, self-reported attitudes. However, to the extent that words such as "lesbian" and "gay" conjure up the images of Whites, measures of general prejudice against homosexuality may not accurately represent attitudes toward sexual minorities of color.

Enacted Stigma

A sizable body of research documents the pervasiveness of anti-gay harassment, discrimination, and victimization (e.g., D'Augelli, Pilkington, & Hershberger, 2002; Herek, 1993, 2009; Herek, Gillis, Cogan, & Glunt, 1997; Otis & Skinner, 1996; Pilkington & D'Augelli, 1995; Rayburn, Earleywine, & Davidson, 2003). For example, a national poll found that nearly three quarters of LGBs had experienced verbal harassment and nearly one-third reported physical abuse due to their sexual orientation (Kaiser Family Foundation, 2001). However, prevalence estimates for hate crimes and other types of victimization can differ widely depending on the age of the sample, the time period queried, and the methodology used; in addition, much of the research in this area has been conducted with nonprobability samples, which may differ in important ways from the larger LGB population. Nonprobability sampling can introduce biases leading to the selection of people who are more comfortable with their sexual orientation, more highly educated, and more often living in urban areas than those found in comparable probability samples (Sandfort, Bos, & Vet, 2006).

Fortunately, research in this area is increasingly using sophisticated sampling techniques to obtain more representative samples and to improve the accuracy of hate crime prevalence estimates. In a national probability sample of over 600 lesbian, gay, and bisexual individuals, which likely provides some of the most reliable estimates to date, 20% of respondents reported being a victim of a sexual orientation bias-related property or person crime (Herek, 2009). Although women reported less victimization than men, approximately 15% of lesbian and bisexual women

reported being a victim of a crime or attempted crime (versus 39% for gay men and 20% for bisexual men). In addition, over one-half of lesbians and one-third of bisexual women reported experiencing verbal abuse due to their sexual orientation. Moreover, in a survey comparing sexual minority women to their heterosexual siblings, sexual minorities showed elevated levels of types of victimization not necessarily directly linked to their sexual orientation, such as childhood sexual and physical abuse, adult domestic violence, and sexual assault (Balsam, Rothblum, & Beauchaine, 2005).

Unfortunately, determining the levels of victimization for sexual minority women of color is particularly problematic due to their insufficient representation in many samples and the lack of disaggregated findings in many research reports. Nonetheless, within-group studies of racial and ethnic minority LGBs indicate that sexual orientation-based discrimination and victimization is common (Bowleg, Huang, Brooks, Black, & Burkholder, 2003; Diaz, Ayala, Bein, Henne, & Marin, 2001; Mays, Cochran, & Rhue, 1993; Walters, Evans-Campbell, Simoni, Ronquillo, & Bhuyan, 2006), and some research suggests that these experiences are more prevalent for sexual minorities of color than White LGBs (Morris & Balsam, 2003). Another study, however, found that White youths experienced more victimization than youths of color (Pilkington & D'Augelli, 1995). Clearly, additional research is needed to better document the physical and psychological risks that sexual minority women of color face.

Regardless of its prevalence, though, one disturbing recent finding sheds light on the context of victimization for these women. Dunbar (2006) found that women of color, who are targets of sexual orientation-based crime, are the least likely to report their crimes to law enforcement (52% versus 81% for White gay men). While there are numerous possible explanations for this disparity, it is important to bear in mind the intersectional identity of womans/persons of color/sexual minority when examining them (Crenshaw, 1994). First, the levels of distrust toward members of law enforcement present in many minority communities – often high due to past discrimination – are clearly relevant to decisions regarding crime reporting. In order to report a bias crime, the victim must disclose her sexual orientation to police, which she may believe will predispose her to more discrimination. Then, if charges are filed, this information may become public, which can have myriad implications, particularly if the woman has not yet disclosed her sexual orientation widely. If the perpetrator is a member of the victim's racial/ethnic community, the victim may also feel pressure to avoid negatively portraying another community member, and by extension, the entire community.

Sexual Stigma in the Workplace

Employment is a major arena in which sexual minorities have historically been subject to, and continue to face, discrimination. At the current time, only 20 states

and the District of Columbia have legislation prohibiting employment discrimination based on sexual orientation in public and private businesses, and even fewer (12 states and District of Columbia) include gender identity protections (Human Rights Campaign, 2008). Accurately assessing the prevalence of workplace discrimination is difficult, but one review of primarily convenience-drawn samples estimated the proportion of LGBs experiencing some form of job discrimination at 25–60% (Croteau, 1996). Findings from a large survey of service industry workers in the Netherlands, a country known for its tolerance, found that discrimination was present but perhaps less pervasive than previous estimates indicate. For example, approximately 14% of women reported that their careers had been thwarted in some way due to heterosexism (Sandfort, 2006). Furthermore, Hebl, Foster, Mannix, & Dovidio (2002) demonstrated that even in the absence of formal job discrimination, such as discriminatory hiring and firing practices, prejudice seeps into interpersonal interactions between LGBs and coworkers (e.g., in the length of their conversations).

Due to the potential threat of formal and informal discrimination if their sexual orientation is known, lesbian and bisexual women are faced with the challenge of deciding how to manage their sexual identity in the workplace. Whether, when, how, and to whom to disclose one's sexual identity must be continually negotiated. For example, some individuals make up fictional other-sex partners in order to pass as heterosexual; some censor personal information to hide their sexual orientation from coworkers; some just avoid explicitly identifying as LGB at work; whereas others are more explicitly out (Griffin, 1991). Already facing race- and gender-based harassment and their adverse consequences (Berdahl & Moore, 2006; Buchanan & Fitzgerald, 2008), lesbian and bisexual (LB) women of color might worry that sexual identity disclosure could add another stigmatized status for which others to respond negatively. In a qualitative study with Black sexual minority women, one participant voiced this concern: "Living as a Black woman in this White society, I am already challenged. So in my day to day interactons in my job and all, . . . I choose not to add the lesbian factor," (Bowleg, Brooks, & Ritz, 2008). Women in this study reported experiencing a range of discriminatory experiences in the workplace, ranging from minor – other women assuming sexual interest in them – to more serious – losing a job.

Sexual Stigma in Communities of Color

Many writers have discussed the challenges that sexual stigma in communities of color presents for LGB racial and ethnic minorities (e.g., Chan, 1995; Chung & Katayama, 1998; Conerly, 2000; Espin, 1987; Greene, 1994; Savin-Williams, 1996; Walters, 1997). Anecdotal and qualitative evidence show that sexual minorities of color commonly perceive high levels of heterosexism within their racial/ethnic groups (Bowleg, 2003; Loiacano, 1989; Mays et al., 1993; Morales, 1990; Poon & Ho, 2002; Tremble, Schneider, & Appathurai, 1989). Numerous explanations have

been posited to account for the perceived heterosexist attitudes. Because of the racism that communities of color experience, LGBs may be seen as threatening the group's survival either by decreasing reproduction or by taking energy away from fighting racism. (Greene, 1994; Savin-Williams, 1996; Walters, 1997). Homosexuality and bisexuality are sometimes seen as White phenomena that do not naturally exist in ethnic minority communities and represent the negative impact of acculturation (Morales, 1990; Rust, 1996).

However, sexual stigma is not unique to communities of color; as discussed above, it exists throughout the majority culture as well. Therefore, evidence of negative attitudes toward homosexuality in these communities does not necessarily mean that they contain higher levels of heterosexism than in mainstream White culture. Empirical studies comparing attitudes toward sexual minorities among Whites and people of color provide limited support for elevated levels of heterosexism in communities of color (e.g., Waldner, Sikka, & Baig, 1999). However, findings are mixed and indicate that the differences may be primarily a function of religious commitment and demographic factors. For example, findings from a national probability sample indicated that negative attitudes were not more common among Blacks than among Whites (Herek & Capitanio, 1995), whereas findings from other studies have shown that differences disappeared when accounting for religious attitudes (Schulte & Battle, 2004), church attendance, and socioeconomic status (SES) (Negy & Eisenman, 2005). In addition, a recent review of 31 studies found that once researchers controlled for religious and educational differences, Blacks remain more disapproving of homosexuality but more supportive of gay civil liberties and protection from discrimination (Lewis, 2003).

Clearly, to the extent that sexual stigma is present in Black communities, religious settings play a significant role in the expression of such negative attitudes. For example, focus groups have highlighted homophobic denouncements in Black churches, while concealed homosexuality was sometimes tolerated among clergy (Fullilove & Fullilove, 1999). Thus, for Black LB women for whom religion is important, as well as other sexual minority women with religious ties, coping with heterosexist attitudes of other members of the religious community may be a significant challenge.

Sexual Stigma Within the Family of Origin

Because families are located within racial, ethnic, and cultural communities, heterosexist attitudes in communities of color can have implications for families' reactions to a lesbian or bisexual daughter. Cultural values emphasizing the importance of family and upholding the traditional gender roles, including the expectations that women will become wives and mothers, are predominant in many non-Western cultures, though gender roles tend to be more flexible among African Americans (Greene, 1994). These traditional values tend to be viewed as incompatible with

homosexuality. For example, the pressure to procreate is particularly strong for women in many racial and ethnic groups (Chan, 1995; Greene, 2000), and parents may believe that being lesbian or bisexual will prevent their daughter from fulfilling her role as mother to the next generation of the family. Furthermore, in some collectivist cultures, such as Asian societies, responsibility to the family is paramount and takes precedence over personal freedom and happiness; thus, familial obligations would be considered more important than a child's sexual fulfillment (Collins, 2007).

Cultural values and attitudes that are incongruous with homosexuality complicate the process of coming out for sexual minority women of color. Merely broaching the subject of sexuality with family members is challenging for some women. In Asian cultures, for example, traditional attitudes toward sex preclude discussion of sexual matters (Poon & Ho, 2002). Thus, it would not be surprising if sexual minority women of color disclosed their sexual orientations to family members and other members of the community at lower rates than White LGBs. Findings regarding the rates of coming out among LGBs of color and their family's reactions are mixed, but they show a general pattern of LGBs of color feeling less comfortable disclosing their sexual identities to others than do White LGBs (e.g., Parks, Hughes, & Matthews, 2004; Kennamer, Honmolde, Bradford, & Hendricks, 2000). Pilkington & D'Augelli (1995) found that youths of color felt less comfortable coming out to members of their community and experienced more rejection from their mothers than did White youths. Similarly, Rosario, Schrimshaw, & Hunter (2004) observed that Black youths were more uncomfortable with others knowing about their sexual orientation, and Black and Latino youths disclosed to fewer other people than White youths.

Fear of familial rejection is a common impediment to sexual orientation disclosure (Ben-Ari, 1995; D'Augelli, Hershberger, & Pilkington, 1998). This fear may be particularly strong and have additional weight for women of color due to their marginalized racial/ethnic status. Because the family provides a support system in a hostile racial environment, rejection by family can be particularly problematic (Greene, 1994). Fortunately, the strong emphasis on family in many non-Western cultures can act to discourage family members from outright rejecting the person (Morales, 1990; Tremble et al., 1989).

Although little systematic research exists examining the sexual disclosure outcomes across racial and ethnic groups, there is evidence that the acceptance of LGB children sometimes comes at the cost of not explicitly disclosing or discussing sexual orientation with family members. Even when family members are aware of the child's sexual orientation, often there is an expectation that the family will not discuss it or that it will be concealed in public (Bowleg, 2003; Poon & Ho, 2002). Lesbian and bisexual daughters may comply with their family's wishes to some extent because they want to maintain ties with their families and cultural groups, and they are sensitive to the effects their disclosure will have on the family's reputation in the community. Ultimately, however, each individual must balance these concerns with her need to support her sexual self (Meghiri & Grimes, 2000; Morales, 1990;

Tremble, 1989). Thus, the implications of coming out for a woman's relationship with her family and standing in her community may be very different for women of color than for White women.

Biphobia

The experiences of bisexual women of color must be understood in the context of the highly negative attitudes about bisexuality, which are widely held among heterosexuals and gays and lesbians alike (Israel & Mohr, 2004; Ochs, 1996). It appears that bisexual prejudice is not merely an extension of prejudice directed toward gays and lesbians; evidence exists that heterosexuals actually view bisexuals more negatively than they do gays and lesbians (Herek, 2002). Compounding this, some lesbians believe that bisexuals benefit from heterosexual privilege, question their loyalty to lesbian community, and have difficulty trusting bisexual women in romantic relationships (Mohr & Rochlen, 1999; Ochs, 1996; Rust, 1993; Udis-Kessler, 1991). In order to explain these reactions, scholars point out that sexuality has traditionally been constructed as a heterosexual–homosexual dichotomy; in such a view, the existence of bisexuality is questioned and bisexuals are rendered invisible and inauthentic (Bohan, 1996; Bradford, 2004; Rust, 2000; Zinik, 1985).

Not surprisingly, given the prevalence of negative attitudes toward bisexuality, bisexual women report discrimination both in mainstream culture and within lesbian/LGB communities (Bradford, 2004; Ochs, 1996). Moreover, bisexual women report lower levels of self-disclosure and community connection than their lesbian peers (Balsam & Mohr, 2007). Very little research has specifically examined bisexual issues among women of color; however, similar to other sexual minorities, bisexual women of color report difficulties integrating racial and sexual identities (Rust, 1996).

Racism, Sexism, and Classism

Racism in Majority White LGB Communities

Being a racial/ethnic minority in the United States involves coming into contact with racial and ethnic prejudice in its interpersonal, cultural, and structural manifestations. In a majority White society, LGB-focused community groups and social networks typically reflect the makeup of the larger society and are not immune to the types of prejudice that exist within it. For example, one survey found that one-half of Black LGBs polled reported experiencing racism from White LGBs (Battle, Cohen, Warren, Fergerson, & Audam, 2002), and, in interviews with Black lesbians, racism in White lesbian communities and in interactions with White sexual minority women was a prominent theme (Mays et al., 1993).

Additionally, Black youths are less likely than White youths to participate in gay-related social activities, ostensibly due to the racism and marginalization they face in these settings (Rosario et al., 2004). This suggests that sexual minority women of color may have difficulty finding support for their gay identities in the place traditionally thought to provide such support – LGB communities. If they perceive a large amount of sexual prejudice in their cultures of origin, facing racism within LGB communities can lead them to feel conflicted allegiances to each community and make integrating the two identities difficult (Espin, 1987; Greene, 2000, 1994; Loiacano, 1989; Walters, 1997). (See Chapter 1 of this volume for a more detailed discussion regarding conflicting identities and identity integration.) Tensions among identities and community allegiances can be exacerbated for individuals who do not easily fit into one racial/ethnic group (i.e., biracial and multiracial sexual minorities; Collins, 2007; Stanley, 2004). For biracial or multiracial individuals who are also bisexual, finding a place where some part of them is not marginalized or invisible may be particularly difficult.

Class and Its Intersections with Race

The differential distribution of income across racial and ethnic groups makes economic concerns very salient for many people of color. In 2005, 24.9% of Black individuals and 21.8% of Hispanic individuals reported incomes below the poverty level, in comparison to 10.6% of Whites and 11.1% of Asian and Pacific Islanders (US Census Bureau, 2008). Comparing sexual minority women with their heterosexual counterparts illuminates the class implications of sexual minority status for women of color. In 2000, the median annual household income for Black female same-sex households ($42,000) was 21% less than that of Black married opposite-sex households ($51,000) (Dang & Frazier, 2004). Similarly, Hispanic female same-sex households reported a median income of $40,000, 11% less than Hispanic married opposite-sex households, who earned a median income of $44,200 (Dang & Frazier, 2004).

Heterosexist social policies disproportionately disadvantage low-income sexual minority women. With fewer economic resources, discriminatory policies such as the Defense of Marriage Act may be even more damaging for them; in addition, classist stereotypes about LGBTs (i.e., that they are for the most part upper middle class and childless) render the needs of low-income LB women invisible to policymakers (Lind, 2004). However, because poor women are largely absent from the psychological literature (Reid, 1993; Saris & Johnston-Robledo 2000), the context of poor and working-class LB women's lives and their experiences of discrimination remain hidden. One study that attempted to shed light on some of the ways social class impacts sexual minority women of color was Hall and Greene (2002) examination of class differences in Black lesbians' romantic relationships. The authors found that such disparities were often the source of conflict, for example, contributing to fears of abandonment, resentment about a partner's educational aspirations and

attainments, discomfort with how a partner treats service workers, feelings of paternalistic treatment by a partner's family, criticisms of a partner's middle-class values, and disagreements about vacations and discretionary spending. Clearly, conflicts related to finances are not unique to the relationships of LB women of color (e.g., Bryant, Taylor, Lincoln, Chatters, & Jackson, 2008; Dew, 2008). However, class differences may take on an added weight for some sexual minority women of color because of the common association of middle-class status with White privilege. Moreover, expectations of shared values based on similar racial backgrounds and social characteristics can lead to disappointment and hurt when differences emerge (Hall & Greene).

In addition to being seen as predominantly White, mainstream LGB communities tend to be perceived as having a middle-class focus, ignoring the interests and realities of working-class and poor LGBs (Ramirez-Valles, 2007). Valocchi (1999) argues that modern lesbian and gay collective identities evolved in such a way that they reflect middle-class interests. Thus, sexual minority women of color from poor and working-class backgrounds may find they face a lack of acceptance in middle-class lesbian and bisexual communities. For example, working-class women in the United Kingdom reported being devalued in lesbian spaces for failing to conform to middle-class lesbian norms for appearance (Taylor, 2007).

Sexism and Its Intersections with Race and Sexual Orientation

For women of color, sexism often takes on a specifically racist tone. This is particularly pronounced in the pervasive sexual stereotypes and mythologies that exist regarding women of color (Greene, 1996, 2000; Wyatt, 1997). Stereotypes about Black women's sexuality, which derive from their treatment during slavery in the United States, paint Black women as sexually permissive and promiscuous. These stereotypes appear in Black women's representation in the media and in popular culture, and Black women themselves may internalize these images (Wyatt, 1997). Consequently, Black women are presented with a very limited set of possibilities for the expression of their sexuality, none of which are entirely positive: they can embody the sultry seductive "she-devil," the nurturing but asexual Mammy, or the high-achieving "workhorse," who downplays her sexual needs and is undesired by men (Wyatt, 1997).

A striking example of combined racist and sexist media portrayals of Black women can be found in the remarks that White male radio talk show host, Don Imus, and his co-hosts made regarding the Rutgers women's college basketball team. The day after they competed in the 2007 NCAA championship game, Imus described the primarily African-American team as "rough," apparently due in part to the tattoos that some team members had. Then, after his co-host called the team "hardcore hos," Imus proceeded to refer to the women as "nappy-headed hos," and later another commentator on the show compared the women to the Toronto Raptors men's basketball team (Media Matters for America, 2007). In addition to being

demeaning, this language invokes stereotypes of Black women as both unfeminine and sexually promiscuous. The impunity with which Imus felt he could publicly make remarks containing sexually degrading and racist language illustrates the level of prejudice against Black women, which exists just below the surface in American culture.

Another realm in which racist and sexist stereotypes about Black women operate is the workplace. Women of color are susceptible to harassment based on race/ethnicity and gender (in addition to other marginalized statuses they may possess); as such, they report higher levels of harassment in the workplace than do White women (Berdahl & Moore, 2006). There is some evidence that women of color experience more workplace *sexual* harassment, as well (Bergman & Drasgow, 2003), but other studies have not observed this finding (Berdahl & Moore, 2006; Wyatt & Riederle, 1995). Nonetheless, congruent with the racist sexual stereotypes discussed above, some Black women's experiences of sexual harassment include comments and attention that are linked to assumptions that Black women are hypersexual and have loose sexual boundaries (Buchanan & Ormerod, 2002; Mecca & Rubin, 1999). For example, some Black women reported that White coworkers and supervisors appeared to feel freer to discuss explicit sexual matters with them than with other employees and also made sexualized comments about their dress and appearance (e.g., implying that one participant looked like a prostitute; Buchanan & Ormerod, 2002).

For sexual minority women, such intrusiveness regarding sexual behavior could be particularly problematic. For example, the assumption of substantial heterosexual experience could be awkward for a woman who has chosen not to come out to her coworkers, possible forcing her to disclose her sexual identity unwillingly or create a heterosexual persona. Moreover, Black sexual minority women are not immune to the unwanted sexual advances of male coworkers, but they must also guard against accusations of making unwanted sexual advances toward female coworkers (Bowleg et al., 2008). The role that racist sexual stereotypes play in such perceptions about the behavior and intentions of Black and other sexual minority women of color is an important area for further exploration.

Case Study: Experiences of Black Lesbian and Bisexual Women

In order to illustrate some of the issues and challenges confronting sexual minority women and the intersections of race, class, gender, and ethnicity in their lives, we present findings from a qualitative study conducted in 13 Black women self-identified as lesbian ($n = 8$) or bisexual ($n = 5$). These women are part of a larger group of Black lesbian, gay, bisexual, and transgender (LGBT) individuals ($N = 29$) recruited to participate in a study about identity, discrimination, and stress and coping in Black LGBT communities (Bowleg, 2000). Recruitment materials, flyers posted in LGBT community settings, and ads in two local newspapers (a free

LGBT weekly and a free community weekly) offered a $40 cash incentive for participating in the study and instructed interested individuals to call a toll-free (800) telephone number, where they were screened for eligibility. In order to participate in the larger study, individuals needed to identify as Black or African American and as gay, lesbian, bisexual, or transgendered; reside in the metropolitan area where the interviews were conducted; and be 18 years or older. The study received IRB approval from the University of Rhode Island's Institutional Review Board.

Demographic questionnaires were filled out at the time of the interview by 12 of the 13 participants in the present study. Their ages ranged from 24 to 52 years ($M = 34.42$). Participants reported education levels ranging from high school graduation or GED attainment ($n = 2$) to graduate degrees, with 10 having at least some college or professional training. Annual personal income ranged from between $10,000 and $14,999 to between $60,000 and $69,000, with almost a third of participants ($n = 4$) reporting an annual income between $30,000 and $39,999. Household income was somewhat higher, with 4 participants reporting an annual household income between $50,000 and $59,999.

Materials and Procedure

Four Black women, including the second author, conducted the individual semi-structured interviews, which lasted approximately 1 to 1-1/2 hours and were tape-recorded. In order to promote consistency, interviewers were trained to follow a standardized interview guide created by the principal investigator. The interview guide consisted of a series of open-ended questions designed to elicit extensive remarks about participants' social identities, as well as their experiences with racism, sexism, and heterosexism; stress produced by these experiences; and methods of coping with stress. Interviewers were encouraged to probe for more information about a particular topic when deemed necessary. At the conclusion of the interview, participants completed a short questionnaire of demographic items.

Analytic Strategy

The audiotaped interviews were transcribed verbatim and transcripts edited to remove identifying information. The first author analyzed the interviews in consultation with the second and third authors using a number of techniques derived from the grounded theory method of qualitative analysis (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Grounded theory offers a systematic approach aimed at "discovering concepts and relationships in raw data and then organizing these into a theoretical explanatory scheme" (Strauss & Corbin, 1998, p. 11). After reading the interview transcripts multiple times to gain an understanding of the women's experiences as a whole, the analysis proceeded via open coding, axial coding, and memo writing. These analytic procedures allowed us to identify important concepts related

to identities and discrimination in the data; group these concepts into categories; and further develop, refine, and specify relationships between categories.

Results

Participants discussed the role that their racial, gender, and sexual identities played in their lives, but were hesitant to exclude any aspect of themselves in order to "rank order" their identities. Some participants noted that although White women appeared willing to focus primarily on sexual orientation, they were less able to do this and saw themselves as complex collections of multiple characteristics and group memberships. When asked, though, many did discuss their identities somewhat separately while recognizing the artificiality of this endeavor. The majority noted the importance of race in their lives, largely because its visibility greatly influenced others' treatment of them. For example, Sherice, a 36-year-old grant-writer, said, "When it comes down to it, I'm Black and that's the way the world sees me, and that's where I face a lot of discrimination and issues and problems."

Although participants viewed their sexual identities as less visible than other identities, some believed their sexual minority status strongly influenced their lives and interactions with others. Lora, a 21-year-old student, noted, "Being a lesbian has had such an impact in my life that it has put me into a different category than just being an African American. . . . If someone had a choice to hate me or discriminate against me for something that I was, that would probably be the first thing picked."

Experiences with Discrimination

Experiences of Sexual Stigma and Prejudice. Participants described numerous incidents of sexual stigma and prejudice. We provide some examples that illustrate the importance of examining intersections among race, gender, and sexual orientation for these women.

Many participants reported struggling to gain acceptance from family members and heterosexist incidents involving their families. Barbara, 42, reported by far the most devastating treatment at the hands of her family members: "My mom would let my baby brothers beat me up like a man because she wanted to prove a point that she was going to beat me up until I become a woman again because she didn't have no understanding of it." As a result of this abuse, Barbara left home at the age of 18 and struggled with chemical addiction for many years. However, despite her family's treatment of her, Barbara worked very hard to maintain a connection with them, noting with pride her mother's role in her recovery to be free from addiction.

Heterosexist incidents occurred in a variety of contexts. Jo, 36, reported experiencing five homophobic attacks in public places between the ages of 18 and 24. She noted a racial dimension to these attacks in that all occurred in the company of White women, and she was disappointed that on three of these occasions Black men

were involved. In the workplace, milder forms of heterosexist discrimination were reported, for example, having female coworkers express fear of sexual advances. This type of treatment seems to reflect mainstream cultural perceptions of lesbians as predatory, but can also be interpreted in light of the sexual stereotyping of Black women as sexually permissive and promiscuous.

Participants also discussed experiences of heterosexism and sexual prejudice within Black communities, particularly in religious contexts. Lora reported experiencing ostracism from her entire Christian community when she came out. Other participants reported hearing anti-gay religious statements (e.g., that homosexuals are going to hell) from members of the church community, family members, and even on prerecorded sermons played in their presence. (Loue discusses religion and spirituality among nonheterosexual-identified minority women in Chapter 9.)

Bisexuals noted experiencing sexual stigma as well, but often in mainstream LGB and Black LGB communities. Theresa, 32, reported experiencing a great deal of discrimination because of her bisexuality, including an incident where she was called a "freak" by a woman at a lesbian bar. She explained her struggle to have her identity respected:

> I really do hear a lot of negative comments from the Black lesbian community, which can be painful, but you know I feel that I need to make a stand in a sense, because this is who I am, you know. It's just like me telling a woman that "you're not a lesbian," but [they're] trying to tell me that I'm not a bisexual. I know what I like.

Experiences of Racism, Classism, and Sexism. Participants also reported a number of incidents of racism, classism, sexism, and their intersections. Racism and sexism in the workplace produced very stressful situations for some participants. Wanda, 52, was working for a boss whom she believed disrespected her because she was a Black woman: " He would not hand [work] to me, he would throw work at me and I refused to even acknowledge it because I'm a person. You don't have to do that. To me that was a very overt act of bigotry." Grace, 45, discussed the constant stress of working in an environment where she believed racial discrimination was common:

> Every morning I wake up, I'm on pins and needles, my stomach is in knots. You know, 'Am I going to get fired today? Am I going to step out of bounds? Is this going to happen?' And then one day I went to work and it happened.

She reported that the owner had her fired for "slipping into Black Ebonic language" when talking to a customer who was an old friend.

Class issues were evident in participants' romantic relationships and friendships. For example, Sherice reported feeling alienated when her middle-class colleagues preferred spending time in the affluent areas of the city and bristled at going into certain lower income areas. Barbara reported being belittled by a more class-privileged partner for having a fourth-grade reading level.

As a whole, the mainstream LGBT community was perceived as primarily White, and some participants believed that the community members were overly concerned with perceived White, middle-, and upper-class issues, such as attaining the rights to marry and serve in the military. These issues held less relevance for them than

other concerns, such as racial economic disparities and the impact of HIV/AIDS on women and children. Moreover, some participants felt exploited and ignored in their interactions with White lesbians and gay men, ultimately becoming disillusioned by these experiences. The sentiment expressed was that, whether intentional or not, women of color were not treated as full and equal members of mainstream sexual minority communities. Interestingly, a few participants noted that the marginalization of poor and working-class individuals extends to segments of the Black LGBT community. A focus on upward mobility, status, and prestige among some Black gay men and the hefty admission fees levied at some community functions were cited as evidence of this upper-class focus.

Racism, Gender, and Gender Presentation. The ways that race and gender interact in sexual minority women's experiences depend on a number of factors including the context of the situation (e.g., public versus private, with strangers versus acquaintances) and other personal characteristics, such as gender presentation. For example, Jo noted that because of her masculine presentation she is often mistaken for a man in public, and when this occurs she is temporarily viewed according to the stereotypes associated with Black men, such as " the thug." When perceived as a Black man, she has witnessed strangers grab their bags upon seeing her. In addition, in an incident occurring immediately before the interview, a security guard regarded her with suspicion until he realized she was a woman. These examples illustrate how racism, sexism, heterosexism, etc., are not merely additive so as to accumulate disadvantage, but rather they interact in complex and sometimes unexpected ways.

Discussion and Conclusions

Race, ethnicity, gender, sexual orientation, and class statuses intersect in the lives of sexual minority women, leading to the experience of multiple forms of stigma and discrimination. A growing body of research has begun to examine the impact of stress arising from stigmatization experiences on the psychological health of marginalized group members (Clark, Anderson, Clark, & Williams, 1999; Meyer, 2003). Ample evidence exists that sexual minority status in women is associated with challenges to emotional well-being (e.g., Case et al., 2004; Cochran & Mays, 2006; Diamant & Wold, 2003). In two large nationally representative surveys, lesbian and bisexual women showed elevated levels of anxiety and mood disorders in comparison to heterosexual women (Cochran & Mays, 2006; Gilman et al., 2001). In addition, homosexually active Black women have reported higher levels of depressive distress than population estimates for heterosexual Black women (Mays et al., 2003), at levels similar to those of HIV-positive Black men (Cochran & Mays, 1994).

According to the minority stress perspective, lesbian, gay, and bisexual people's elevated risk for psychological disorders stems from stressors specific to being gay, such as discrimination and fear of rejection (Bowleg, Huang, Brooks, Black, &

Burkholder, 2003; Brooks, 1981; Diplacido, 1998; Meyer, 2003). Research examining predictors of psychological distress shows that discrimination and other gay-related stressors are important contributors to negative mental health outcomes (D'Augelli et al., 2002; Diaz et al., 2001; Diaz, Bein, & Ayala, 2006; Huebner, Rebchook, & Kegeles, 2004; Otis & Skinner, 1996). However, because much of this research has been conducted on male-only samples, additional data are needed to document these mechanisms in women.

Because they are often subject to stressors associated with sexual stigma, racism, and related social barriers (e.g., poverty, immigration status), sexual minorities of color may be at increased risk for mental health disorders (Cochran & Mays, 1994; Diaz et al., 2001), suggesting that they could exhibit levels of psychiatric distress over and above those of White sexual minorities. Of the relatively few studies that have directly tested this proposition, though, convincing evidence has not yet been found. For example, a population-based study of Latino and Asian LGB adults yielded rates of psychiatric risk similar to or lower than those found among LGBs in general (Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007); in addition, in a racially and ethnically mixed sample of adolescents, White female sexual minorities showed the most compromised mental health relative to their heterosexual counterparts (Consolacion, Russell, & Sue, 2004).

Alternatively, some researchers and theorists have suggested that LGBs of color become adept at using coping strategies, perhaps developed in response to their experiences with racism, to buffer the effects of sexual stigma (Battle & Crum, 2007; Greene, 1994). Zea, Reisen, & Poppen (1999) found that among Latino lesbians and gay men, those with higher levels of active coping – involving actively planning and setting goals – showed lower levels of depression and higher levels of self-esteem. For Black lesbians, having a stronger lesbian identification best predicted the use of active coping strategies, suggesting a role for collective identity processes in encouraging successful coping efforts among sexual minority women of color (Bowleg, Craig, & Burkholder, 2004).

Evidence also points to the importance for sexual minorities of color of finding community support and integrating identities. Indeed, community involvement, such as volunteering in LGBT organizations, can lessen the relationship between experiencing sexual stigma and negative health outcomes (Ramirez-Valles, Fergus, Reisen, Poppen, & Zea, 2005). In addition, for African-American gay and bisexual men, the integration of racial and sexual identities was found to be important for psychosocial functioning (Crawford, Allison, Zamboni, & Soto, 2002). We are not aware of parallel research examining this relationship in sexual minority women of color. However, in a sample of Black women unselected for sexual orientation, an integrated Black woman identity was rated as the most important group identity; in addition, feeling that their African-American and woman identities interfered with each other was associated with depression and low self-esteem (Settles, 2006). This suggests that for sexual minority women of color, integration among racial, sexual, and gender identities may be vital for optimal well-being.

In this chapter, we have identified some issues and experiences germane to lesbian and bisexual women's experience of multiple stigmatized statuses. We

presented selected interview findings from Black lesbian and bisexual women to illustrate the often complex ways that racism, sexism, classism, and sexual stigma intersect in these women's lives. Unfortunately, we were not able to provide in-depth information about the experiences of women from every racial and ethnic group, and even within any particular ethnic or national group, much variety exists. Additional research is needed to document the extent and operation of intersecting forms of discrimination for members of specific racial and ethnic groups and to elucidate the methods sexual minority women of color use to manage stigma-related stress.

The information presented here should be useful in helping mental health practitioners think about the ways multiple stigmatized identities can impact their clients, but we caution against over-generalizing these findings and stereotyping individual group members. Our findings suggest that common difficulties presented in therapy, such as work and relationship problems, may be linked at least in part to lesbian and bisexual women of color's interface with multiple forms of oppression (Hall and Greene, 2002). Finding support to deal with multiple minority stress can be challenging because of the reality of often being the "only one" with the set of marginalized identities in a particular setting. However, sexual minority women of color use a wide range of strategies to deal with potential discrimination, from concealing their sexual orientation to educating others in their various communities (Bowleg et al., 2008). Therapists can explore with their clients the benefits and disadvantages of choosing (implicitly or explicitly) particular strategies, which may differ substantially from the implications of these strategies for White middle-class women. Clients may be unable or unwilling to distance themselves from communities and groups in which they perceive prejudice, because of the positive benefits these groups provide in coping with other oppressions and due to the practical realities of living in a society stratified by race and class. As the intersections of race, gender, sexual orientation, and other social statuses receive greater attention in psychology, therapists will be better prepared to assist their clients in confronting the challenges, complications, and opportunities that lie ahead.

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Chapter 4
Minority Status Among Sexual Minority Women

Jessie Daniels

Introduction

This chapter examines the ways that the minority status of African-American, Latina, or Asian-American women within sexual minority populations shapes the lived experience of women who identify as lesbian, bisexual, or transgender. Consider the following:

- In 2008 elections, voters elected Barbara "Bobbi" Lopez, an out Latina lesbian, to the San Francisco school board. In the same election, California voters cast statewide ballots eliminating the right to same-sex marriage and overwhelmingly voted for the first African American as president.
- Alice Wu left her successful career as a software engineer to become a filmmaker. Her first film, the award-winning *Saving Face*, was inspired by her own experiences coming out as a lesbian and the struggle to reconcile her identity both as a lesbian and as a Chinese American.
- African-American lesbian Charlene Cothran, a successful publisher of the magazine *VENUS*, geared toward African-American LGBTQ community, shocked many people when she announced in 2007 that she had "come out again." In explaining her conversion in a written statement in her magazine and online, she said: *"As a believer of the word of God, I fully accept and have always known that same-sex relationships are not what God intended for us."*
- Sanesha Stewart, 25, a transgender African-American woman from the Bronx, was murdered in February 2008. In August of that same year, Angie Zapata, a transgender Latina woman was murdered in San Francisco. In November, Duanna Johnson, an African-American transgendered woman in Memphis, Tennessee, was murdered. Experts estimate that one trans woman is killed in the United States about every three months.

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- When Sylvia Rivera, a transgendered Latina woman and Stonewall pioneer, passed away in 2002, her dying wish was that her community of faith, Metropolitan Community Church of New York (MCCNY), reach out to homeless LGBTQ youth. Today, MCCNY Charities maintains an overnight shelter, 365 days a year, for homeless queer youth in New York City. The shelter is called Sylvia's Place.

These vignettes suggest just some of the complexities of the lives of women and girls of color who also identify as sexual minorities. These opening stories also convey some of the central themes that connect lesbian, bisexual, and transgender women of African-American, Latina, and Asian-American descent. Whether working to get elected to public office, direct a film, or publish a magazine while reconciling disparate communities or struggling to avoid the streets, homelessness, and violence, there are some consistent themes. African-American, Latina, and Asian-American women within the United States who identify as lesbian, bisexual, or transgender share some key areas of lived experience. In the chapter that follows, I explore several of these key areas, including stigma and discrimination and the impact this has on health; the response of "mainstream," predominantly White LGBTQ organizations to racial and ethnic minority women; the development of social support systems and the pressure to choose between cultures, and the impact this has on young women; and the similarities and differences in political agendas of sexual minority women.

Stigma and Discrimination

Social stigma and discrimination clearly have an impact on sexual minority women who are African American, Latina, and Asian American. Lesbian, bisexual, and transgender women of color experience discrimination within multiple communities simultaneously. Within racial ethnic minority communities, sexual minority women face social stigma for being queer, whereas in the larger LGBTQ community, racial/ethnic minority women experience racial discrimination. This push and pull – being pushed out by homophobic stigma toward sexual minority status from within racial and ethnic communities, while being pulled toward LGBTQ communities, yet being pushed away from those communities by racial discrimination – creates a complex set of individual, social, and political dilemmas for women caught in this back and forth. Yet, multiple identities are not experienced as "either/or." African-American, Latina, and Asian-American lesbian, bisexual, and transgendered women experience identity holistically encompassing both race and sexual orientation, rather than either one or the other. However, the organization of communities along the axis of *either* racial minority status *or* sexual minority status results in a set of constrained choices that leave many with limited social support and few resources to assist them in negotiating the complex processes of identity development.

The process of identity development and adjustment for sexual minority women who are African American, Latina, and Asian American is made more difficult by

the fact these women find themselves at the bottom of multiple hierarchies. In a study exploring the issues of minority lesbians, Greene (1994, 2000) notes that being a female or an ethnic minority confers a higher status than being a lesbian. As a result of this hierarchal perception, minority lesbians face the struggle of choosing between their ethnic community and their sexual identity. This identity struggle further leads many to reject their sexuality in order to fit in and function within their predominantly heterosexual ethnic community.

Racism and discrimination are central to the American experience and continue to negatively affect people of color regardless of their sexuality (Feagin, 2006; Feagin & Sykes, 1993). A number of research studies report that gay African Americans and Latinos continue to live in a hostile environment that limits their ability to succeed socially and economically (Greene, 1994, 2000; Greene & Boyd-Franklin, 1996; Icard, 1996; Jackson & Brown, 1996; Monteiro & Fuqua, 1994; Wagner, Serafini, Rabkin, Remien, & Williams, 1994). Overall, this literature suggests that the process of identity development for gay men and lesbians of color is hindered by rejection from the gay community. Yet these studies, like much of the existing research at the intersection of race and sexual orientation, tend to not focus attention on sexual minority women, or on the experiences of Asian-American or Native American men or women (Aukerland & Cheung, 2000 is one notable exception with respect to Asian Americans; and Walters' work, 1997, on identity among Native American sexual minority men and women is another). Asian-American minorities in the United States also face racism, but until very recently this has received little attention either from the mainstream press or from the scholars (Chou & Feagin, 2008). There is scant literature on the experiences of Asian-American sexual minority women, but the literature that does exist on the impact of stigma and discrimination on sexual minority women suggests that these social forces take a toll on women's health. The example of Chinese American filmmaker Alice Wu included in the opening of this chapter highlights the accomplishments of one of the few prominent Asian-American sexual minority women. Throughout the remainder of the chapter, I will include references to Asian-American women where there is available research but, for the most part, research into the lives of sexual minority women has paid little attention to the lives of Asian-American women.

Impact of Stigma and Discrimination on Sexual Minority Women's Health

Research has begun to identify the impact of stigma and discrimination on sexual minority women's health and homophobic stigma and access to quality health care are at the top of the list (Roberts, 2001; Solarz, 1994, 1999). Fifteen years of research shows that lesbian women frequently do not disclose their sexual orientation to medical providers, fearing it could compromise the quality of care that they receive (Solarz, 1994, 1999; Stevens, 1992; Stevens & Hall, 2007). This fear is grounded in a real context of homophobia, with one survey of nursing educators reporting that

34% of respondents felt lesbianism is "disgusting" and 52% viewed it as "unnatural" (Randall, 1989). More broadly, the *Michigan Lesbian Health Survey*, which included a sample of more than 1500 women, found that 60% of the respondents felt unable to come out to their providers (Solarz, 1994, 1999). This research suggests that the health-care providers may be unable to address the specific needs of lesbian clients due to lack of knowledge and/or their own homophobic biases.

Access to care is a central issue of concern for lesbian, bisexual, and transgendered women. Lesbians report the use of primary health-care services at a significantly lower rate than women identifying as heterosexual (Solarz, 1994, 1999). The implications of these findings also extend to research, where lesbian and bisexual women are considered a hidden population. One of the most repeated criticisms of survey research within this population is poor sampling design and sampling bias (Solarz, 1994, 1999). For example, a recent study that reported comparatively high smoking rates (62%) among lesbian and bisexual women in the predominantly African-American and Latino South Bronx recruited women from a block outside of a women's nightclub (Sanchez, Meacher, & Beil, 2005). Smoking rates among women frequenting the nightclub may be higher than those among lesbian and bisexual women in the community as a whole. Random population-based samples are rare in lesbian health research, but some studies have successfully reduced bias through the use of snowball sampling originating in multiple and diverse research sites (Dolan & Davis, 2003; Matthews, Hughes, Johnson, Razzano, & Cassidy, 2002). Research in this area has also been criticized for inconsistent measures of sexual orientation (Roberts, 2001).

The health outcomes of sexual minority women are of concern and include mental health; sexually transmitted infections, including HIV/AIDS; substance use; and cancer (Solarz, 1994, 1999). Unlike the use of primary health-care services, some studies have shown more frequent use of mental health services among lesbian and bisexual women than among heterosexual women (Roberts, 2001; Solarz, 1999), and a recent *American Journal of Public Health* article reports comparatively higher levels of suicidal ideation and some risk factors for depressive distress within a community sample of lesbian and heterosexual women (Matthews, Hughes, Johnson, Razzano, & Cassidy, 2002). These findings are in keeping with earlier research on depression among lesbians (Rothblum, 1990). Mental health issues may overlap with findings concerning substance use and abuse between lesbian and bisexual women. While findings conflict, there is evidence of higher rates of alcohol and illegal drug consumption among lesbian women when compared with both heterosexual women and gay and bisexual men (Plumb, Rankow, & Young, 1998; Skinner, 1994).

An increasing number of studies focus specifically on lesbian and bisexual women's risk for HIV as an overlooked research area. Some qualitative work has suggested that women in lesbian and bisexual communities often do not consider themselves at risk for HIV (Dolan & Davis, 2003), despite self-reported high rates of known risk factors, such as injection drug use and sexual contact with men (Case, Downing, Fergusson, Lorevick, & Sanchez, 1990; Deneberg, 1991; Magura, O'Day, & Rosenblum, 1992). Moreover, a community-based survey of sexual risk

among women in Northern California found that those reporting sexual contact with both men and women had significantly higher rates of HIV risk behaviors, such as injection drug use and sex with gay or bisexual men, than a comparison group of exclusively heterosexual women (Scheer et al., 2002). However, it should be noted that the HIV prevalence level was less than 1% for both heterosexual and bisexual women in this survey (Scheer et al., 2002).

Women of color, particularly African-American and Latina women, are at higher risk for some negative health outcomes, also identified as key concerns for lesbian, bisexual, and transgendered women, including HIV/AIDS and cancer (Mays, Cochran, Yancey, Weber, & Fielding, 2002). Despite this, there is very little research on the intersection of race or ethnicity and sexual orientation with respect to its impact on the health of women. One key health issue for lesbian women of color is social support, and the literature on this topic reveals that African-American and Latina women who also identify as lesbian or bisexual often feel pressured to choose between seeking support within a Black or Latino community and a gay/lesbian community. In some cases, neither of these contexts adequately addresses their particular health or social support needs (Bowleg, Craig, & Burkholder, 2004; Ward, 2004). Many of these women also suffer multiple levels of discrimination within health organizations and agencies. Jane Ward provides an excellent illustration of this issue in her ethnographic study of gender issues within a Latino AIDS service organization in Los Angeles (Ward, 2004). Within this organization, the health and social service needs of Latina lesbians were routinely subordinated to those of gay and bisexual male clients, with some female employees reporting feeling pressured to stop advocating for female client needs or leave the organization (Ward, 2004). In summary, the health needs of lesbian, bisexual, and transgendered women of color continue to go unmet, due to the lack of both culturally competent services (Solarz, 1999) and multiple levels of social stigma within the health-care system and health-care research. (O'Shea discusses health service utilization in detail in Chapter 6 of this volume.)

Underfunded and inadequate health care is a critical issue for incarcerated women, including bisexual and lesbian women. HIV prevention and treatment is a particularly pressing concern among women in the criminal justice system, wherein HIV rates as high as 20% are routinely reported (AIDSAction, 2001). Despite the overlap between sexuality, HIV/AIDS, and other pressing health concerns among this population, there is a paucity of research looking at the specific health needs of incarcerated lesbian and bisexual women. The Institute of Medicine's *Lesbian Health Report* (Solarz, 1999) formally overlooked the needs of incarcerated sexual minority women by not including them in the index of the official report. However, research by Katherine Maeve has situated open discussion of sexual identity as a central health concern for adjudicated women, and she calls for further research in this area (Maeve, 1999).

Thus, while a body of scholarly literature on the specific health needs of lesbians continues to grow, the marginalization of this research within both women's health and gay/lesbian health literature remains an important public health and social justice concern. The 1999 Institute of Medicine report concludes its chapter on the

specific health concerns of lesbians by calling for further research on health issues of particular concern to lesbians, including cancer, addiction, and mental health (Solarz, 1994, 1999). This should be supplemented by a call for lesbian health research to be brought to the attention of a wide range of primary health-care providers, as well as for specific research focusing on the health concerns of lesbians of color and lesbian and bisexual women in the criminal justice system.

Response of LGBTQ Organizations to Minority Women

Many historians point to the Stonewall uprising in Greenwich Village, New York, in the summer of 1969 as the spark that helped ignite the gay rights movement in the United States (Duberman, 1994; Jay, 1994). There were other events in the United States that predate the events in Greenwich Village, which contributed to an emerging consciousness about the possibility of sexual minority status as an identity around which it was possible to mobilize. Nevertheless, the uprising at Stonewall had some unique features that make it relevant for a discussion of the minority status of sexual minority women. Stonewall was a response to police brutality against queer people – lesbians, gay men, and "drag queens" (before the neologism "transgendered") – of diverse racial and ethnic backgrounds (Duberman, Vicinus, & Chauncey, 1989). Two of the "drag queens" at Stonewall – both of whom would later identify as transgendered women – were people of color; Marcia P. Johnson was African American, and Sylvia Rivera was Puerto Rican (Rivera, 2002). Johnson and Rivera became galvanized by the events at Stonewall and were actively involved in the early days of the gay rights movement in New York City. Yet, despite the contributions of pioneers like Johnson and Rivera, the gay rights movement and the LGBTQ organizations that grew out of those early protests remain largely White-dominated (Chasin, 2001; Sender, 2001) and male-led (Ault, 1996; Cruikshank, 1992), and have done little to recognize and include the voices and perspectives of lesbian, bisexual, and transgendered women of color in the planning and decision-making processes (Loiacano, 1993). The agenda-setting by relatively privileged White gay men in LGBTQ organizations has meant that their issues and concerns are placed at the center of discussions, while concerns of lesbian, bisexual, and transgendered women of all backgrounds are pushed to the margins. Thus, the race, gender, and class hierarchies within mainstream LGBTQ organizations reflect and reproduce the hierarchies in the larger society.

The exclusion of people of color of all genders from mainstream LGBTQ organizations is thoroughly documented in a two-year ethnographic study by Jane Ward (2008) of the Center, a Los Angeles lesbian, gay, bisexual, and transgender organization. In her research, Ward finds that despite indicators of racial diversity at the Center, such as a national reputation for multiculturalism, a visible presence of people of color in leadership, and a staff of more than 50% people of color, the organization also maintained a local reputation among queer people of color as the White LGBT organization in Los Angeles. She argues that White normativity, that is, the often unconscious and invisible ideas and practices that make whiteness

appear natural and right, is sustained even in organizations, such as the Center that seem to be attentive to structural factors. Thus, the Center's public attempts to build and proclaim a racially diverse collective identity, along with its reliance on mainstream diversity frames available in the broader environment, became the very practices that employees of color identified as evidence of the White normative culture of the organization.

Making sense of the response of LGBTQ organizations to minority women also means understanding the predominant role that large urban centers, such as New York, Los Angeles, and San Francisco, play in shaping the contours of queer people's lives. People are drawn to cities for the wide variety of opportunities, cultural attractions, and amenities that they offer; indeed, more people now live in cities than in rural areas. For LGBTQ people, who may have been rejected by homophobic families or may be fleeing less tolerant regions of the country, cities hold a special appeal (Finkelstein & Netherland, 2005). As a result, specific neighborhoods, such as Greenwich Village in New York, the Castro in San Francisco, and West Hollywood in Los Angeles became identified as "gay ghettoes." Ironically enough, the emergence of these areas made residents more vulnerable to homophobic attacks, as the neighborhoods became more visible and easily identifiable destinations for attackers.

In response to such attacks, many neighborhoods set up so-called "safe streets patrols" in the mid- to late 1970s. In a compelling analysis of these patrols, Christina Hanhardt argues that attempts to curtail homophobic violence in the 1970s and 1980s were shaped by "culture of poverty" discourses that pathologized poor people and people of color (Hanhardt, 2008). Hanhardt demonstrates that safe streets patrols ultimately contributed to processes of urban gentrification as elite residents, particularly gay White men, transformed formerly marginal gay neighborhoods into wealthy enclaves and deployed oppressive quality-of-life policing strategies that disproportionately targeted people of color, including those who identified as queer (Hanhardt, 2008). Furthermore, much gay antiviolence work ignores violence against women as a hate crime and fails to interpret anti-gay violence as gender-motivated and therefore does nothing to challenge male domination (Ault, 1996). Thus, while urban centers, such as New York, San Francisco, and Los Angeles, hold appeal as "gay meccas" for relatively privileged White gay men, the establishment of these enclaves represents a much more complicated reality for sexual minority women and for people of color. Cities are also difficult places to navigate and survive for young people without many financial resources.

Homeless LGBTQ Youth

Each year, thousands of young LGBTQ people are drawn to live in cities, yet those without access to substantial economic resources to cover exorbitant housing costs or job skills that can quickly be exchanged for money to pay for housing, soon end up homeless and on the streets. Young girls and women are among the thousands of

lesbian, gay, bisexual, and transgender youth who end up on the streets of New York City each year, majority of them being invisible to others (Dunne, Prendergrast, & Telford, 2002; Grossman & D'Augelli, 2006; Kruks, 1991). An estimated 25–40% of New York City's 20,000 runaway and homeless youth are lesbian, gay, bisexual, and transgender (New York City Association of Homeless and Street-Involved Youth Organizations, 2005). In fact, the National Gay and Lesbian Task Force refers to the high levels of homelessness among LGBTQ youth as an "epidemic" (Ray, 2006). In a 2008 report, the Empire State Coalition of Youth and Family Services found that among the ranks of homeless youth in New York City, almost half of the respondents identified as African American, a third as Latina. More than a quarter reported time spent in foster care, jail, or prison, and half of those interviewed did not have a high school diploma or diploma equivalent (GED) (Empire State Coalition of Youth and Family Services, 2007).

Societal level homophobia has a differential and negative impact on LGBTQ youth (Baker, 2002; Harper & Schneider, 2003; Noell & Ochs, 2001). Many LGBTQ youth are forced into homelessness when their families reject them after being open about their sexual or gender identity. Some of these youth are physically ejected from their homes by their parents; others run away. For LGBTQ youth who have grown up in the foster care system, they often age out of the system and then become homeless. In addition to residential instability, LGBTQ youth often face intense harassment, bullying, and violence in schools, a leading contributor to increased dropout rates (Bontempo & D'Augelli, 2002). In turn, dropping out of school also increases the likelihood that adolescents will run away. Without a high school diploma or many job skills, finding and sustaining employment that pays enough to provide housing is especially challenging for LGBTQ youth.

In addition to homophobia, young people of color face racial discrimination in employment. Transgendered youth, across racial and ethnic categories, face employment discrimination when the gender identity they present in face-to-face interaction does not match the gender identity on their identification papers, such as birth certificate, state ID, or driver's license. Given the constraints of finding regular employment, a significant minority of LGBTQ youth turns to sex work in order to survive. This puts them at greater risk for a number of related health issues. A public health survey of six states reports that in addition to the public health risks young people face merely by being homeless, these risks are exacerbated for those who self-identify as lesbian, gay, or bisexual (van Leeuwen et al., 2006) and include increased risk for mental health issues, substance use, and sexually transmitted infections. Youth who are transgendered also face an increased likelihood of being targeted for violence (D'Augelli, Grossman, & Starks, 2006). LGBTQ youth engaged in survival sex are perhaps most vulnerable to violence and STIs (Haley, Roy, Leclerc, Boudreau, & Boivin, 2004; Weber, Boivin, Blais, Haley, & Roy, 2002).

The existing shelter systems are not welcoming places for sexual minority women and girls. While there are some services in place for homeless youth, LGBTQ youth are often excluded, harassed, or violated when attempting to access these services either by other non-LGBT homeless youth or by staff who lack cultural competency necessary to address the needs of LGBTQ youth (Berberet, 2006).

Transgendered women are especially vulnerable to violence in these settings and are frequently the targets of attacks. The presence of sexual minority women and young girls challenges the presumption of heterosexuality that is built into the structure of the shelters, and transgendered women call into question the strictly gender-segregated organization of the shelter system. Thus, while young sexual minority women of varied racial and ethnic backgrounds are drawn to cities for the same reasons as others are, the reality of housing costs and the lack of jobs for those with limited skills mean that many of these young women, two-thirds of whom are African American or Latina, end up homeless.

Developing Support Systems and the Pressure to Choose Between Cultures

Sexual minority women of color are resilient and develop their own support systems to help them deal with stigma, discrimination, and multiple levels of oppression. Many sexual minority women find ways to navigate the homophobia in their own neighborhoods and ethnic communities in order to draw on institutions, such as family, extended kin, folk healers, merchant groups, social clubs, and religious institutions for social support. (For a discussion of various additional issues relating to family, such as adoption, see Mendez' Chapter 5 in this volume.) However, the cultural norms and expectations of some ethnic groups make the involvement in these support systems more problematic than helpful for lesbian, bisexual, and transgendered women of that ethnic group, which is often the case for Latinas (Baez, 1996; Morales, 1989).

In Alice Wu's *Saving Face*, the main character in the film struggles with coming out as a lesbian while trying to reconcile her identity both as a lesbian and as a Chinese American. This is a central dilemma for sexual minority women of diverse racial/ethnic backgrounds. The organization of LGBTQ communities exclusively around sexual identity, and the organization of racial and ethnic communities solely around racial identity, makes many sexual minority women feel as if they have to choose between two cultures. This was surely part of what was in play when, as mentioned in the opening, African-American lesbian Charlene Cothran, publisher of the LGBTQ magazine *VENUS*, announced that she had "turned her life over to God" and "away from the lesbian lifestyle" and would, henceforth, be using the magazine to encourage other African-American LGBTQ folks to do the same. It is not insignificant that in Cothran's own telling of her conversion story, a local African-American minister plays a prominent role in her decision. The Black Church remains the linchpin of African-American communal life, and the power of its influence can be seen in music, fraternal organizations, neighborhood associations, and politics (Collins, 2005). Again, in her own words, Cothran recalls her conversation with Rev. Vanessa Livingston and says:

> I don't remember how we got on the subject of salvation but she could not have known how much I had been struggling with trying to reckon my spiritual upbringing with my lesbian lifestyle (Cothran, 2008).

The reckoning that Cothran struggles with, between her "spiritual upbringing" and her "lesbian lifestyle," speaks to the impossible position that many sexual minority women must negotiate. Cothran's struggle also reflects the fact that the Black Church has incorporated the homophobia of the dominant, White society. Part of the reason the Black Church has been resistant to challenge notions of homophobia is that it has long worried about protecting the community's image within a larger context of racial and gender oppression (Collins, 2005). Many African-American ministers preach that homosexuality is unnatural for Blacks and is actually a symptom of a "white disease," thereby constructing lesbian, bisexual, and transgendered African-American women as somehow disloyal to their racial community (Collins, 2005, p. 108). Thus, sexual minority women are faced with tremendous pressure to choose between cultures, pulled in one direction by family, religion, and "spiritual upbringing," and pulled in a different direction by sexual expression and individual identity. This dichotomous construction of a choice between spirituality and connectedness on one side, and sexual orientation and individual expression on the other, sets up sexual minority women for precisely the kinds of dramatic decisions that Cothran made in her attempt to achieve wholeness. Some sexual minority women do find ways to reconcile these two.

Toward the end of her life, Sylvia Rivera, transgendered Latina and Stonewall Veteran, joined Metropolitan Community Church of New York (MCCNY). More than a "welcoming congregation" (the term for congregations that accept lesbian and gay members), MCCNY offered Rivera a queer-positive perspective on spirituality and her own life as a Latina transgendered woman (Rivera, 2002). In her research about two Metropolitan Community Churches (MCC) in California, Melissa Wilcox documents the way that this religious institution facilitates forging an identity that is both LGBTQ and Christian (Wilcox, 2003). This message has had significant global appeal based on the evidence of membership in MCC churches worldwide; as of 2007, MCC was the largest queer organization in the world (Bumgarnder, 2007).

While the denomination of MCC in the United States tends to be White- and male-dominated, the congregation in New York that Rivera joined is racially and ethnically diverse and led by a lesbian pastor, Rev. Pat Bumgardner. Rivera and Bumgardner met at a protest march for LGBTQ rights in New York City, and Bumgardner invited Rivera to attend the church. Rivera did attend, soon became a member, and shortly afterward began working full time as the director of the church's food pantry. Rivera spoke to Bumgardner many times about the desperate plight of transgendered street youth, many of whom were African American and Latina, and urged her to take action. The last of these conversations happened as Rivera lay dying of lung cancer, and Bumgardner promised to make her wish a reality (Bumgarnder, 2007). MCCNY began its Homeless Youth Services in 2002 by opening Sylvia's Place, a six-bed emergency shelter for self-identified LGBTQ youth aged 16 to 23 years. The mission of Sylvia's Place is to provide safe, welcoming overnight shelter for LGBTQ youth in crisis. Sylvia's Place provides food, clothing, a place to sleep, and showers for youth who would otherwise be on the street. In 2006 alone, Sylvia's Place provided shelter to 206 young people, half of them sexual minority women (Michaels, 2007).

Similarities and Differences in Political Agendas

There are key differences between mainstream, predominantly White- and male-dominated gay political agendas, and those of sexual minority women who are also members of racial/ethnic minority groups. For African-American, Latina and Asian-American lesbian, bisexual, and transgender women, political issues of importance include HIV/AIDS, hate crimes and discrimination, police brutality and mass incarceration of people of color, and same-sex marriage. For issues, such as HIV/AIDS, hate crimes, discrimination, and same-sex marriage, there is some overlap with the mainstream gay rights agenda, yet there are significant differences in emphasis and approach to these issues.

HIV/AIDS

Today, HIV/AIDS threatens the lives of African-American and Latina women (Bowleg, Belgrave, & Reisen, 2000; Collins, 2005). The epidemic has a disproportionate impact on African-American communities. In 2000, of the 45,156 AIDS cases reported to the Centers for Disease Control (CDC), African Americans accounted for 47% of the total even though they made up only 12% of the total US population. For African-American women with the virus, 42% attributed the cause to intravenous drug use (IVDU), 38% to unprotected heterosexual contact, and 18% reported no particular risk behavior (Battle, Cohen, Warren, Fergerson, & Audam, 2000).

Sexual minority women, particularly transgendered women, are especially vulnerable to HIV/AIDS (Bockting, Robinson, & Rosser, 1998; Haley et al., 2004; Lombardi, 2001; Mallon, 1999; Weber et al., 2002). However, racial and ethnic minority women do not often represent "the face" of HIV/AIDS, as there remains a strong "AIDS-gay male" connection in public framing and discourse about the epidemic. This is tied to the emergence of the HIV/AIDS epidemic in the United States in the 1980s and 1990s, which was framed in terms of urban gay men's experience and activism (Patton, 1996). This understanding of the epidemic, in turn, provided the impetus to include those infected with the virus in clinical trials and experimental treatments; yet, this very activism of "inclusion" relied on notions of difference (Epstein, 2007). These epidemiological categories of risk and difference, White gay men, Haitian immigrants, and IV drug users, excluded sexual minority women from public health discussions about the epidemic. Such systems of classification were predicated on already existing notions within medicine that conceive of the woman patient as White, heterosexual, middle class, able-bodied, young, and HIV negative (Wilkerson, 1998). When African-American and Latina women are the focus of HIV/AIDS interventions, they are often framed as "vulnerable women" who acquire HIV through heterosexual contact. Dworkin (2005) argues that the underlying emphasis in public health on the popular frame of "vulnerable women" who acquire the virus through heterosexual activity simultaneously renders

sexual minority women "unfathomable," that is, invisible and unknowable, within current frames. Dworkin also suggests that public health must consider more constructive ways of addressing bisexual and lesbian transmission risk (Dworkin, 2005).

Beyond the issue of infection and risk-of-infection, sexual minority women in African-American and Latino communities are deeply affected by the HIV/AIDS epidemic in complicated ways. In a nationwide survey of African Americans attending "Black Pride" events across the United States, Black lesbians, unlike their male and transgender counterparts, did not rank HIV/AIDS in the top three issues affecting all Black people (Battle et al., 2000). Just over half (54%) of the women surveyed did, however, rank HIV/AIDS among their top three political issues affecting the gay community. While differences in perceived risk of transmission may be influencing these results, the impact of AIDS on Black communities can be felt in ways beyond individual risk. Black women in general, including bisexual women, are increasingly at risk for transmission of HIV. The need to care for family and friends – often the responsibility of women in most communities – and the economic impact that comes with the loss of income and the additional costs of health care and drugs are also the concerns of Black women. Any analysis of these findings should take in account the complex structuring of Black communities and their struggles with HIV and AIDS (Battle et al., 2000).

Hate Crimes and Discrimination

The murders of Sanesha Stewart, Angie Zapata, and Duanna Johnson, all transgendered minority women mentioned in the opening of this chapter, illustrate the importance of hate crimes to understanding the experience of sexual minority women. Experts estimate that one transwoman is killed in the United States about every three months (Gender Public Advocacy Coalition, 2007). Sexual minority women who are also racial/ethnic minorities face a vulnerability to hate crimes as both queer and African American, Latina, or Asian American. According to an FBI report in 2007, overall hate crime incidents decreased while there was a surge in crimes targeting gays and lesbians (the only sexual minority categories for which the agency collects data). The FBI reported more than 7600 hate crime incidents in 2007, down about 1% from last year. The decline was driven by decreases in the two largest categories of hate crimes – crimes against race and religion – but attacks based on sexual orientation, the third-largest category, increased about 6%, the report found. Racial bias remained the most common motive, accounting for more than half of all reported hate crimes. According to the report, Blacks, Jews, and gays were the most frequent victims of hate crimes.

Sexual minority women may also be the targets of violence because they are women, yet these sorts of attacks are not included in hate crime statistics (Ault, 1996). While the federal government collects data on hate crimes against lesbians and gays (but not bisexuals or transgenders), there is currently no federal hate crimes legislation that includes sexual orientation or gender expression that would make

such attacks carry a harsher sentence. A number of mainstream LGBTQ organizations, such as the Gay and Lesbian Alliance Against Defamation (GLAAD) and the National Gay and Lesbian task Force (NGLTF), have made hate crimes a political priority, but none of these mainstream organizations note the disproportionate toll this violence takes on women of color nor have they formed alliances with minority organizations to battle this violence.

Sexual minority women of color, particularly transgendered women, are concerned about the political issue of employment discrimination (Battle et al., 2000). There is currently no federal nondiscrimination legislation in the United States which includes sexual orientation or gender expression that would make firing someone because of their sexual minority status illegal. Although there are some municipal protections, such as nondiscrimination laws in New York, Los Angeles, San Francisco, and a handful of other cities, the lack of federal legislation makes these local laws less powerful and more difficult to enforce. In 2007, the US Congress debated legislation that would address this gap in equal protection in the form of the Employment Non-Discrimination Act (ENDA). The legislation would have offered protection from discrimination for gays, lesbians, bisexuals, and transgendered people. Yet, the inclusion of transgenders proved controversial for many in the mainstream gay rights movement. An article by Dale Carpenter (n.d.) for the San Francisco Bay Reporter entitled "ENDA Now. Transgenders Later," is typical of gay opposition to transgender rights. In the article, Carpenter makes the case that the inclusion of transgenders in the nondiscrimination legislation is too controversial and risks endangering passage of legislation that would protect gay rights. The ENDA legislation failed to pass. Whether or not the legislation would have passed without the inclusion of protection for transgendered men and women remains a point of contention in the mainstream gay rights movement.

Same-Sex Marriage

Same-sex marriage and domestic partnership is an important issue for racial ethnic minority lesbian, bisexual, and transgender women, but it is not the most important issue (Battle et al., 2000). Yet, in recent years, the same-sex marriage has come to dominate the mainstream gay rights agenda. This is a particularly fraught issue for sexual minority women who are also members of racial/ethnic minority communities, as suggested by the conflicting trends in the November 2008 elections. As mentioned in the opening, "Bobbi" Lopez, an out Latina lesbian, was elected to the San Francisco school board, while in the same election California voters cast statewide ballots eliminating the right to same-sex marriage (known as Proposition 8) and overwhelmingly voted for the first African American as president. The complicated politics of the battle over same-sex marriage, a key feature of the mainstream gay rights movement and of importance to sexual minority women of diverse racial and ethnic backgrounds, contains numerous political fissures along lines of race, class, gender, and religion.

When Proposition 8, eliminating already legal same-sex marriage, in California and a number of other anti-gay measures around the nation were voted into law by a significant majority of voters, many members of the mainstream gay rights community voiced legitimate anger at this defeat. Simultaneously, some of those angry gay rights protesters engaged in racist name-calling in street protests, in part because many blamed African-American voters for the passage of laws prohibiting same-sex marriage. And, the polling numbers did demonstrate that African-American, Latino, and Asian-American voters supported the elimination of same-sex marriage, highlighting once again the bind for sexual minority women from those communities.

Alongside the racist name-calling by some gay rights advocates was much more measured and putatively reasonable race-baiting commentary by prominent White gay writers, like Dan Savage and Andrew Sullivan. Relatively privileged White gay male writers like Savage and Sullivan wrote blog entries and appeared on national television talk shows arguing that it was the homophobia of racial ethnic minority communities, specifically African-American voters, who should be held accountable for the elimination of same-sex marriage rights. Many in the gay rights movement reiterated similar arguments in actively scapegoating Black people for this defeat. What Savage, Sullivan, and other relatively privileged White gay men failed to take into account is that supposedly single-issue propositions, such as Proposition 8, are embedded in larger systems of inequality that have to be at least partially addressed with voters. The defeat of same-sex marriage ballot measures at the same time that the first African-American president succeeded suggests that same-sex marriage advocates failed to forge alliances across differences (Bystydzienski & Schacht, 2001).

While the overt White racism of gay rights protestors hurling racist epithets at same-sex marriage rallies after the election may not have been a factor in the repeal of same-sex marriage, others point to the lack of inclusion of people of color in the campaign. According to reporter and blogger for BET News, Rod McCollum, there was not one African-American lesbian or gay couple in any of the "No on 8" political advertisements (McCollum, 2008). At the same time that White gay rights leaders failed to include people of color in their political campaign advertising, there was a way in which they simultaneously assumed an alliance with African Americans while disparaging the church (more about which, in a moment). The scapegoating of Black people for the failure of Proposition 8 assumes that Black people are more homophobic than White people; such claims are flawed to the extent that they erase the lives of people of color and sexual minority women. In a statement by Dean Spade and Craig Willse entitled, "I Still Think Marriage is the Wrong Goal," the authors write about the rhetorical strategy to blame Black people for the passage of Proposition 8 (eliminating same-sex marriage):

> Beneath this claim is an uninterrogated idea that people of color are 'more homophobic' than white people. Such an idea equates gayness with whiteness and erases the lives of LGBT people of color. It also erases and marginalizes the enduring radical work of LGBT people of color organizing that has prioritized the most vulnerable members of our communities. Current conversations about Prop 8 hide how the same-sex marriage battle has been part of a conservative gay politics that de-prioritizes people of color, poor people, trans

> people, women, immigrants, prisoners and people with disabilities. Why isn't Prop 8's passage framed as evidence of the mainstream gay agenda's failure to ally with people of color on issues that are central to racial and economic justice in the US? (Spade & Willse, 2008).

The authors' reframing of the passage of Proposition 8 (and the elimination of same-sex marriage) as a failure of the mainstream gay political organizations to form coalitions across difference speaks volumes about the similarities and differences on this issue between predominantly White gay men and sexual minority women of color. The mainstream gay political movement has largely not done the hard work of coalition building with people of color, whether straight or lesbian, gay, bisexual, or transgender. The failure to connect the fight for same-sex marriage with broader social justice goals that sexual minority women care about is indicative of the disconnect between this supposedly shared political issue and the differences created by a predominantly White and gay-male movement.

When leaders in the struggle for same-sex marriage frame this issue exclusively in terms of "rights and benefits," they unconsciously adopt a class-based rhetoric. This class-based rhetoric may resonate with sexual minority women for whom the "right to inherit" and "job benefits" are salient political issues, yet such language may further exclude sexual minority women who do not enjoy the same class privileges. For example, prominent television talk show host and White lesbian, Suze Orman, says that she would marry her long-time partner, K.T., if she were able to because:

> Yes. Absolutely. Both of us have millions of dollars in our name. It's killing me that upon my death, K.T. is going to lose 50 percent of everything I have to estate taxes. Or vice versa (Bright, 2008).

While Orman's rhetoric of inheritance and "estate taxes" may galvanize sexual minority women who enjoy the same class privilege, it is not as effective with poor and working-class sexual minority women. Even when proponents use a working-class lesbian to make the case for same-sex marriage, the particularities of that example may further alienate women of color. For example, proponents of same-sex marriage incorporated the story of a terminally ill lesbian police officer in Freehold, New Jersey, who was not able to give her partner the death benefits that she would have received if her partner had been a man. Yet, given the context of racial profiling and police brutality, particularly several prominent cases involving New Jersey State Police, the image of a White police officer – even a lesbian police officer – may not be the most effective strategy for building coalitions across lines of class and race with sexual minority women.

The recent political campaign for same-sex marriage may alienate sexual minority women of color to the extent that they reinscribe notions of gender, race, and "normal" families. The language of "marriage," rather than "domestic partnership," is a powerful narrative both in dominant culture and within racial and ethnic communities. For many sexual minority women, particularly lesbians who came to feminist consciousness in a certain era, marriage is and remains a repressive patriarchal institution based on the transfer of women-as-property. Still, marriage is the primary way that our society recognizes people as adults, citizens, and human beings. So, by

denying an entire group of people the right to marry, it really is denying a basic, fundamental human right.

But the movement for same-sex marriage, and indeed much of the scholarship on this issue, is framed in terms of assimilation and acceptance as "normal families" rather than in terms of human rights. The "normal family" is a central feature of what one scholar refers to as "the white racial frame," in which the world is interpreted through a white lens (Feagin, 2006). The normal family seen through the white racial frame is captured in the "virtuous white Ozzie and Harriet family," a reference to a 1950s sitcom that featured a nuclear, White family. What White gay same-sex marriage advocates seem to encourage looks and sounds a lot like assimilation into that heteronormative model of the family, that many sexual minority women may not be interested in reproducing. A movement for same-sex marriage that emphasized social justice and human rights, which celebrates a range of expressions of gender and sexuality rather than conformity to a particularly narrow conceptualization of what constitutes a family might be more appealing to sexual minority women who are African American, Latina, and Asian American.

The battle over same-sex marriage is embedded in complicated politics around religion and race and may alienate some African-American and Latina sexual minority women. The predominantly White Mormon Church and others on the religious right funded the political campaign to take away marriage rights in California, following a long history of vicious religion-sponsored homophobia toward LGBTQ people. Understandably, many LGBTQ people have no patience with religious arguments intended to undermine our rights. Yet, for many people, especially African-American sexual minority women, the Black Church is the central social institution (Collins, 2005). And, most churches remain among the most racially segregated social institutions in the United States (Hadaway, Hackett, & Miller, 1984).

Given the fact that marriage is a religious rite (as well as a human right) that is being defended by religious people in racially segregated congregations means that those interested in marriage equality need a ground game that engages, rather than alienates, church folk and does so with a real awareness of racial issues. Following the passage of Proposition 8, "No on 8" graffiti appeared on several churches. Thus, the rhetoric of mainstream gay marriage supporters that polarizes "black churches" and all religious folks as diametrically opposed to "gay supporters of No on 8" keeps both sides locked in a symbiotic relationship in which each side significantly affects the evolution of its counterpart (Fetner, 2008). Such dichotomous, either/or, views of same-sex marriage obfuscate the fact that religious LGBTQ people, like Sylvia Rivera and the people at Metropolitan Community Churches, who have been pioneers in the movement, framing the issue in the context of the global fight for racial and social justice.

For sexual minority women who are African American, Latina, or Asian American, the shared political issue of same-sex marriage is complicated by the politics of race, class, gender, and religion. Thus, the White-and-gay-male-framing of the issue, and the failure to build coalitions across difference, becomes another occasion for sexual minority women to feel the pressure to choose between cultures.

Discussion

The minority status of African- American, Latina, or Asian-American women within sexual minority populations shapes the lived experience women who identify as lesbian, bisexual, or transgender in complex ways. Sexual minority women of color experience homophobic stigma from their racial and ethnic communities, while they simultaneously experience racist discrimination from the predominantly White LGBTQ community. The stigma and discrimination that sexual minorities face has significant consequences for the health of racial and ethnic women who are at increasing risk for HIV/AIDS, yet remain largely invisible and unfathomable as affected by the epidemic.

In spite of stigma and discrimination, sexual minority women are resilient and develop support systems that work for them, either in racially or ethnically based neighborhoods and religious and social institutions, or within the LGBTQ community. Asian- American lesbians such as filmmaker Alice Wu illustrate a central struggle for many sexual minority women to reconcile their identity both as a sexual minority and as a racial/ethnic minority. For African-American sexual minority women, the centrality of the Black Church profoundly alters that struggle to achieve an integrated sense of self, as the conversion experience publisher Charlene Cothran suggests. The recent election of Latina lesbian Bobbi Lopez to the San Francisco school board suggests that some sexual minority women have found ways to reconcile their racial/ethnic status with their sexual identity. Despite the profound resilience of sexual minority women, there are serious political divisions between African-American, Latina, and Asian-American sexual minority women and the mainstream, predominantly White gay rights movement.

In the same election in which Bobbi Lopez was elected to citywide office in San Francisco, a majority of voters in her state also voted to take away her right to marry her same-sex partner. This disjuncture illustrates some of the divisions between women such as Lopez and the mainstream gay rights movement around the issue of same-sex marriage. The battle over same-sex marriage is complicated for sexual minority women by the politics of race, class, gender, and religion. While many sexual minority women report that same-sex marriage and domestic partnership are important issues, the framing of same-sex marriage by the predominantly White, gay-male mainstream movement has distanced the fight from potential allies in African-American, Latino, and Asian-American communities. This division is particularly stark in the racist attacks by some same-sex marriage proponents, thus reinforcing the dilemma of sexual minority women who feel they must choose between standing in solidarity with their racial and ethnic communities against such attacks, or stand against the homophobia within those same communities that would deny them the right to marry. The false dichotomies of choosing either one's racial identity or one's sexual identity belie the fact that sexual minority women experience their identities holistically. The politics of same-sex marriage is further complicated by the politics of class-based appeals to "rights and benefits" and heteronormative visions of "normal families" rather than to broader social justice goals that may be more salient for sexual minority women's lives.

Further illustrations of the disjuncture between the mainstream gay rights movement and the concerns of sexual minority women from diverse backgrounds are the epidemic of homelessness of LGBTQ youth and the prevalence of hate crimes, particularly African-American and Latina transgendered women, such as Sanesha Steward, Angie Zapata, and Duanna Johnson. A large portion, possibly as high as two-thirds, of homeless LGBTQ youth in the United States are African-American and Latino young people who have either been thrown out of homophobic families or aged out of foster care systems where they were warehoused by the state. The lack of education, employment, or viable job skills of many homeless LGBTQ youth means that they are more likely to end up engaging in survival sex work and consequently are more vulnerable to arrest, incarceration, violence, infection with HIV/AIDS or other STIs, and early death. The attacks on African-American and Latina transgendered women highlight the life-threatening issues that some sexual minority women face at the bottom of multiple hierarchies of oppression. However, the concerns of these sexual minority women rarely make it to the top of the mainstream gay rights agenda. And, when "hate crimes" are a subject of concern for gay rights organizations, the definition of these crimes excludes race and gender, thus obscuring the fact that minority transgendered women are particularly vulnerable to attack.

There is, perhaps, some hope for wholeness and for reconciling these disparate political agendas in the legacy of Sylvia Rivera. Rivera, a transgendered Latina woman and Stonewall pioneer, fought against homophobia and racism and for the rights of homeless LGBTQ youth in New York City. In the last years of her life, she chose to situate that struggle within her community of faith, MCCNY. Today, MCCNY Charities continues that work in the form of a year-round overnight shelter for the homeless queer youth in New York City, named in her honor. The fact that Rivera found solace, comfort, and purpose at MCCNY may not be the path for every sexual minority woman who is African American, Latina, or Asian American. It may not even be the path for most transgendered Latinas, but the fact that Rivera could find a way to integrate multiple identities within a queer-positive religious institution committed to fighting for social justice suggests a path forward out of the pressure that shapes the lives of many sexual minority women who feel they must choose between cultures.

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Portrait 2
An Interview with "Daddy"

Natoya Cody

Daddy is a 24-year old African American woman who self-identifies as a lesbian. This is an excerpt from an interview with her in which she discusses her childhood, how she "came out" to her family, and her hopes for her future and that of her community.

I moved to Cleveland in 1999. When I moved here, my mom, she just set me down in the room and she told me that I was a lesbian and that it was okay. When it come down to me tryin' to tell my father, it really took me like two years. I didn't really tell my father until I was like twenty, twenty-one. He's stayin' in Columbus so it really didn't matter to me 'cause he really didn't take care of me my whole life but I felt like, it was cool for me to let him know the lifestyle that I live. He accept it now, but like his wife, I don't think she accept it. I don't go down there and visit them 'cause they don't accept me. They are not my mother, so I don't feel comfortable around them. And everybody else in my family? It really didn't matter to me 'cause the number one person that matters, she accepts me, so everybody else, they really didn't, it didn't affect me in any type of way.

My mother said she could just tell. She told me that she messed with women. I was shocked that she said that. She said that she could just tell from the visit, me and her, when I would visit her in jail. When she was in jail, I come down there and visit her and so she said she could just tell so. Like I used to play a game on the phone where I used to act like a boy and had a lot of girlfriends who did not know my gender [identification]. I used to tell them I was a boy.. I was like probably like thirteen . . . Probably twelve or thirteen . . . Young real young.

My mom was in jail. . . . My brother was getting abused. I was getting abused. People telling me that you ain't going to be nothing, you going to be just like your mom, pregnant at thirteen in jail. You know, just the negative stuff from the people [godparents] that took care of me. People always telling you negative stuff about you, never telling the good stuff that you do. You know, so that really sticks with you, you know what I'm saying, and it's like, man, the stuff that I went through when I was younger. I mean it made me stronger, but I don't know. My mom, she was cool but I still felt like she owed me somethin' cause she took like seven years from me and my brother. We somewhat felt as though we suffered in her absence. You got to want it [a better life] for yourself because if you don't want it for yourself, ain't nobody else going to give it to you. Man, they going to give you a hand but if

you keep shutting them down, they going to give up on you. I just went through a lot when I was younger.

So that's probably why I have low self-esteem. My friends say to this day that I still somewhat got low self-esteem but I don't know why. 'Cause you have to have people who tell you you're doing the right thing, they know that the stuff that you're doing is positive, you got that, that, backbone or that, that support that you need. Everybody needs support.

My brother went through a lot. I went through a lot. My brother, he's sufferin' still to this day though. I've been dealt with what I went through and got over it, but it still come across my mind. But the stuff that the people did to us that took care of me and my brother, I tell him all the time that didn't do nothing but make me stronger because they'll look at me, yeah, I'm a lesbian but I got a high school diploma, I got a nice job, and I help my mom. You know, I'm not running around the streets catching it, all these diseases, passing it around to other people. I'm out here educating other young people like me.

So my godmother, she had so many other kids. It's like seven of us in one house. It was just like they didn't really care about us, they were acting as if they was just in it for the money. And even with them having the money that they was getting, they still didn't take care of us. We went around looking like bums. So my first time ever having a pair of Jordans [sneakers], I mean it don't matter, but Jordans, I bought 'em myself.

You know, so I mean the stuff that people go through in their childhood, it sticks with them. For real. Physical abuse, mental, all that. You know, a person telling you that you dumb you know? That hurts, man. 'Specially when I'm supposed to come to you and talk to you about stuff. So I couldn't go to them and tell them that I was twelve having sex with men because I'm not getting the love that I want at the house so I'm going out in the streets having sex at a young age. Might be at risk for all types of stuff.

So I want a new life. And my brother though, he's so messed-up in his head now. He didn't even go to our grandmother's funeral, that's how bad it is. You know what I'm saying, to face the people 'cause we knew that they were going to be at our grandmother's funeral. He didn't even want to go; that kind of messed my head up, too, that my brother still can't get over the fact that we went through what we went through. And like, I say he's probably not as strong as me. He's about to be twenty. He used to steal and . . . we used to get whooped with switches. Um, stick and cords. We used to have to stay in one room for like the whole mark period [school term]. So I understand you all want us to do right in school, but you all not giving us the tools to do right or make the grade so how do you all expect us to do right and at a young age, being young, we can't voice that.

But my mom, when my mom came home she let us know that you can say. It's not what you say, it's how you say it. You can say whatever you want to say to me. So I feel that I can go to my mom and talk to my mom about anything in the world. Even when I'm messin' up, I know I'm going to hear it, but I'd rather hear it from her than her finding out and then hearing it. It's going to be ten times worse, so me and my mom's relationship gotten better.

So they say people come in your life for various reasons. I feel like when [my former supervisors] has stepped into my life, they really played a major part in my life today. [My supervisors] worked with me on how to be professional and got me to where I'm at now.

'Cause I was so ashamed of not knowing and thinking I'm the only person out here that's like this that. Back then I wasn't really focused on getting, you handing me the hand, like actually I was so ashamed of not knowing. I was at an age where I was not a skilled worker. I was with people that support you, people really letting you know that you can do whatever, regardless, I'm going to be here for you. And like I say, I feel like it, there was no shame to be or whatever.

I want to further my education. If I have one wish my wish is just for everybody to take it, the education, the free education that people is given you. Right now, if they just taking it and do something with it instead of just, oh I don't want to go to school because they make fun of me. They made fun of Jesus Christ but you know I just want my community to really get focused and really be successful 'cause gay people, black people, white people, anybody can be successful if you really want it, if you really want it and you really put your mind to it.

Every night even before I eat, I mean I believe in the lord. I listen to gospel music. I don't go to church though and I don't read the bible. I don't question Him [God]. I don't question Him. I don't ask Him why He did this 'cause He did it for a reason. I mean, I believe in Him, I believe everything that He does is for a purpose so I don't question nothin' that the Man do upstairs, nothin'.

Chapter 5
Lesbian Families

Nancy Mendez

Background: History of Families in the United States

Prior to the early 1800s, love was not considered to be a critical aspect of marriage in the United States. In the American colonies, marriage among White European immigrants was regarded as a social obligation and as an economic necessity (Malone & Cleary, 2002). By the 1920s, the United States experienced a movement toward marriage formed on the basis of love as opposed to an exchange in property. Concurrent with this shift toward marriages premised on love, the United States evolved from a primarily agricultural economy to an industrial economy, with the movement of population from farms and rural communities to large cities in search of industrial jobs. In 1890, only 28% of the population lived in cities, but by 1930 it was 56%. In fact, by 1920, for the first time in US history, more people lived in cities than farms. The urbanization of American society led to the disappearance of the extended family. By 1947 a "nuclear family" became the norm (Hunter, 1991; Lehr, 1999). Today many American "families" consist of parents (a married man and a woman) and children, but for much of our history, family often included grandparents, uncles, aunts, and cousins.

Currently in the United States, nuclear families appear to constitute a minority of households; there is an increasing prevalence of other family arrangements, such as blended families, binuclear families (separated spouses marrying new spouses with children), and single-parent families. Today, nuclear families with the original biological parents constitute roughly 24.1% of households, compared to 40.3% in 1970. Approximately 75% of all children in the United States will spend at least some time in a single-parent household (Bogenschneider, 2000; Hartman, 1990).

The decline of the traditional nuclear family is due in part to the rising divorce rate, which had been increasing throughout the 20th century until its peak in the late 1970s. In the most recent data, there were about 20 divorces for every 1000 women over the age of 15. This number is slightly down from about 23 divorces per

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1000 women in 1978, but it is still significantly greater than the rate of divorce during the 1950s. At that time, the rate of divorce was about 5 per 1000 women (Calhoun, 2002). This increased divorce rate has been observed in every industrialized country in the world. There are three significant factors affecting the rising divorce rate in the United States and elsewhere: (1) men and women are less in need of each other for economic survival, (2) gains made in birth control allow men and women to separate sexual activity from having children, and (3) more young people are cohabiting rather than getting married (Wilson, 2007). Many conservative advocates argue that the rise of the nontraditional families, including lesbian and gay families, have also contributed to the decline in the traditional nuclear family.

How Americans Define Family

A recent study looked at how society determines what constitutes a family. Respondents were asked about different kinds of living arrangements and whether they constituted a family unit (Bogenschneider, 2000). While people were in complete agreement about the traditional family unit consisting of a husband, wife, and children, opinions about other living arrangements were affected by the presence of children in these relationships. Eighty-one percent of respondents nationwide said they believed that an unmarried man and woman with children constituted a family. This number dropped to 54% when people were asked about two lesbians living together as a couple with children and to 52% when two gay men were a couple with at least one child. However, when children were not a factor, approval for less traditional living arrangements dropped considerably. Acceptance of an unmarried man and woman as a family unit fell to 31%; two gay men without children, to 27%; and two lesbians without children, to 28%. Interestingly, 93% of respondents said they viewed a traditional married couple as a family when there were no children involved (Bogenschneider, 2000). Therefore, marriage and children appear to be crucial components in the societal definition of family.

Current laws impede lesbians and gays in their efforts to marry and to parent children. Prohibitions on same-sex marriage and a widespread lack of nondiscrimination protections leave LGBT families particularly vulnerable both economically and socially. In several studies of lesbians, the absence of legal recognition has been found to be a major source of concern and anger. Lesbians are aware of the lack of social and political recognition of their relationships and how that also exposes them to further discrimination (Bogenschneider, 2000).

Despite the lack of protections for gay and lesbian families, the United States has experienced a substantial increase in the number of visible lesbian and gay households. The United States 2000 census counted 601,209 same-sex unmarried partner households in the United States, which represents a 314% increase from 1990, when the census counted only 145,130 same-sex unmarried partner households. Gay and lesbian families now live in 99.3% of the 22 counties that reported data, compared to 1990, when gay and lesbian families reported living in 52% of all reporting counties (United States Census Bureau, 2000). The Human Rights Campaign estimates that

the 2000 census may have undercounted the number of gay and lesbian families by as much as 62%; some of these families may have chosen not to report themselves as such. A recent study examining the 1990 census estimated that the census may have underreported the number of same-sex couples by as much as two-thirds (Abu-Laban & Abu-Laban, 1994).

Today, over 150 local governments and thousands of companies, nonprofit organizations, unions, colleges, and universities recognize same-sex partner relationships through the provision of civil unions and/or domestic partnership benefits (Allen, 2000). However, this effort did not receive widespread national attention until the 1990s, following a series of court rulings, legislative votes, and political actions that both encouraged supporters and galvanized opponents.

Lesbian/Gay Marriage

When most people refer to committed love, life-long partnership, and marriage they think of the union between a man and a woman. It falls within the "dream" that many have embraced as children: finding a soul mate, buying a house, and raising a family. However, the debate is growing as to why this dream is reserved only for heterosexual couples. Many lesbian women and gay men also fall in love and also desire to enter into lifelong unions. These same-sex couples live together and sometimes raise children. Many critics of gay marriage believe that if government were to sanction marriage between two people of the same sex, it would threaten the traditional institution of marriage between a man and a woman. However, some advocates of gay marriage believe that it would strengthen, rather than weaken, the institution (Allen, 1997; Balsam, Beauchain, Rothblum, & Solomon; Brumbaugh, Sanchez, Nock, & Wright, 2008; Stacey & Davenport, 2002).

Governments recognize and even reward heterosexual marriages with numerous benefits that range from tax breaks to certain legal protections. Even though same-sex couples live in similar arrangements, these benefits are not extended to them and their unions are not recognized by most laws. Recognition and equality are at the forefront of the same-sex marriage movement, which is gaining momentum (Stiers, 2000). The message is clear that love and commitment in same-sex couples is the same as within heterosexual couples and therefore should reap the same benefits.

Same-sex marriage is currently legal in two states, California and Massachusetts; additionally, New York and New Jersey will recognize gay marriages that are legally entered into elsewhere. Connecticut, Vermont, New Jersey, and New Hampshire have created legal unions that, while not called marriages, are explicitly defined as offering all the rights and responsibilities of marriage under state (though not federal) law to same-sex couples. Maine, Hawaii, the District of Columbia, Oregon, and Washington have created legal unions for same-sex couples, which offer varying subsets of the rights and responsibilities of marriage under the laws of those jurisdictions (Werum & Winders, 2001). LGBT (lesbian, gay, bisexual, and transgender) organizations and individuals are working effectively through legislatures and

courts to make gains toward legal acceptance of gay marriage, whereas opponents are effectively using ballot initiatives to prevent the legalization of gay marriage (Jones, 2004; Werum & Winders, 2001).

The legal issues surrounding same-sex marriage in the United States are complicated by the nation's federal system of government. Traditionally, the federal government did not attempt to establish its own definition of marriage; any marriage recognized by a state was recognized by the federal government, even if that marriage was not recognized by one or more other states (as was the case with interracial marriage before 1967 due to antimiscegenation laws). With the passage of the federal Defense of Marriage Act in 1996, however, a marriage was explicitly defined as a union of one man and one woman for the purposes of federal law (Liptak, 2008). Thus, no act or agency of the federal government currently recognizes same-sex marriage.

Before November 2004, four states had antimarriage constitutions, which had been relied upon for legal arguments against the recognition of *any* nonmarital status, such as same-sex civil unions, and the conferral of benefits on nonmarital partners, such as employment-based health care benefits (Seltzer, 1992). The November 2004 election brought 11 more antimarriage state constitutional amendments, as well as Louisiana and Missouri earlier in that same year. In all, 17 states have amended their constitutions to ban gay marriage; 10 of these extend beyond marriage to eliminate other forms of partnership recognition, including civil unions and domestic partnerships (Ruthblum, Balsam, & Solomon, 2008).

When the California Supreme Court ruled in May of 2008 that same-sex couples have a constitutional right to marry, Chief Justice George wrote "In view of the substance and significance of the fundamental right to form a family relationship the California Constitution properly must be interpreted to guarantee this basic civil right to all Californians, whether gay or heterosexual, and to same-sex couples as well as to opposite-sex couples" (Liptak, 2008, p. A1). Although a majority of Americans continue to view homosexuality as morally wrong, a growing number of individuals are unwilling to restrict the civil liberties of gays and lesbians (Liptak, 2008).

Lesbian and Gay Families

Until recent decades, most children of lesbian, gay, and bisexual parents were the offspring of heterosexual relationships where one of the parents later discovered his/her same-sex sexual orientation. In recent years, however, the increasing availability of donor insemination and progress in combating antigay discrimination among private and public adoption agencies have resulted in a dramatic increase in the number of lesbian, gay, and bisexual couples who are planning families and parenting children (Nelson, 1996). Lesbian, gay, bisexual, and transgender individuals are actively pursuing different paths toward parenthood (Kurdek, 2005). Some have children through the use of reproductive technologies, such as donor insemination

or surrogacy, while others adopt or become foster parents. However, in some states same-sex couples are banned from adopting or becoming foster parents and those that do may have relatively few protections (Abrams, 1999; Van Dam, 2004).

Lesbian Motherhood

In the 1960s and 1970s, the children of gay men or lesbian women were often the product of a heterosexual marriage that had ended. The children were then brought into the parent's new same-sex relationship. Those gay parents often had been through a painful coming out process and a bitter divorce. Most did not think about having more children (Cheal, 1993). For many lesbians, the court fight begins just after they leave their husbands, or the fathers of their children. If a woman has publicly declared her wish to live with another woman, she is particularly vulnerable. In most states, courts cannot find a mother "unfit" solely on the basis of homosexuality. It must consider the best interests of the child. However, a judge ruling on custody issues may find in favor of the father, or the in-laws, because they represent the heterosexual value system, and thus the child's placement with them must be in the "best interest of the child" (Abrams, 1999; Golombak, 2002).

Numerous studies have shown that homosexuality alone does not deem a parent unfit. For example, a 1995 study involved interviews with over 12,000 US teenagers and their families. The teens were part of the National Longitudinal Study of Adolescent Health, the largest and most comprehensive study of the age group in the United States. The researchers found no differences between the children of heterosexual parents and those of gay or lesbian parents in terms of depression, anxiety, self-esteem, and school grades. Exactly the same proportion of both groups also reported having had sex (34%) (Patterson, 2000). But while a previous study suggested children of gay parents were more likely to consider homosexual relationships, this study was unable to provide such information because so few teens reported same-sex attractions and romances. The single most important predictor of the teens' well-being, the study showed, was their relationship with parents, regardless of the family structure. Rather, the quality of the relationship was the most critical factor with respect to their well-being. As a result, the authors concluded that no justification exists for the imposition of limitations on child custody or visitation by lesbian mothers and that lesbian and gay adults are no less likely than others to provide good adoptive or foster homes.

Several studies found that children raised by lesbian and gay parents do not differ from children raised by heterosexual parents in terms of their mental health, peer relations, or gender role behavior, except for often being more tolerant of others (Javaid, 1993; Patterson, 2003; Wainright, Russell, & Patterson, 2004). This indicates that children raised by lesbian and gay parents function as well as children raised by heterosexual parents. Lesbian and gay couples function much like heterosexual couples but tend to be somewhat closer, more flexible, and more egalitarian (Laird, 1999). In contrast to popular stereotypes, they only rarely reflect a pattern where one partner takes on a traditional masculine role and the other assumes a

traditional feminine role (Patterson, 2000). There is no evidence that family relations or sexual orientation of parents cause homosexuality. Children are particularly treasured in gay and lesbian families because of the very conscious, complex choice involved in conception (who will be the donor and in what role) or adoption (how will the child be found and how will the adopting family be accepted, legally and socially) (Bos, van Balen, & Van De Boom, 2005; Sullivan & Baques, 1999).

Children raised in lesbian households have a chance to experience the world differently from the children of heterosexual couples. They see women as independent human beings, rather than being in positions of inferiority and subservience to men. Many of them witness a romantic relationship that does not reflect the traditional sexual role stereotypes and may be encouraged to develop in freer and less limited ways than the conventional "boy" or "girl" roles. Although family functioning in lesbian families might be just as varied, challenging, comforting, amusing, and frustrating as it is in heterosexual families, it is the stigma of lesbianism and the lack of acknowledgment of lesbianism that make their family life different (Bos et al., 2005). Lesbian mothers are concerned that their children will experience discrimination and prejudice as a result of their own experiences with homophobia and rejection (Dunne, 2000; Laird, 1999).

Given the growing number of openly gay and lesbian families in recent years, more services are being made available specifically for this population in urban centers of the United States. However, due to persistent homophobia in many locales, gay and lesbian families may establish and nourish their intimate relationships in the midst of prejudice. This can often create a strong, loyal family unit and community, but can also result in considerable tension (Stacey & Biblarz, 2001).

Gay Adoption

The lesbian and gay adoption boom may be less about support for gay rights than it is about the urgency of finding homes for abandoned children. In 1999, there were approximately 547,000 children in foster care in the United States; approximately 117,000 were available for adoption (Sullivan & Baques, 1999). However, there were qualified adoptive families available for only 20% of them. It has been estimated that approximately 10% of the US population is homosexual, suggesting that many couples, whose biological resources for children are reduced, are currently prevented from filling in the adoption gap (Connolly, 1998). After Congress ordered states in 1997 to move more quickly to find more families willing to take in these children, child welfare organizations and legislatures became more willing to allow any qualified parent to adopt, regardless of their sexual orientation. Support for gay and lesbian adoption grew further following the 2002 statement by the American Academy of Pediatrics indicating that the "health, adjustment and development" of children adopted by gay parents were no worse than that of children placed with heterosexuals (Bos, van Balen, & Van De Boom, 2003). A Pew Center poll found that support for gay adoption had risen from 38% in 1999 to 46% in 2006 and that opposition had fallen from 57% to 48%. (Johnson & O'Connor, 2002).

While it was rare to find adopted children in gay and lesbian homes even a couple of decades ago, adopted children in same-sex households now number 65,000 (Wilson 2007). Almost 2% of the nation's 3 million same-sex households include adopted children. It has been estimated that these placements save the US taxpayers as much as $130 million a year in costs of maintaining children in foster or institutional care (Connolly, 1998).

The number of foster children living in same-sex households has also increased. According to a March 2007 report compiled by the Urban Institute and the Williams Institute at University of California at Los Angeles School of Law, there are more than 14,100 foster children living with one or more gay or lesbian foster parents (Wilson 2007). There are various types of legal arrangements for the care of children, outlined below.

Types of Adoption, Guardianship, and Foster Care

Single, or individual adoption, is the traditional type of adoption whereby an unmarried person seeks to adopt a child that has been made available for adoption by the birth parent(s) or by the state. If both of the same-sex partners want custody of the child, one must apply for parent co-adoption.

Joint adoption by an unmarried couple requires that the couple petition the court to adopt a child that has been made available for adoption by the birth parent(s) or by the state.

Second-parent adoption involves one parent who already has legal custody of the child and a second parent that is petitioning for joint rights. The initial parent does not give up parental rights. Usually, gay couples in states that do not allow joint same-sex adoption choose this option.

Step-parent (domestic partner) adoption requires the filing of a step-parent or domestic partner adoption when a child is already living with both same-sex parents.

Guardianship may be the best solution in jurisdictions in which gay adoption is not legal. Although parents can protect their families by applying for guardianship, guardianship does not provide the same legal rights as adoption.

Foster care may be another option, although it differs from adoption in a number of ways. A foster parent assumes care responsibility for the foster child, but the state maintains legal guardianship of the child. In contrast, adoption transfers legal responsibility and care over to the adopting parents.

Factors in Adopting

Enduring the time-consuming adoption or foster care process is difficult enough for heterosexual couples, but gays and lesbians face additional complications.

Many states do not have specific laws or court decisions on gay adoption or gay foster parenting (Connolly, 1998). Even in areas that have gay adoption laws, gay couples adopting may find they face prejudices within the system. Mainstream assumptions about gay parenting have led to the belief that gay parents should be a

child's last resort. Often in gay adoption, parents will receive more difficult children because social workers leave them last on the list (Johnson & O'Connor 2002). It is ironic that bureaucracies that believe that lesbians and gay men are not suitable parents will place children who require the most highly skilled parenting with them (Van Dam, 2004). Some gay families have unique strengths that help troubled children. Gay couples adopting usually accept differences, understand what it is like to be in the minority, assign different gender roles, and have the skills to be open about sexuality with children who have been sexually abused (Bos, 2003; Cameron & Cameron, 1996; Patterson, 2000).

Florida is the only state that has specifically banned gay adoption rights, by barring the adoption of children by gay and lesbian adults. Utah prohibited all unmarried couples, including same-sex couples, from adopting children in a bill passed in February 2000. California, Massachusetts, New Jersey, New Mexico, New York, Ohio, Vermont, Washington, Wisconsin, and the District of Columbia have allowed gay adoption in specific cases. In the remaining 36 states, gays and lesbians who want to adopt or take in foster care children are at the mercy of judges and adoption and foster agencies (Werum & Winders, 2001).

One reason for supporting gay marriage is to ensure protection for children with gay parents. Gay parents face many legal struggles through gay adoption laws in ensuring their children have the protection of both parents (Wainright et al., 2004). At present, in most states of America and in many countries around the world, when a child is born into a gay relationship the nonbiological parent has no legal rights to the child. Similarly, gay couples who circumvent prejudicial adoption laws by having a single parent adoption have trouble when the other partner wants to adopt (Werum & Winders, 2001).

Many countries have laws in place that streamline adoption processes for stepparents. Some states within the United States that allow civil unions have introduced similar streamlining gay adoption laws for the nonbiological parent in a civil union. Advocates of gay marriage often also seek the same parental rights as nonbiological parents in heterosexual marriages, which ensure that each child has the legal protection of two parents (Arnup, 1999).

International Adoption

Gay men and lesbians who adopt abroad must often hide their lives from suspicious antigay governments. Of the handful of countries where nonnationals can adopt, not one allows gays and lesbians to do so openly (Sullivan & Baques, 1999). To avoid being identified as a gay couple, parents-to-be may designate one partner to adopt the child, while the other stays in the background or makes herself invisible during visits to the country. Only when they have brought their legally adopted child back to the United States can the new parents seek a second-parent adoption, if their state allows it (Sullivan & Baques, 1999).

Some countries have what amounts to a "don't ask, don't tell" policy; others prohibit all single-parent adoptions (Connolly, 1998). Some look suspiciously at unmarried people but still allow them to adopt. China now requires the adopting

parents to sign a statement of heterosexuality. The majority of countries now are putting limits on the number of single parents that agencies can send them. They know that gay and lesbian individuals from the United States are filtering through the system (Sullivan & Baques, 1999).

Artificial Insemination

Insemination is effectuated through the insertion of sperm into the uterus in order to initiate a pregnancy. Artificial insemination is a popular way for lesbians to become pregnant. A woman may choose to use sperm from a known donor or from a sperm bank. Lesbian families and single women potentially could become the largest group using donor insemination at fertility clinics (Card, 1995).

There are several advantages to reliance on sperm banks. Sperm banks require donors to waive any parental rights; accordingly, there is no danger of the donor seeking custody or visitation of the child. However, some sperm banks permit the child to access the donor once the child becomes an adult. Sperm banks test semen for diseases and collect health and genetic information from donors (Baetens & Brewaeys, 2001).

The use of a sperm bank may, however, entail various difficulties. Sperm banks can be expensive and most insurance plans do not cover the cost. Although certain characteristics of the donor can be selected, a face-to-face meeting cannot occur so that it is impossible to know his personality. Finally, because sperm banks use frozen semen, which is not as vigorous as fresh sperm, an extended period of time may be required in order to become pregnant (Baetens & Brewaeys, 2001).

Reliance on a known sperm donor also presents both advantages and disadvantages. This is often a close friend or sometimes even a relative of their partner (Peplau & Spalding, 2003). Because the donor is known, the woman having the artificial insemination may have access to a significant body of information about him, including his health, family history, physical and mental health, characteristics, and personality. The man involved may be willing to extended involvement in the child's life. There is also no cost for the sperm, although there is generally a cost for the insemination procedure (Baetens & Brewaeys, 2001; Card, 1995).

The greatest risks of reliance on a known donor are the possibility that he will sue for visitation or custody of the child; the risk of contracting HIV, AIDS, or other sexually transmitted diseases; and disagreements relating to parenting issues should the sperm donor decide to remain a part of the child's life (Card, 1995).

Family Structure, Family Rights, and Geography

Millions of gay Americans with children face uncertainty due to ever-changing state laws and statutes that affects everything from who is a legal parent to who may have what when a loved one dies. For families headed by gay and lesbian couples,

any out-of-state move requires a consideration of basic questions: Can I become a parent? Can I take time off work if my mate or child is gravely ill? Will I be able to inherit the home I live in and assets built over my lifetime and pass them along to my children? (Hanson & Lynch, 1992). Laws vary so widely from state to state on some issues that a person who is in many ways secure in one state can cross into a bordering state and be in hostile territory. New Jersey, New York, Pennsylvania, and Vermont allow same-sex couples to complete a second-parent adoption, which makes a same-sex partner a child's legal parent without affecting the other partner's parental status. Some counties in 15 other states have allowed such adoptions (Sullivan & Baques, 1999). Other locales do not afford same-sex couples similar rights. Essentially, this variation across states means that an individual's parental rights are a function of geography.

Many gay parents do not think to ask such specific questions when they are interviewing for a job, or they assume that domestic partner benefits will mean that the whole family can get coverage. When a family is moving from state to state, experts suggest that lesbian and gay parents assume nothing and check everything before making a decision. For instance, one should seek the advice of a gay-friendly lawyer in the state of intended residence and have him/her prepare necessary legal documents. These may include a will, a health care proxy statement, a living will, and a power of attorney granting decision-making authority to the partner.

Challenges for Lesbian of Color

Research on lesbian families has tended to focus on the experiences of women who are White, college-educated, and middle- or upper-income (Comas-Diaz & Greene, 1994). The literature has focused more on lesbian identity and parenthood among White gay populations (Kurdek, 2004) or family formation among heterosexual women of color. We know very little about how other kinds of familial structures, such as same-sex unions or co-parenting families, are formed and enacted among racial minorities or in racially segregated environments. We do know, however, that because of competing loyalties between subcultures, lesbians of color must navigate multiple marginalized identities (Boykin, 1996).

The experiences of lesbian women of color generally differ from those of most middle- and upper-income non-Hispanic White lesbians. Black-identified and Latina-identified lesbian women who create families are a socioeconomically heterogeneous group but tend not to be as economically privileged as White women. The networks of families headed by lesbians of color tend to lack information about such things as gay-friendly schools or service providers (Rotosky et al., 2007). Most of these minority women have not amassed the type of wealth needed for alternative insemination procedures, adoption, private schooling, or many other forms of support that more advantaged lesbians are able to obtain. They may live in Black or

Latino neighborhoods where heterosexual norms and expectations are practiced and imposed on their families (Garcia, 1998).

Minority lesbians who have internalized the negative stereotypes, particularly sexual stereotypes of African Americans, may regard any sexual behavior outside of dominant cultural norms as reflecting negatively on their racial/ethnic group as a group and threatening their chances for acceptance. Few lesbians of color are able to avoid the charge of racial disloyalty. The assumption that a lesbian's sexual orientation is inconsistent with her ethnic identity represents another expression of homophobia, one that complicates the process of integrating one's sexual orientation identity with other aspects of one's person (Comas-Diaz & Greene, 1994). Although churches have been important in the lives of many women of color, they have been less than supportive of their lesbian members. (See Chapter 7 of this volume for Loue's review of religion and spirituality among nonheterosexual minority women.) Lesbian women of color often find that their families support their struggles with racism and, perhaps sexism, but do not support their same-sex relationships or their struggles with heterosexism.

Consequently, lesbians of color must struggle with the convergence of racism, sexism, and heterosexism. This struggle often affects the development of their sexuality and sexual identity. These struggles are reflected in the need to negotiate a dominant culture that devalues women, people of color, and lesbians; the need to manage relationships with family, community, and partners; and the need to form a consolidated personal identity (Ritter & Terndrup, 2002). In addition to maintaining personal psychological integrity in the face of a hostile environment, a lesbian of color is confronted with the task of finding and maintaining intimate relationships in a social environment that provides little or no support. African-American lesbians provide an example of women who face the challenge of integrating more than one identity in an environment that devalues them on several levels. Of course, many lesbians of color do survive and even thrive; they do so, however, in spite of a social climate that is replete with hostility (Rostosky, Riggle, Gray, & Hatton, 2007).

As a result, minority people who are lesbian or gay tend not to be as outwardly expressive of their sexuality, especially when compared to those who live or spend a great deal of time in communities with more visible and "out" populations. Those who have children from prior heterosexual unions often have complicated relationships with the biological fathers of their children (Bennett & Battle, 2001). Many first- and second-generation women of color have unique issues stemming from the homophobia they have escaped in their countries or families of origin, and these factors may also produce a different set of experiences compared to non-Hispanic White lesbians who are creating families.

Legal immigration status and citizenship represent another issue of particular concern to Latino and Asian same-sex couples. Among Latino same-sex households in which both partners are Latino, 51% of men and 38% of women are not United States citizens (Garcia, 1998). Asian same-sex partners are also much more likely than White non-Hispanic or African-American same-sex partners to be noncitizens. Many of these noncitizens are partnered with US citizens. The immigration laws of

the United States currently do not recognize same-sex marriages, civil unions, or domestic partnerships for the purposes of immigration, even when they have been entered into legally in the immigrating partner's country of origin or a third country (Garcia, 1998).

Conclusion

Although lesbian and gay families have made significant gains in recent years in building and protecting families, minority lesbians generally have not experienced the same protections and opportunities as heterosexual couples. Benefits from state and federal programs designed to promote family formation, stability, home ownership, and other values that contribute to strength and stability in families should be made accessible to all members of the LBGT community.

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Chapter 6
Navigating Health Systems

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The World Health Organization has defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. It is the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs and, on the other hand, to change or cope with the environment" (Brotman, Ryan, Jalbert, & Rowe, 2002, p. 27). Solarz (1999) has noted that by emphasizing social and personal resources in addition to physical capacities, this definition acknowledges the relationship and need for balance between individuals and their environment. Brotman and colleagues, (2002) further observe that this broad, holistic construct for health is of particular importance for lives and experiences of sexual, gender, and racial/ethnic minorities. These experiences include the challenges of coming out, locating community, and managing oppression in a context of homophobia, racism, and/or marginalization.

The chapter focuses on institutional, provider, and personal barriers to health care for often stigmatized and marginalized lesbian, bisexual, transgender, transsexual, or questioning (LBTTQ) women of color, followed by recommendations and models to improve access to care, health, and well-being. Because specific information on LBTTQ women of color is extremely limited, much of the discussion will focus on research drawn from work with lesbian, gay, bisexual, and transgender (LGBT) individuals and LGBT persons of color in general.

Introduction

Although knowledge about women's health problems, including prevalence, diagnosis, cause, prevention, and treatment, is increasing, some subgroups of women have received little attention (Solarz, 1999). Racial/ethnic minority women who also self-identify as LBTTQ are at high risk for a variety of health problems, which may or may not be directly related to their sexual orientation or gender identity. Factors

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that influence access to and appropriate delivery of health care for minority LBTTQ women include stigma, disclosure to providers, legal issues, socioeconomic status, and health-care insurance coverage. Real or perceived rejection and discrimination characterize social conditions that differentiate public health access and service delivery to LBTTQ populations from the general population. In addition, LBTTQ women who belong to racial/ethnic minority groups may experience an even greater degree of racism than heterosexism. These factors require special public health attention and unique approaches to their investigation, prevention, and treatment (Beatty, Madl-Young, & Bostwick, 2006).

A special issue of the *American Journal of Public Health* in 2001 focused for the first time solely on health care and public health related to the LGBT community, including a resolution calling for research on the relationship among sexual orientation, gender identity, and disease (Hernandez & Fultz, 2006). Few studies of LGBT populations have included adequate numbers for separate analyses of racial/ethnic minority groups outside the realm of HIV prevention and treatment for gay and bisexual men. The interaction of gender and race/ethnicity is not always in the same form in LGBT populations as reported in other non-LGBT-specific research. LGBT individuals and LBTTQ women who belong to racial/ethnic minority groups are subjected to both antigay and racist attitudes and treatment by the larger dominant/mainstream community, and may also be stigmatized by their own racial/ethnic and sexual minority communities. As a result, they occupy a peripheral position in all of these cultures and may be perceived as "selling out" by some (Beatty et al., 2006).

Although for LGBT and LBTTQ women the most often addressed public health area is risk related to sexual behavior, risks tied to social conditions are also very important. These conditions, including prejudice, discrimination, and rejection (antigay violence and/or racial stress), may directly impact mental and physical disorders, access to care, health-care utilization, and quality of care. Lack of sensitivity related to sex or gender roles can also lead to the development and implementation of public health interventions and prevention programs that fail to respect the values and needs of LGBT individuals, thereby further alienating them. A specialized focus is required in all public health areas, even in those which LGBT populations do not have a unique or increased risk for disease. "Insensitive or hostile care may lead to inappropriate interventions, fail to effect change, and further add to alienation and mistrust of public health recommendations" (Beatty et al., 2006, p. 213).

These issues affect the selection of research priorities: design of public health prevention and intervention programs, development of standards of care, access to care and provision of culturally sensitive care (Beatty et al., 2006). The traditional health-care system has based its care and treatment of women on assumptions of heterosexuality, ignoring the health-care needs of LBTTQ women (Buchholz, 2000). LBTTQ women's health needs require study to gain knowledge to improve their health status and health care, to confirm beliefs and counter misconceptions that exist about LBTTQ women's health risks, and to identify health areas in which LBTTQ women are at risk or tend to be at greater risk than heterosexual women or women in general (Solarz, 1999).

Stigma in the Context of Health care

Stigma destroys the health and well-being of individuals and results in population-level health disparities (Battle & Crum, 2007). Both racial and homosexual stigma shape the health and lives of LBTTQ women of color. Although negative views toward race and homosexuality continue to decline, stigma remains a significant barrier for some LGBT individuals and people of color in the United States. Lack of cultural competency among health-care providers, fear of *coming out* to providers, and lack of LGBT focus in health care create significant personal and cultural barriers to accessing care (Solarz, 1999).

Definitions

According to the research of Ramirez-Valles (2007, p. 301), *stigma*

> refers to a labeling of individuals or groups in a way that discredits them. It is a process by which differences between groups of people are enacted and labeled; undesirable characteristics are attached to the labeled group; a social separation is created between the labeled and the labeling group; and the labeled group is subjected to discriminatory practices. The stigma process is usually initiated by a dominant group against a minority or oppressed group.

Brotman and colleagues (2002, p. 27) note that the term *homophobia* was defined by George Weinberg in 1973 as "an irrational fear, dislike, or hatred of lesbians and/or gay men," and that *heterosexism* was described by Ruth Simkin in 1993 as "the presumption that heterosexuality is the norm and that any other form of sexual expression is deviant." Similarly, a literature review by Buchholz (2000) revealed heterosexism as a belief in the superiority of heterosexuality. Lombardi (2007, p. 646) describes *genderism* as

> how a person is ascribed a gender and to the response people have to any individual who fails to fit within their normative understanding of men and women. Genderism results in the policing of gender identities and expression. All members of society – not only trans-people – are constantly evaluated based on whether they look or act in a manner that is consistent with the gender they identify as or present as. As entrenched as genderism might seem within the United States and other societies, the problems trans-people experience as a result of genderism are not insurmountable.

Homophobia, heterosexism, and genderism are used to oppress LGBT in the United States and other countries.

Solarz (1999) identifies *cultural competency* as that set of skills required in order to provide individuals with culturally appropriate services that are of high quality. This skill set includes an understanding of both the relevant culture and the impact of group membership on the individual in terms of his/her health status, behavior, and attitudes, as well an ability to communicate in the appropriate language.

The Effects of Racism and Heterosexism

The stigma of homosexuality has serious consequences for many LGBT, such as stress, low self-esteem, suicide, unemployment, and dislocation. For LGBT who belong to racial/ethnic minorities, this may be particularly critical because of the added racial discrimination (Ramirez-Valles, 2007). By historically (prior to 1973) defining LGBT individuals within medical terms as mentally ill, the health-care system was able to exert control over their lives in terms of "healing" them from so-called unhealthy same-sex attractions. Health research on LGBT individuals was used as a tool to support the appropriateness of these interventions. Consequently, LGBT individuals, similar to racial/ethnic minorities, have an uneasy relationship with, and lack of trust of, the health and social service system (Brotman et al., 2002).

A semblance of "neutrality" has been created in health policy and practice based on the ideological belief that health care must be accessible to all. The American Psychiatric Association removed homosexuality as a mental illness from the *Diagnostic and Statistical Manual of Mental Disorders* in 1973. The American Medical Association abolished in 1994 its policy, adopted in 1981, which encouraged physicians to recognize that reversal of sexual preference was possible in selected cases.

Nevertheless, similar to members of the general public, health-care providers and medical faculty have their own personal biases and prejudices; those with negative attitudes toward LGBT individuals may carry these views into the health-care arena (Hernandez & Fultz, 2006). Many continue to view homosexuality as a mental disorder and/or hold a heterosexist and antigay/lesbian bias. A 1994 national survey of over 700 physicians and LGB medical students revealed that two-thirds knew patients who were refused care or received lesser quality care due to their sexual orientation (Brotman et al., 2002). A comment collected in this survey from a faculty member underscores this point: *I've gotten used to Blacks and Jews, but I can't get used to homos* (Stein & Bonuck, 2001, p. 87). Investigators conducting a 1998 Kings County (Seattle, Washington) survey of nursing students found that between 40 and 43% of the respondents believed that LGBT individuals should keep their sexuality private (8–12% despised LGBT individuals; 5–12% found LGBT individuals disgusting) (Beatty et al., 2006). Additional studies cited by Brotman et al. (2002) suggest a discrepancy between cognitive attitudes and feelings of health-care staff, which may have a negative influence on staff behavior and the health care offered to LGBT patients.

A lack of awareness and understanding of sexual orientation, homophobia, and heterosexism continues to dominate many health-care settings, leading to further isolation and vulnerability. This is reflected in practices that include intake and demographic forms that fail to recognize LGBT relationships and differences in gender identity; questioning techniques by doctors, which assume a heterosexual orientation; visitation policies restricting same-sex partners from visiting their significant others while in the hospital; and systemic discrimination by adoption services against LGBT couples (Brotman et al., 2002).

Discrimination and prejudice by both physical and mental health-care providers against LGBT individuals have been reported in many forms, including reluctance or refusal to treat, negative comments or rough handling during examination, and forced birth control. Experiences with negative attitudes and responses by some health-care providers may cause LGBT individuals to avoid seeking health care altogether (Solarz, 1999). According to historical survey data summarized by O'Hanlan and Isler (2007), lesbians have reported ostracism, rough treatment, and derogatory comments by their medical providers. As a result, some are reluctant to return or continue routine health maintenance visits; many choose not to disclose their sexual orientation in future encounters with health-care providers. Dr. Katherine O'Hanlan of the Gay and Lesbian Medical Association noted in a New York Times article that, because of insensitive treatment and the prejudice of doctors, lesbians have fewer checkups than necessary; fail to present for important screening tests such as Pap smears, mammograms, and cholesterol tests; and, as a consequence, are less likely than heterosexual women to have cancer and heart disease diagnosed at a stage when these diseases would be most easily treatable (Stein & Bonuck, 2001).

Experiences of discrimination may negatively impact LGBT health and well-being by fostering isolation, shame, hate, anger, and resentment, further reinforcing individuals' need to hide their sexual orientation. This can lead to mistrust of health-care practitioners and/or institutions and create feelings of disentitlement (Brotman et al., 2002). LGBT focus groups participants, in a study by Brotman et al. (2002), identified "feeling safe" as critical to access health services successfully and to achieve good health. Examples cited by participants of discrimination in the health-care system included seeing posters about LGBT individuals torn down in health and social service settings, being discussed by health-care professionals in a derogatory manner, and being referred to with hurtful labels and names. Elder LGBT individuals, in particular, perceive significant marginalization, impacting the delivery of long-term care and social support (Hernandez & Fultz, 2006). Bisexual women (and men) face stigma from both outside and inside gay and lesbian communities, creating a sense of disenfranchisement and invisibility (Brotman et al., 2002).

In addition to developing their LBT identity, racial/ethnic minority LBTTQ women face the challenge of developing an identity that reflects their racial/ethnic status, thereby integrating their sexual, gender, and racial identities in the context of multiple, sometimes conflicting cultures. These include the dominant American culture and the culture of their racial/ethnic group (or groups) of origin. Racial/ethnic minority culture can be a source of conflict as well as strength and support for racial/ethnic minority LBTTQ women. Experience in dealing with their racial/ethnic minority status may better prepare them to also address their sexual minority status. Sexual identity and behavior can vary significantly across cultures and racial/ethnic groups, and should not be assumed to be identical with the mainstream lesbian or other sexual/gender minority culture, (Solarz, 1999). Data gathered by Mays, Cochran, and Rhue (1993) through semi-structured ethnographic interviews with self-identified African-American lesbians indicate that, in spite of the conservative views and negative reactions of the African-American community toward

homosexuality, half of the participants expressed continued interest in involvement with the African-American community.

Racial discrimination is a potent source of stress associated with negative health effects. Stress effects may be greatest for racial/ethnic minority LBTTQ women who are subject to multiple forms of discrimination. The "triple jeopardy" of homophobia, racism, and sex-based discrimination compounds the negative effects that homophobia potentially has on health. For example, while racism may be encountered by members of racial/ethnic minority groups in general, minority lesbians can also encounter racism from the lesbian community. Individuals with multiple lower social statuses (i.e., lesbian, racial/ethnic minority, and female) may be particularly at risk for stress-induced depression (Solarz, 1999).

Communities and specifically health-care and social service organizations may be particularly unsafe places for racial/ethnic minority LBTTQ women who face discrimination based on these multiple factors. Racial/ethnic minority LBTTQ women, who are poor, are more likely to face multiple forms of prejudice in health-care encounters that limit access to good care and make it difficult to address their concerns within the health-care system. Those who live in rural settings may have limited choice in health-care practitioners if they encounter prejudice upon coming out. Instead, they may choose to remain in the closet or delay treatment instead of coming out and playing an active role in their own health care (Brotman et al., 2002).

Prior to contact with European cultures, LGBT Native Americans were culturally accepted as a third male-female gender, now called two-spirit persons, and held valued positions in their tribal communities. Subsequent European colonization and cultural imposition on Native Americans eradicated or drove this tradition underground for most North American tribes (Brotman et al., 2002). Despite considerable heterogeneity among more than 562 federally recognized tribes in the United States today, the universally shared history of colonization has shaped distinctive conditions of health risk and resilience for two-spirits. Two-spirits experience significant antigay as well as anti-Native violence, including sexual and physical assault and historical trauma typically linked to adverse health and psychosocial functioning (Fieland, Walters, & Simoni, 2007).

According to Ramirez-Valles (2007), stigma related to homosexuality and race is part of the lives of LGBT Latinos from early childhood. Many grow up feeling rejected and alienated, knowing they are different and are valued less. This stigma creates a variety of negative outcomes, such as poverty, truncated education, unemployment, depression, suicide, substance use, risky behavior, and lack of access to appropriate health care. Some are able to cope with, or confront, racial and homosexual stigmas and to prevent or redress the negative effects. Community involvement, activism, and volunteerism assist in these efforts.

Transgender individuals, including transsexual individuals, are additionally challenged to navigate a health-care system that is unable to comprehend, let alone support them. Few health-care programs are tailored to specifically serve this population (Beatty et al., 2006). Anecdotal reports exist of hospital staff uncertainty with respect to the classification of some patients' gender and the placement of a transgender patient in a male or female semi-private room (Hernandez & Fultz, 2006).

Additional cultural sensitivity training is needed for health-care providers, including those providing mental health and substance abuse treatment, to work with transgender individuals and to understand the relevance of gender issues, which may be central, peripheral, or unrelated to treatment (Beatty et al., 2006). Health-care providers need to understand, in particular, the social challenges faced by transgender individuals in order to provide culturally sensitive prevention and health care. Transgender individuals often experience some form of harassment; discrimination, including economic discrimination; and/or violence during their lives, which can significantly affect their mental health, health risks, and experience with health-care systems. Transgender youth will likely have a greater need for services and support (Lombardi & van Servellen, 2000).

Cultural Competency of Health-Care Providers

Ease of communication with health-care providers is predictive of health risks, health-seeking behaviors, and ease of access to competent and sensitive care. However, as Solarz (1999) reports, few physicians have the knowledge or sensitivity to address lesbian (and other LBTTQ women's) health risks or health-care needs appropriately. Health-care staff remain relatively uninformed about the unique health and social issues of LGBT individuals, including disclosure issues or differing familial relationships; staff training has been largely limited to HIV/AIDS. Medical schools spend little or no part of their curriculum on LGB issues or the health-care needs of transgender and intersex patients. As a consequence, even LGBT-sensitive providers are often unaware of LGBT health-care issues (Hernandez & Fultz, 2006). Diversity training is key to recognizing and overcoming biases toward clients with unfamiliar life styles (Solarz, 1999).

While medical encounters create stress and uncertainty for most, this is magnified for many LGBT individuals by concerns related to sexual orientation (Stein & Bonuck, 2001). Although gathering information about sexual behavior history is essential to good medical care, many physicians are uncomfortable taking detailed histories, particularly in relation to same-sex behavior. Providers should be trained to discuss these issues without embarrassment in a nonthreatening or judgmental manner. Questions also need to be developmentally appropriate in the case of adolescents (Solarz, 1999).

Disclosure of Sexual Orientation and Gender Identity to Providers

Historically, health-care providers have assumed that sexual orientation did not affect health and took no interest in LGBT issues. Homophobia and heterosexism exacerbated the relative lack of acknowledgement of or attention given to the health needs of LGBT. Reaction of health-care providers to disclosure of LGBT identity

documented in various studies include embarrassment, shock, anxiety, inappropriate reactions, sexist remarks, ostracism/patient rejection, unfriendliness, hostility, excessive curiosity, invasive and/or insensitive questioning, pity, fear, and condescension (Brotman et al., 2002). Homophobia and heterosexism, reflected as nonverbal behavior or overt negative stereotyping, may interfere with appropriate obstetric and gynecological care to LBTTQ women (Buchholz, 2000).

Brotman and colleagues' (2002) research identified four mechanisms through which sexual orientation may be disclosed to health-care providers: screening, unplanned (inadvertent or forced) disclosure, planned disclosure, and nondisclosure. Screening refers to the selection by an individual of a provider who is sensitive to LGBT issues and is aware of the patient's orientation due to deliberate or inadvertent disclosure. Nondisclosure may be the strategy of choice for those who live in areas in which disclosure could bring about adverse consequences. As an example, in many areas of the country, disclosure of sexual orientation can lead to employment problems or the denial of housing and social services, or loss of child custody during a custody dispute (Beatty et al., 2006). Fear and isolation may cause LBTTQ women to leave their community or hide their identity (Brotman et al., 2002). Consequences of inappropriate disclosure can be devastating under these circumstances. Physical, mental, and other health-care providers and programs treating this population must be particularly vigilant to maintain confidentiality (Beatty et al., 2006).

Although the Health Insurance Portability and Accountability Act (HIPPA) seeks to protect the confidentiality of patients and their medical conditions and records, it allows health-care providers to use and disclose specific information for the purposes of treatment, payment, and health-care operations without the patient's specific written authorization. Organizations that self-insure employees cannot guarantee that medical record information will remain confidential. HIPPA permits access to employee medical records and detailed insurance invoices for billing and utilization review. This can discourage employees from seeking care for sensitive medical and psychiatric conditions or disclosing information to health-care providers, which could place them at risk of discrimination, harassment, or even termination based on their sexual orientation. The end result may be a decline in the quality of care for those who do not disclose their sexual orientation to their health-care providers. In the US Armed Forces, the largest organization to self-insure, LGBT soldiers can be discharged, the military equivalent of termination, for affirming their sexual orientation in any manner. Conversations between patients and health-care providers and any information in medical records are not considered confidential. As a result, LGBT soldiers are likely to hide their sexual orientation from health-care providers, thereby limiting their ability to seek help for concerns that may be related to LGBT behaviors (Hernandez & Fultz, 2006).

LBTTQ women who are coming to terms with self-identification may be uncomfortable talking to their health-care providers about their sexual orientation or gender identity or may be concerned that disclosure of this information will affect their care. In addition, shame or embarrassment over behaviors or identity and/or prior negative experiences with health-care providers (lectures, ridicule) can also reduce comfort in discussing their health-care concerns (Hernandez & Fultz, 2006).

Honesty about sexual orientation is crucial in determining health-care needs; lack of disclosure may lead to incorrect diagnosis and inadequate treatment (Brotman et al., 2002). Beatty et al. (2006) note that, not infrequently, an LGBT person's approach to health care has been shaped by his/her previous negative experiences with health-care providers. Many health-care providers are unaware of the degree of discrimination already experienced in the health-care setting by an LGBT individual, and the reasonable and well-grounded fear, discomfort, and mistrust of the system.

The most significant medical risk for LGBT in not disclosing is subsequently avoiding routine medical examinations or delaying medical appointments due to fear of the possible consequences if their sexual orientation is revealed. The fear may be compounded by excessive emotional stress if he/she believes or knows a disease or symptom is linked to their sexual practices. Health-care providers frequently underestimate the proportion of LGBT patients in their practice due to reluctance to disclose their sexual orientation. As such, LGBT individuals may feel dissatisfied with their treatment (Brotman et al., 2002).

In a study conducted by Brotman and colleagues (2002), LGBT focus group participants identified coming out and being out as critical to good health and health care; the relationship between choosing to come out and locating environments of acceptance and support was also deemed to be essential. If the process is supported and encouraged, the development of a positive self-concept is facilitated, leading to good health outcomes and a sense of empowerment with regard to advocating within the health-care system to meet one's needs. Coming out represented a move toward self-affirmation essential to attain good health and practice good health care. On the other hand, not being out was perceived as not being in a good state of health. Participants revealed that hiding their orientation/identity or denying it caused inner turmoil/struggle and difficulty; related shame and fear for safety were strong impediments to accessing health care. Having a safe and accepting space in which to listen to others and to speak about their own lives and experiences facilitated the coming out process, assisting in normalizing their experiences and developing a positive self-concept. Participants were skeptical about the ability of some providers to provide such a safe and accepting space in the context of the power differential of service provision. Strategies considered were to talk only with "safe people," to wait, or to use "another door in" to gain access to trusting service providers (Brotman et al., 2002).

Several participants already out in their daily lives felt a sense of personal responsibility to advocate for appropriate health-care services in the community, educate health-care providers about LGBT issues, locate gay-positive service providers, and help others more likely to experience or fear discrimination and violence within the health-care system, including transgender, elderly LGBT, and visible racial/ethnic minority LGBT individuals. Others emphasized the responsibility of health-care providers and institutions to develop an appropriate level of comfort, ask direct questions about sexual orientation or gender/sexual identity in health-care encounters, acknowledge the diverse experiences of access barriers, and work proactively to ensure equity within the health-care system (Brotman et al., 2002).

Although knowledge of a patient's sexual orientation is important to assure high-quality medical care, this can present a special barrier to care for lesbians due to fear or embarrassment (Solarz, 1999). A survey by Stein & Bonuck (2001) of 575 lesbians and gay men revealed that women were almost twice as likely as men to be concerned about negative reactions or care as a result of disclosure to health-care providers. Lower disclosure rates were also noted in the survey among both young adults (under 30 years of age) and elderly (over 60 years of age), suggesting discomfort in discussing personal issues as well as greater concerns about discriminatory care. Solarz (1999) notes several studies that indicate the majority (53–72%) of lesbians do not disclose their sexual orientation to physicians when they seek medical care.

Some lesbians are able to protect themselves against negative consequences by managing their coming out process, beginning with themselves. Negative consequences include "being the target of discrimination or violence or experiencing rejection or physical or verbal abuse by family members or peers" (Solarz, 1999, p. 49). On the other hand, hiding sexual identity increases stress, negative health and mental health outcomes, and high-risk behaviors that can further compromise health. Acceptance of their own identity is fundamental to good mental health for lesbians and is associated with heightened self-esteem, improved psychological adjustment, increased satisfaction, and reduced depression or stress (Solarz, 1999). Many lesbians may come out to themselves and to other LGBT individuals but not to their families of origin or coworkers. Solarz (1999) has suggested that additional information is needed with respect to the components of a psychologically healthy coming out process, particularly as it relates to lesbians from diverse racial/ethnic groups, socioeconomic statuses, and urban and rural residents.

An analysis of data from the 1984 to 1985 National Lesbian Healthcare Survey by Bradford, Ryan, & Rothblum (1994) documented a link between being out, access to mental health information, and increased emotional and psychological health. Being out was correlated with the development of coping and survival skills along with friends and alternative social supports.

In focus groups conducted by Brotman and colleagues (2002), coming out was identified as particularly unsettling for bisexual women and men. Assumptions about ambiguity related to their sexual orientation or being straight when in opposite-sex relationships led to inappropriate treatment. Based on these assumptions, health-care providers frequently reacted with a sense of discomfort, particularly in discussing intimate relationships and sexual health. Bisexual participants suggested that providers need to avoid assuming anything about people's sexual practices or histories.

Lack of confidentiality is also a concern for LGBT youth and adolescents under the age of 18, who are typically covered by their parent's health insurance. They are less likely to discuss their sexual orientation openly with their health-care provider for fear that the information will be passed along to their parents, sometimes with disastrous results. Many states have provisions for limited confidentiality, but these typically cover only specific issues, such as sexually transmitted diseases, drug and alcohol use, and mental health conditions (Hernandez & Fultz, 2006).

Older LGBT adults also fear disclosure of sexual orientation to health-care providers, exacerbating negative clinical disease outcomes. Research studies have identified high rates of internalized homophobia, alcohol abuse, and suicidal ideation among LGBT elders with lower self-esteem, who have hidden their sexual orientation. Another concern is that long-term care facilities, such as personal care and nursing homes, will fail to provide a supportive and safe environment for older LGBT persons if their sexual orientation is disclosed. In one study, some older LGBT people reported changing their last names to match that of their partner to appear to be family, so they could remain together while living in a long-term care facility (Hernandez & Fultz, 2006).

Research suggests that there is an increased likelihood that individuals will receive appropriate and satisfactory health services if their health-care providers integrate sexual orientation issues into their usual practice. Health-care providers should be aware of where LGBT patients are in the coming out process and how they are coping. Health-care providers also need to be aware of LGBT-related psychological and social traits, and the distinction between homosexual behavior and gay sexual orientation. Physicians need to ask questions about sexual orientation and sexual behavior. Disclosure of sexual orientation is particularly relevant for gynecological care, screening for sexually transmitted diseases, and mental health counseling. Information on sexual orientation should always be considered as part of routine checkups (Brotman et al., 2002). As an increasing number of lesbians have children, attitudes of health-care providers and experiences of lesbian couples are also important in determining the quality of care during childbirth (Buchholz, 2000).

Legal Issues

LGBT patients face significant barriers in the search for clinically competent health care at hospitals and medical centers that is also respectful of LGBT family. The Joint Commission for the Accreditation of Hospitals has defined family as "The person(s) who plays a significant role in the individual's [patient's] life. This may include a person(s) not legally related to the individual" (Hernandez & Fultz, 2006, p. 183). However, many hospital and health-care staff are not adequately trained to understand variations of the family unit or to recognize families beyond the traditional nuclear family.

Access to Records and Visitation

While the legality of lesbian and other same-sex relationships is outside the purview of health-care institutions, individual health-care providers should be sensitive to the needs of the lesbian couples. Lesbian spouses are often not afforded the same visitation rights or access to partner medical information as heterosexual spouses.

Some providers refuse to honor the designation of a lesbian partner as a health-care proxy by the patient. Nine percent of lesbians responding to the Michigan Lesbian Health Survey (MLHS) reported health-care workers had refused to allow their female partners to stay with them during treatment or in a treatment facility; a similar percentage reported partners being excluded from discussion about the treatment (Solarz, 1999). Same-sex couples in another study summarized by Buchholz (2000) reported several instances of frustration related to lack of acknowledgment or understanding of their relationship by health-care providers. These included refusal to treat partners as family members; refusal to acknowledge legal documents, such as a power of attorney or guardian selection naming the partner as the child's legal guardian; difficulties understanding the necessity of the power of attorney papers, so the partner could make any necessary medical decisions; and completing a birth certificate with only one name when a father could not be specified.

Medical Decision Making

Regardless of how their family unit is defined, LGBT individuals and LBTTQ women of color need to ensure that their medical affairs are in order and their wishes will be respected by their health-care providers, including visitation rights, medical decision making, or withdrawal of resuscitative and life-sustaining care when no longer able to make medical decisions on her/his own behalf (living will). Creation of legal documents outlining these requirements is the best way to ensure this will occur. Designation of a medical decision maker to maintain sole responsibility for all medical decisions, should the patient become incapacitated, is critically important. These documents, typically known as an *advanced directive* and a *durable power of attorney*, have become essential to LGBT patients and their families. For a durable medical power of attorney, the individual selected to carry out the patient's wishes is known as the health-care proxy or agent. Once that person is selected, the document should be drafted, signed by the patient and notarized, with copies distributed to the patient, his/her lawyer, the primary health-care provider, and the designated proxy or agent. A copy should also be placed in the medical record when the patient is admitted to a hospital. Many LGBT advocacy groups offer information to assist in the creation of advance directives and a durable power of medical attorney. The Lambda Legal Defense and Education Fund offers comprehensive information on their website (http://lambdalegal.org) (Hernandez & Fultz, 2006).

Directives for the care of children with same-sex parents who have not both legally adopted the children are also crucial. Documentation needs to provide both parents with the right to seek medical care for the children, and should be distributed to both parents, the children's pediatrician, the children's schools or day care centers, and any sporting/recreational organizations in which the children participate (Hernandez & Fultz, 2006).

Although the creation of these legal documents is an important mechanism to protect the wishes of the individual and family unit, this might not be enough if the health-care institution or provider fails to acknowledge them. Education of individual health-care providers and hospital administrators, and enactment of LGBT-specific policies addressing visitation rights medical decision making, and recognition of LGBT families are still needed to ensure these documents and rights are truly respected and honored (Hernandez & Fultz, 2006).

Socioeconomic Status, Health-Care Insurance Coverage, and Insurance System Barriers

Mays, Yancey, Cochran, Weber, and Fielding (2002) note that public health efforts seek to address the existing health disparities that result in disadvantages among racial/ethnic minority women. However, intragroup variations exist in risk due to personal, regional, and socioeconomic factors. The same is true for access to health-care insurance, and sexual orientation and gender identity contribute to these variations. While health insurance coverage is the primary avenue to health care in this country, LBTTQ women are at distinct disadvantage compared to their heterosexual counterparts.

Socioeconomic status (SES), particularly income, is predictive of health status, mortality, and morbidity, encompassing the stress of living and working environments, economic factors, and physical security. On average, individuals who are less educated and are of lower SES have significantly poorer health and shorter life spans, are more likely to encounter negative life events, and have fewer social and psychological resources for stress. For LBTTQ women of color at lower socioeconomic levels, this stress may be significantly compounded by discrimination (Solarz, 1999).

Bradford et al. (1994) noted that the low income level of respondents to the National Lesbian Healthcare Survey was an inherent barrier to receiving quality mental health care. Fifty-seven percent of the respondents worried about money; finances were an even greater concern for African-American and older lesbians. In a study comparing health indicators among self-identified lesbians/bisexual women to heterosexual women in Los Angeles County, Mays et al. (2002) postulated that rates of preventive care were lower, particularly among Latina and African-American lesbians and bisexual women, due to frequent lack of health insurance among these women in comparison with heterosexual women. Both full-time employment and married status result in more opportunities for health insurance coverage, which increases access to health care (Mays et al., 2002). Solarz (1999) noted that 16% of all NLHCS respondents reported not receiving health care because it was unaffordable; 27% of middle-aged NLHCS respondents and 12.3% of MLHS respondents reported not having health insurance. Of some concern, analysis of NLHCS data indicated that there may be a connection among lesbians between lack of insurance and, particularly, serious health conditions, including heart disease and

eating disorders (both overeating or undereating); lack of insurance was also predictive of lesbians being victims of physical and sexual abuse and antigay violence (Solarz, 1999).

Group health insurance plans offered through employers often do not include health insurance coverage for same-sex domestic partners, thereby limiting access to health care. This is particularly true for small and mid-sized organizations. Consequently, both partners must seek and maintain gainful employment with health insurance coverage, creating an economic burden of dual co-payments and deductibles. A same-sex couple without domestic partner benefits and insurance coverage similar to that of a married heterosexual couple may face double the cost of out-of-pocket expenses compared to the married heterosexual couple, as well as additional costs for the partner's health insurance premiums. Besides the added economic cost, this circumstance also prohibits stay-at-home parenting for the children of same-sex couples. Many may be forced to choose between increasing their medical and child care expenses and foregoing health insurance coverage for one or more family members, thereby risking their medical and financial health (Hernandez & Fultz, 2006). Members of lesbian households are generally unable to secure family or household health insurance coverage, often resulting in the use of different health-care providers without family-focused care or the related multiple benefits (Solarz, 1999).

Solarz (1999) observed that structural barriers of health-care insurance programs, including managed care systems, affect access to health care for lesbians in tandem with the legal standing of lesbian relationships compared to heterosexual marriages. Some of the negative aspects of managed care for lesbians include the following. Pressure to keep visits short limits the ability to build trust needed to disclose sexual orientation. While fee-for-service plans allow unrestricted access to providers with the option of seeking out lesbian or lesbian-friendly providers, managed care plans are generally restricted to providers who belong to the plan. The opportunity to find a lesbian or lesbian-friendly provider is much more limited, particularly since fewer exist overall. These barriers can be overcome if the plan recruits and identifies lesbian- or gay-friendly providers in the plan, and institutes cultural competency training programs on the care of lesbians (Solarz, 1999).

Socioeconomic status and access to insurance and appropriate health care are also significant issues for transgender individuals. Interviews conducted by Clements-Nolle, Marx, Guzman, & Katz (2001) with 392 male-to-female and 123 female-to-male transgender persons revealed that male-to-female individuals were more likely than female-to-male to identify as heterosexual, to report prior incarceration, and to have unstable housing, low education, and low monthly income. Fifty-two percent of male-to-female and 41% of female-to-male participants had no health insurance. Of those insured, 70% of male-to-female participants relied on public insurance, compared to 19% of female-to-male participants. Twenty-five percent of male-to-female and 18% of female-to-male participants reported using an emergency department within the past six months. Twenty-nine percent of male-to-female participants reported getting hormones from the streets, black market, or friends (Clements-Nolle et al., 2001).

Access to Care

Significant health disparities exist in terms of poorer health status and riskier health behaviors among women of color compared to Caucasian women. Women of color on the whole, in comparison with Caucasian women, also demonstrate less access to preventive health services, including cervical cytology, mammography, clinical breast examination, and screening for cholesterol and blood pressure. These services play a major role in early detection of many chronic diseases. Sexual minority status heightens health risk for racial/ethnic minority women and needs to be considered in addressing health disparities affecting this population. These increased health risks include increased mortality due to heart disease, diabetes, and cerebrovascular disease; elevated levels of dietary fat consumption, overweight, and obesity; reduced levels of physical exercise; and decreased intake of fruits and vegetables, as well as shorter life expectancy. Unfortunately, sex-based research among subgroups of racial/ethnic minority women and the factors that contribute to these differences are very limited (Mays et al., 2002).

Studies of the health status, risky health behaviors, and access to care of sexual minority lesbian and bisexual women in general have been uncommon; those that have occurred have been primarily based on convenience sampling of visible lesbians in urban areas. The relation between sexual orientation and beliefs and attitudes about illness, health-care access, or types of care or providers desired is consequently not well understood (Mays et al., 2002).

While lesbians tend to prefer female health-care providers who are knowledgeable and sensitive to lifestyle issues associated with minority sexual orientations, racial/ethnic minority lesbians and bisexual women are challenged to balance concerns linked to both sexual orientation and racial/ethic minority status. Findings from a study by Mays et al. (2002) document that health risks among racial/ethnic minority women can vary on the basis of little more than sexual orientation. However, the issues and needs of lesbians and bisexual women within racial/ethnic minority groups tend to be neglected due to an erroneous perception that homosexuality is less common among members of such groups.

In the United States, LGB people of color may experience great difficulty accessing high-quality health care and/or health-related interventions, which correlates with a disproportionately higher prevalence of poor health outcomes than other populations. Racial/ethnic minority LGB individuals are more likely to experience physical and mental heath problems and have higher rates of sexually transmitted diseases, certain cancers, depression, and substance abuse than heterosexuals and Caucasian LGB individuals. Three major factors are attributed to high risk for poor health outcomes among LGB of color: (1) the negative impact of discrimination on health and risk behavior; (2) racism and homophobia in health care and research settings; and (3) immigration experiences that may negatively affect health-care access and utilization (Wilson & Yoshikawa, 2007).

Spinks, Andrews, and Boyle (2000) reviewed micro- and macrolevel heterosexist barriers encountered by lesbians in health care. Macrolevel refers to heterosexual assumptions built into the structure of the health-care delivery, while

microlevel entails heterosexual assumptions in the personal interactions between lesbians and members of the health-care team. The latter serves to reinforce the former. *Macrolevel barriers* include preventive services structured around contraception and obstetrics, isolating lesbians from the health-care process. By assuming heterosexuality, the health-care provider misses an opportunity to discuss sexual practices relevant to providing appropriate care. Waiting rooms set the stage with heterosexist health brochures, reading material, advertisements, and posters. This is followed by intake forms that do not provide reasonable choices for lesbians with a partner; partners remain unidentified and unacknowledged if a lesbian client chooses "single," but choosing "married" often leads to queries about the husband's identity. Many hospital intensive care units allow only immediate family to visit patients. Partners are prevented from accompanying patients in an ambulance or obtaining information from hospital and health-care staff about their sick partners and are often denied the right to make health-related decisions without a durable power of attorney for health care.

Microlevel barriers include shock and unease by health-care providers when learning clients are not heterosexual, increasing unease and discomfort of the patient, and possibly denial of care. This attitude is a frequently cited reason for lesbians to delay seeking health care. Some lesbians feel more comfortable with female health-care providers, regardless of the provider's sexual orientation. Lack of understanding of lesbian health issues, combined with these barriers to the health-care system, places lesbians at an increased risk for undetected and untreated disease and also inhibits preventative services that decrease the risk of disease and enhance good health (Spinks et al., 2000).

Few studies have been conducted of bisexual women or included sufficient numbers of bisexual women to permit separate analyses. Combining data for bisexual women with lesbians implies an unproven assumption that they have more in common with lesbians than with heterosexual women (Beatty et al., 2006). As a result of these limitations, there is a lack of understanding among health-care professionals about the needs of bisexual women (Brotman et al., 2002).

Recommendations and Models to Improve Access to Care, Health, and Well-Being

Wilson and Yoshikawa (2007) suggest that institutional, community, and policy-level interventions are needed to improve access to health care by LGB of color. Institutional interventions include efforts to reduce the isolation of health-care programs from racial/ethnic minority LGB individuals, training of health-care providers to be culturally sensitive to racial/ethnic minority LGB needs, and promoting research on LGB populations in health-care settings. Community-level interventions should increase the comfort level for LGB of color to access the health-care system and trust in health-care professionals by incorporating racial/ethnic-centered models of health and increasing the number of racial/ethnic minority and LGB health-care professionals. Policy-level interventions are needed to reduce disparities in health

insurance access among LGB of color, thereby improving access to health prevention and treatment services (Wilson & Yoshikawa, 2007).

Although coping mechanisms and resiliency are important in dealing with racism (both structural and interpersonal) and homophobia, greater visibility of LGBs in the African-American community, particularly in churches, may help build tolerance and create a "network" for accessible social support and self-acceptance strategies. Stigma destroys the health and well-being of individuals and results in population-level health disparities. Initiatives to empower and strengthen physical, mental, and political health of African-American LGBs will also empower and strengthen *all* people, regardless of social, geographic, cultural, or political location (Battle & Crum, 2007).

Most health-related studies of LGBT Latinos have focused on HIV/AIDS and substance use without considering a comprehensive concept of their health-care needs. Interventions beyond just a discussion of cultural sensitivity and tolerance are needed to halt the stigmatization of nonconforming sexual and gender behavior among racial/ethnic minorities. Such interventions should address structural and institutional practices (e.g., education, media) as the source of stigma in labeling LGBTs and minorities as inferior citizens. Health research has in large part overlooked basic questions about the meanings of homosexuality, gayness, and race, and instead focused on ambiguous concepts, such as "gay men," "men who have sex with men," and "Latinos." This may entail closer work with the humanities and social sciences, embracing theoretical frameworks, rather than focusing exclusively on data (Ramirez-Valles, 2007).

Beatty et al. (2006) identified the following components of an approach to HIV prevention viewed by the LGBT population as inclusive and safe. Although suggested for use with alcohol drug treatment and prevention providers, they may be universally relevant to promoting access to LGBT health care in general. They advocate for (1) presentations by experts at meetings of LGBT organizations; (2) the placement of advertisements in LGBT periodicals; (3) the posting of information on LGBT web pages; (4) the tailoring of information to be culturally specific to the geographic area; (5) the inclusion in promotional materials of a nondiscrimination policy related specifically to sexual orientation and gender identity; (6) the establishment of a system for maintaining confidentiality of contracts and records; (7) the development of familiarity among health workers with appropriate LGBT health service providers and LGBT groups or organizations in the area that can provide information on specific treatment services, prevention, and medical contacts that are LGBT safe; (8) the development of research protocols that utilize both qualitative and quantitative methods; and (9) the identification of key figures in the LGBT community, who are willing to disseminate alcohol and drug abuse prevention information (Beatty et al., 2006).

A study by Stein and Bonuck (2001) examining physician–patient relationships in the lesbian and gay community highlighted the need to train medical students and clinicians to communicate better with patients and, as part of the patient history, to conduct an in-depth sexual and family history. As part of that history taking, they should be trained to consider issues related to sexual orientation and homophobia,

including identifying and confronting personal and institutional bias. This communication is essential to addressing LGBT health-care needs related to sexuality, sexual orientation, mental health, health-care planning and advance directives, and family relationships. Physicians who are reluctant to have these discussions place the burden on the patients to initiate these discussions. In these instances, LGBT individuals will need to be assertive with providers to assure that their health needs are addressed; those who are too fearful or uncomfortable to do so risk having unmet health needs (Stein & Bonuck, 2001).

Health-care professionals and other staff members need to be aware of their own homophobic feelings and consciously address them and dispel myths regarding lesbians. The health-care facility and providers must create an atmosphere of acceptance without judgment, where clients feel safe, comfortable, and respected. This can be accomplished through materials sensitive to lesbian clients in the waiting area; posing sensitive questions in an open and accepting manner; taking histories that do not assume heterosexuality, including a thorough sexual history to appropriately assess risk factors; asking clients to identify their immediate family, support person, or emergency contact; and determining whether a durable power of attorney for health care exists or whether there is a partner the client wishes to collaborate with regarding health-care decisions if the client becomes incapacitated and decisions regarding care must be made. Even so, some lesbian clients may be unwilling to disclose their sexual orientation, or provide varying degrees of disclosure, regardless of the environment for a variety of reasons. Placement of sensitive information in the medical record should either be optional or use sensitive documentation techniques. As an example, the record could state that the patient "lives with her female partner" or is "sexually active with female partner" rather than using words, such as *homosexual* or *lesbian*. Health-care professionals serving lesbians should be well versed in alternative therapies, such as alternative diets, meditation/relaxation, and low-cost natural alternatives preferred by some lesbians, ensuring health-care decisions are appropriate based on currently available knowledge (Spinks et al., 2000).

Participants in a study of lesbian couples during childbirth by Buchholz (2000) indicated the need for health-care providers to be sensitive, knowledgeable about lesbian sexuality and female gender, free of heterosexist assumptions, and able to use inclusive gender words. As more lesbians choose to have children by donor insemination, nurses previously educated to focus on a heterosexual model of family and reproduction need to examine their attitudes and develop inclusive and sensitive care for lesbians (Buchholz, 2000).

Given the likelihood of transgender individuals encountering negative health-care and treatment experiences, culturally sensitive health care for these individuals is urgently needed in both prevention and treatment. Guidelines were developed by The Transgender Substance Abuse Treatment Policy Group of the San Francisco Lesbian, Gay, Bisexual, and Transgender Task Force to enhance the capacity and ability of health-care providers to treat the health problems of transgender individuals with greater compassion and understanding. As outlined by Lombardi and

van Servellen (2000), these address both cultural sensitivity and specific program design for transgender individuals. *Cultural sensitivity* guidelines include acknowledgement of categorical social variation, including sexual orientation; freedom to define their own gender rather than imposing an identity; acknowledgement of risk for discrimination and violence in both public and private social settings; sensitivity training for governmental agencies; differentiation from gay men or lesbians (unless as appropriate to an individual's sexual orientation in their preferred gender); acknowledgement of variation between transgender individuals; and ensuring dignity and respect, addressing transgender individuals as the gender with which they identify. *Program design* recommendations encompass inclusion of transgender/gender identity in antidiscrimination policies; protection from forced disclosure of transgender status; no arbitrary dress codes when unnecessary; reasonable accommodations that preserve dignity and privacy in situations where a dress code is required; and no restrictions on access to public restrooms appropriate to a person's gender identity or some other reasonable accommodation. Therapy needs to address self-esteem related to appearance and self-perception; acceptance by self and family; employment- and workplace-related challenges; and discrimination and/or violence. Medical care should be offered in a safe, supportive environment, inclusive of access to hormones and sex reassignment surgery if desired. Housing services are required which acknowledge gender self-identity and provide a sense of safety. HIV/AIDS services need to consider transgender physiology and engagement in sex work. Guidelines for programs targeting transgender youth include discussion of identity and sexuality in the context of transgender issues; assistance with legal and medical procedures required to establish one's social gender; educational support services to prevent school drop out; and fostering peer support and role modeling.

To address the disparity of data related to LGBT and LBTTQ women populations, questions on sexual orientation and sexual identity need to be added to the large, national health-related surveys that assure anonymity, such as the National Health Interview Survey and National Household Survey on Drug Abuse, to provide a large enough population-based sample. To ensure the ability to compare across surveys, the questions need to be standardized and address both self-identity and sexual behavior to capture individuals who may not identify as LGBT. Alternative survey and assessment methods also need to be available to augment information and address gaps in the larger surveys (Ryan, Wortley, Easton, Pederson, & Greenwood, 2001). A 1999 report released by the Institute of Medicine recommended that increased research efforts be focused on lesbian health, with a particular emphasis on the development of more sophisticated methods; definitions of sexual orientation, including measures to reflect the diversity that exists within the lesbian community; barriers that reduce access to mental and physical health care; and mechanisms to increase lesbians' access to medical services (Spinks et al., 2000). Solarz (1999) suggested that research endeavors relating to lesbian health focus on the burden of disease, public health risk, theoretical approaches and frameworks, and the meaning of clinically significant conflicting findings.

Models to Improve Access

In the past several decades, community organizations, nonprofit special interest groups, for-profit commercial and media organizations, academia, clinicians, and government entities have all played a role in reducing health-care disparities. These entities have worked to create and support community outreach, LGBT-specific community health centers and education campaigns targeting both providers and individuals, and policies to support LGBT family units (Hernandez & Fultz, 2006).

LGBT community health centers have played a vital role in improving access to care and meeting health care needs for LGBT individuals, including LBTTQ women. Nine such centers exist in the United States, including Callen-Lorde in New York City; Whitman-Walker in Washington, D.C.; Howard Brown Health Center in Chicago; Fenway Community Health Center (FCHC) in Boston; and Mazzoni Center in Philadelphia (Hernandez & Fultz, 2006). The FHC model is briefly described below.

FCHC's mission is "to enhance the physical and mental health of the general community, with an emphasis on services for LGBT individuals" (Mayer et al., 2001, p. 892). FCHC was founded by Boston community activists in 1971 as a grassroots neighborhood clinic. Rapidly expanding its medical services in response to the AIDS epidemic beginning in the 1980s, FCHC's expertise and cultural competence in LGBT care led to opportunities to address broader community concerns, including substance abuse, parenting, domestic and homophobic violence, and specialized LGBT programs. As a model of comprehensive community-based LGBT health services integrated with other innovative and culturally specific programs, FCHC offers community education about specific LGBT health issues and, for other health-care providers and administrators, standards to address cultural competence for LGBT health care in their own practices (Mayer et al., 2001).

FCHC offers a continuum of health care and prevention services, including primary and specialty medical care (e.g., general outpatient care, HIV care, obstetrics, gynecology, gerontology, etc.); mental health and substance abuse treatment; a variety of complementary therapies; health promotion; community education; domestic and homophobic violence prevention; parenting; family planning; and community-based research. The agency has a professional educational program to train medical students, residents, social workers, mental health interns, nurses, and other health-care professionals. FCHC provides leadership in health policy advocacy and LGBT health-care coalitions, and its programs serve as models for culturally competent and clinically proficient LGBT care in other settings throughout the country (Mayer et al., 2001).

Another community-based model and leader in health care specific for women, including lesbians, the Feminist Women's Health Center (FWHC) in Atlanta takes a proactive role in delivering culturally appropriate care to lesbians. This is accomplished through vigilant staff recruitment, development, and continuing education, and through open communication between the health-care team and the lesbian community. Staff members routinely solicit the input of lesbian groups for information about the lesbian community and their needs, and waiting room literature

includes information on lesbian issues. To ensure a welcoming environment for lesbians, FWHC posts its policy of nondiscrimination in the window and throughout the building, ensures prospective staff members are informed of the nondiscriminatory policy prior to hiring, conducts monthly staff educational in-services and training on sensitivity, and discusses these issues at regular staff meetings. FWHC staff ask neutral questions in an open-ended manner to encourage lesbians or others to freely discuss their sexuality and related health concerns, although it remains the client's choice whether to document their sexual orientation. Same-sex partners are actively encouraged to participate. The nondiscriminatory and open atmosphere is designed to create a safe and understanding environment (Spinks et al., 2000).

Some local, regional, state, and national governmental agencies across the nation have engaged in public awareness campaigns or promoted and funded LGBT-specific research. Examples include the GLBT Health Access Project (http://www.glbthealth.org/) funded by the Massachusetts Department of Public Health in 1997 to eliminate barriers to health care, successfully developing standards for LGBT health-care and provider training programs; and the LGBT Health website (http://www.kingcounty.gov/healthServices/health/personal/glbt.aspx) maintained by the Public Health Department of King County, Washington, with local LGBT-specific resources, including substance abuse counseling, mental health services and resources for the transgender community, and educational material for health-care providers to create an LGBT-positive health-care environment (Hernandez & Fultz, 2006).

Recognizing the *Will and Grace* effect of increased LGBT visibility and exposure, some LGBT providers are helping "healthcare come out of the closet" through mentoring and support of other providers and lending expertise and services on LGBT issues to professional groups, such as the American Medical Association and the American Public Health Association. The LGBT Health, Education, and Research Trust (LGBT HEART) was created in 2004 to offer need- and merit-based scholarships to out LGBT students pursuing careers in the health sciences (Hernandez & Fultz, 2006).

Conclusions

Increasing pressure from LGBT communities, HIV/AIDS and racial/ethnic activist movements, and women's health movements on health-care policy makers, providers, and researchers has resulted in some improvements in the past several decades, but homophobic and heterosexist practices continue to marginalize many LGBT of color, including LBTTQ women of color. The fundamental correlation between disclosure of sexual orientation and/or gender identity to improved LGBT health and well-being has been well documented, as well as the importance of LGBT-positive health-care service environments to facilitate the coming out process (Brotman et al., 2002).

In a predominantly homophobic and heterosexist society and health-care environment, LGBT individuals who disclose their sexual orientation and/or gender identity still risk jeopardizing relationships, societal status, and health. The result

may be inappropriate physical and mental health treatment, stigma, and violence. Nondisclosure, on the other hand, can create barriers to access, negative impacts on the physical and mental health, and dissatisfaction with health care. Disability, health status, race/ethnicity, or socioeconomic status/class for LGBT individuals further complicate disclosure due to additional risks associated with multiple forms of oppression.

Health policy at both institutional and governmental levels is needed to facilitate the development of equitable and accessible health-care services, particularly in LGBT health where evidence of discriminatory attitudes and beliefs of health-care providers persists in spite of legal and social reforms. Policy makers and providers need to recognize the central issue and importance of coming out in formulating health-care policy and practice initiatives. A focus on social justice in health by local and federal governments is needed to foster the development of LGBT-positive health-care practice and promote health and well-being. This includes assisting institutions and health-care providers to develop training programs, guides, and other materials on LGBT health and health care. Initiatives must address systemic, institutional, and individual barriers to appropriate and sensitive care, including specialized services that respond to unique LGBT health and social service needs and create safe and healthy spaces to facilitate the coming out process in health-care settings (Brotman et al., 2002). An important step in this direction was the identification of LGB as one of the six populations with health disparities in *Healthy People 2010*, with several objectives specific to sexual orientation (Ryan et al., 2001).

As with interventions directed at other minority populations, programs that are culturally appropriate for LGBT individuals and LBTTQ women of color must be designed, implemented, and evaluated, and the information disseminated (Ryan et al., 2001). LBTTQ women of color will access routine care more easily when more accurate information is available and health-care providers' offices are more welcoming. Greater familiarity with LGBT individuals and LBTTQ women of color will hopefully lead legislators to vote to ensure equal civil rights for these populations, thereby reducing the homophobia and heterosexism. Reducing homophobia and heterosexism will lessen marginalization and health-care disparities of LGBT individuals and LBTTQ women and improve American public health (O'Hanlan & Isler, 2007).

Health-care providers must understand the barriers to health care for LGBT and LBTTQ women of color clients in order to provide culturally compatible care in a nondiscriminatory environment. To do this, they need to examine assumptions made both on a personal level and within the health-care system and communicate acceptance without judgment to improve trust and rapport. Education is vital to increase self and staff awareness of pertinent issues related to LGBT populations. These efforts will enable health-care professionals to promote health and prevent disease (Spinks et al., 2000).

> For the health needs of the LGBT community to be addressed in a comprehensive manner, clinical, administrative, academic, and policymaking sectors of healthcare must work in tandem, ensuring that needs are identified, research is undertaken, and best practice guidelines are developed. The entire process must be shared with providers on all levels, with

thoughtful input from representatives of the LGBT community and LGBT-focused health, community, and advocacy organizations (Hernandez & Fultz, 2006, p. 190).

Individual health-care practitioners must also strive to ensure LGBT-inclusive health-care setting by training staff to recognize LGBT-specific concerns and family units. Open and honest communication with patients, LGBT-sensitive intake forms, health education materials with information for LGBT patients, and waiting room reading materials and posters with LGBT-positive imagery all contribute to achieving this goal (Hernandez & Fultz, 2006).

Health-care advocates and policy analysts play a crucial role in holding all parties accountable, promoting increased education, and lobbying for legislation to protect LGBT and LBTTQ women's equity, health, and well-being. Most importantly, LGBT individuals and LBTTQ women of color must be supported to come out to their health-care providers and take an active role in their own health care (Hernandez & Fultz, 2006).

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Chapter 7
"No One Place to Call Home": Workplace and Community Safety Among Lesbian and Bisexual Women of Color

Tracy Jones and Earl Pike

"I find myself reluctant to 'talk race' because it hurts."
–bell hooks, 1995, p. 4

"Probably the most serious deterrent to Black lesbian activism is the closet itself."
–Barbara Smith, 1998, p. 171

Introduction

Research-based or narrative-informed discussion of the lives of minority women of nonheterosexual sexual orientation is severely limited by several significant realities. First, much of the research on topics germane to this chapter—work and vocational life and workplace inclusion and nondiscrimination; questions of home, residence, and travel or mobility as they relate to personal safety; rates and impacts of hate crimes and violence; and others—is based on sampling that includes, on the one hand, both nonheterosexual men and women and on the other hand, both European American and "minority" lesbian and bisexual women. Since race and gender, apart from sexual orientation, are significant factors in these and related discussions, general surveys of all lesbian, gay, bisexual and transgender (LGBT) persons or all lesbian/bisexual women may not reveal much about the particular experiences of those within larger samples who are not women or not European American.

Second, more specific research on, for example, employment issues for African-American women is often complicated by the difficulties in constructing an adequate sample size or finding research participants in the first place. Given that "outness" for a large number of minority lesbian and bisexual women is often still highly consequential on a number of levels (a subject discussed more at length later on), identifying and recruiting publicly self-identified minority lesbian and bisexual research participants can be a daunting task.

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And third, allowing for the reality that understanding a community's experience requires not only original research but also an understanding of the narratives (memoirs, histories, fiction, poetry, and other forms) generated by that community, we are left with the fact that the "narrative library," in this case, is small and of relatively recent publication. Researchers and those who would attempt to understand the lives of minority lesbian and bisexual women through community narratives have at their disposal only a small collection of published books and magazine articles to consult.

Conclusions, therefore, are difficult. Intuitive understandings suggest that minority lesbian and bisexual women will face greater difficulties related to employment, housing, threats of violence, and other issues, but that belief quite probably conflates too many identities. The research itself, even in its broader senses, is insufficient, sometimes contradictory, and entirely fluid law, public practice, and inter-/intrapersonal beliefs and attitudes have changed rapidly over the last two decades.

This chapter, then, reviews some of the available literature on employment, hate crimes, community acceptance, and related issues for minority lesbian and bisexual women, but with a full awareness of the aforementioned limitations. More importantly, it suggests a proposed agenda for research construction that can help correct those limitations in the future.

Identity

The Human Rights Campaign estimates that in the 2000 census, the gay and lesbian population of the United States constitutes 5% of the total US population, or 10,456,405 gay and lesbian persons in a population of slightly less than 210 million people over the age of 18 (Smith & Gates, 2001). This is a reasonably accurate estimate of overall numbers; about diversity within the whole, however, we know far less. Greene (2002), for example, estimates that 1.8 million African-American women in the United States could be identified as lesbian, but her conjecture is based on undefined population estimates. The actual number could be significantly larger or smaller, since "sexual orientation" as a fixed identity is sometimes elusive or fluid:

> Sexual orientation is a complex construct in which the dimensions of sexual identity (I am a Lesbian), sexual behavior (I have sex with women), sexual desire (I am attracted to women), and community belongingness and involvement (I am a member of the lesbian community) are all involved. These dimensions may or may not be congruent with each other (Patterson, 1997, p. 3).

To those dimensions, in the present discussion, we must add race and ethnicity, and gender—as well as a number of other potentially relevant modifiers. Such complexity argues vigorously against any tendency to essentialize personhood or

aspects of personhood based on a partial list of identities. And while some writers have argued that sexual orientation often trumps other simultaneous identities—

> An important concept for understanding sexual prejudice is the idea of a *master status*. Western societies have adopted sexual orientation as a characteristic of great importance. As a result, homosexuality and bisexuality have been defined as an overarching master status that takes precedence over everything else about an individual, so that even gender, race, and age become subordinate to the person's sexual orientation (Garnets & Kimmel, 2003, p. 149)

—others have argued against such attempts of prioritization:

> Because African American lesbian and bisexual women have multiple identities, we cannot make arbitrary assumptions about which of those identities is most salient to a given individual (Greene, 2001, p. 2).

Addressing the multiple identities of many lesbian and bisexual women of color, Carla Trujillo extends DuBois' (1987) the concept of "double consciousness" in the case of African-American LGBT persons and suggests that "triple consciousness" is a more accurate description (Trujillo, 1997). For Trujillo, triple consciousness means individuals must contend with "what society thinks of us," "how we think of ourselves," and "how we think of ourselves in response to what society thinks of us"—often, at the same time, and within the same situation (Trujillo, 1997, pp. 271–272). Employing similar language, Greene (1995, 1998, 2000a) has written extensively of the "triple jeopardy" that lesbians of color experience, as have Hughes and colleagues:

> Racism and sexism are persistent, pernicious conditions from which Americans continue to suffer. For lesbians, heterosexism compounds racism and sexism to triply oppress African American lesbians (Hughes, Matthews, Razzano, & Aranda, 2003, p. 52).

In personal practice, the reality of colliding or congruent identities—and how individuals subsequently define themselves and negotiate those definitions in relation to others—will vary significantly across various borderlands of race, ethnicity, language, and culture. Hughes and colleagues (2003, p. 66), for example, suggest that "Many African American lesbians view race as a primary personal characteristic and sexual identity as secondary. Race often serves as a proxy for the influences of biology, culture, socioeconomic status, and exposure to racism," suggesting that for African-American LGBT persons, race—to borrow the language of Garnets and Kimmel (2003)—serves as a "master narrative" for identity. But Chan (1989) found that most Asian-American lesbians and gay men identified primarily as lesbians and gay men, rather than as Asian American, and noted in an earlier study that among Asian Americans, gay/lesbian self-disclosure may be viewed as a threat to continuation of family lines and a violation of appropriate cultural roles. (It is worth noting that it was only in 2001 that the Chinese Psychiatric Association decided—after pressure from mental health and human rights activists from around the world—to remove homosexuality from the Chinese Classification of Mental Disorders.) And, as Espín (1987) and Hildago (1984) have noted, declaring gay or lesbian identity within Latino families or communities may be viewed as an act of interpersonal and

cultural treason. As one Mexican American lesbian put it, "[I have] felt like . . . a traitor to my race when I acknowledge my love for women. I have felt like I've bought into the White 'disease' of lesbianism" (Rust, 2003, p. 232).

In human terms, shifting primacy of "self" within multiple identities—and the need to strategically deploy specific identities based on social context—can create a personal sense of homelessness. As Croom (2000, p. 265) has indicated, "The LGB person of color may be left with a sense of having no one place to call home, where both their ethnicity and sexual orientation can be treated with respect and accepted." Sadie, an African-American lesbian, succinctly described the management of identity prisms, "I had my work world; I had my social world; I had my other world. And [they] didn't cross over" (Mays, Cochran, & Rhue, 1993, p. 11). To closely paraphrase a conclusion that the authors have heard often here in Cleveland, Ohio, over the years, "Cleveland is a town where you *can* be Black and gay—but *not* at the same time, in the same place."

Recognition of the existential homelessness many lesbian and bisexual women of color face is crucial to an understanding of specific challenges related to employment, discrimination, and community acceptance discussed below. Simply put, when identity is multiple and fluid, and one is attacked, it is often difficult to respond because the basis and motivation for the attack is often difficult to discern. In a study of stress and resilience among African-American lesbians, for example, Bowleg, Huang, Brooks, Black, & Burkholder (2003) noted that 21% of the respondents reported that it was equally stressful *not knowing* whether an experience of prejudice or discrimination was based on race, gender, sexual orientation, or some combination of the three identities. In that study, in particular, the workplace emerged as a primary zone of such ambiguity.

Work and Employment/Vocational Life

Van Hoye and Lievens (2003) have noted three research streams in the literature about sexual orientation in the workplace. The first "examines on a general level the discrimination and minority status experienced by gay, lesbian, and bisexual people in the workplace." A second addresses the issues of coming out at work. And a third "pertains to the specific work-related problems of gay, lesbian, and bisexual employees (as opposed to the general and broad-mazed studies of the first research stream)." But, they add, "empirical research about sexual orientation in the workplace is still scarce."

In more recent years, however, a growing and consistent body of evidence has accumulated establishing that sexual orientation discrimination in the workplace is both common and has a negative impact on both employees and employers (American Psychological Association, 2002). The reality of discrimination holds true not merely in traditional workplace settings, but in highly educated and seemingly "liberal" settings as well (Croteau & von Destinon, 1994; Schaltz & O'Hanlan, 1994). According to a recent poll by *The Advocate*, nearly half (49%) of

gay, lesbian, and bisexual respondents reported having been discriminated against at work because of sexual orientation, and nearly one-third of all adults were aware that such discrimination took place (*The Advocate*, 2002).

Outright discrimination, as Van Hoye and Lievens (2003) have pointed out, is only part of the overall picture. It may be, in fact, at least partially accurate to propose that an overt act of LGBT discrimination in the workplace is a *concluding* act that is preceded by the ubiquitous effects of internalized homophobia, outright employer discrimination, and the long and multiply mediated effects of workplace culture. Belz (1993), for example, has suggested that tensions related to employment and sexual orientation may begin long before the actual job seeking takes place, in that attention to career exploration and development tasks may compete, among LGBT adolescents, with the process of coming out. In a similar vein, Hetherington (1991, p. 134) theorized that "during the early stages [of sexual identity development], a bottleneck effect may disallow career exploration" because psychological resources are more widely dispersed. And Nauta, Saucier, and Woodard (2001) have noted the importance of role model support and guidance to career development in lesbian, gay, and bisexual individuals—suggesting that the lack of such support may internally delimit vocational expectations and aspirations among LGBT adolescents. These and similar conflicts may be true throughout the high school and, for some, college period (Schmidt & Nilsson, 2006).

Even after successfully obtaining employment, tensions related to sexual orientation and real/perceived discrimination persist. Gay, lesbian, and bisexual individuals who report higher levels of perceived discrimination based on sexual orientation are, for example, more likely to have negative work attitudes and fewer work promotions (Ragins & Cornwell, 2001). And lesbians, specifically, often face more barriers than heterosexual women as they work to realize career goals and often experience a more lengthy and circuitous career path (Boatwright, Gilbert, Taylor, & Ketzenberger, 1996). In addition, there are likely to be gender and sexual orientation-based disparities in earning power and benefits. While women continue to earn less than their male counterparts, lesbian women report even more comparatively diminished earnings, at 5 to 14% less than the national average for women (Badegtt, 1995). One of the rare studies that specifically analyzed lesbian and bisexual women of color as a discreet subset of a larger study found that lesbian and bisexual women of color had higher rates of full-time employment than counterpart heterosexual women, but were less likely to have access to health insurance through a spouse or relationship partner (Mays, Yancey, Cochran, Weber, & Fielding, 2002). Being "different" than the socially accepted "norm" (however unstable the concept of "norm" is rapidly becoming) remains, from the perspective of employment success, an enduring obstacle. As H. Alexander Robinson, executive director and CEO of the National Black Justice Coalition (an organization that supports African-American LGBT people) put it, "African Americans often cite that one of the barriers to advancement is having divergent cultural norms from their white peers" (Quoted in Harris, 2007).

A continuing frustration with the literature to date is the lack of targeted studies focused on work and vocation issues of lesbian and bisexual *women of color*, as

opposed to nonheterosexual men and women *in general*. The aforementioned literature points to issues and challenges, but does not define them well. The conflation of race, gender, class, sexual orientation, and diversity of sexual expression into a single categorical "gay" identity as it relates to employment makes it nearly impossible to judge, for both individuals and groups of people in workplaces and communities, the precise or even general nature of the tension or form of discrimination that may be taking place.

It is also worth noting that absent from nearly all research on employment and lesbian/bisexual women of color is the role of the military as a significant employer in the United States—especially since African Americans and Latino(a)s still enlist at a higher rate than Whites. Current estimates indicate that there are more than 36,000 gay men and lesbians serving in the US Armed Forces (The Urban Institute, 2008). Recent reports indicate that military *women* are much more likely to be discharged under current "Don't Ask, Don't Tell" policy than military *men* (The Urban Institute, 2008). While women make up 14% of Army personnel, 46% of those discharged under the policy in 2007 were women (Shanker, 2008). This underscores once again that generalizing the experience of all LGBT persons in relation to employment experience is highly problematic.

There are valid arguments to be made that protection from workplace discrimination is legally prohibited for many more people, in many more areas, than was the case even a decade ago. Leonard (2003, p. 14) notes that, based on the 2000 census,

> approximately 95 million people live in states that ban sexual orientation discrimination in employment . . . This accounts for about one-third of the population. If one adds population for cities and counties that ban such discrimination in states that lack such laws, it is likely that a majority of the population is governed by sexual orientation non-discrimination principles.

But once again, whether those protections have been equally secured for all LGBT persons cannot be adequately answered. Success for the gay community does not automatically constitute a success for the Black gay community (Harris, 2007).

Vulnerability to real and perceived workplace discrimination may be amplified by female gender, non-White race, or other factors. In general, research involving LGBT persons has been more successful in recruiting participants from limited segments of the White community; persons of color are rarely included (Croom, 2000). "Rarely included" can easily become "almost never" in the case of research on more specialized topics of concern, such as employment.

Knowing that a wide variety of internal and external factors are likely to influence employment and vocational success and satisfaction for lesbian and bisexual women of color, but that precious little data inform our understanding of the relevant issues, how are LBT women of color coping?

Croteau (1996) described four ways in which lesbians and gay men manage their identity in the workplace: *passing*, in which the individual lies or actively evades or avoids in order to be viewed as heterosexual; *covering*, or withholding information; implicit disclosure, in which the individual employs explicit language and symbols to indicate sexual orientation; and *affirming identity*, in which the individual

actively encourages others to view him/her as lesbian or gay. The framework is, at least initially, useful. If gender and race are assumed as mediating or amplifying factors, then we can reasonably hypothesize that among LGBT men and women in the United States, coping strategies will vary by race and gender, and that, all other things being equal, lesbian and bisexual women of color are less likely to cope by "affirming identity" than their male and White counterparts. At the very least, such a framework provides a useful context for further research; such comparisons, analyzed by race and gender, are urgently needed and will tell us a great deal about the practical, lived experience of lesbian and bisexual women of color.

Safe in the Community: Hate Crimes and Violence

When we confront the reality of hate crimes and violence directed toward lesbian and bisexual women of color in the United States, we are again faced by the lack of specific data. Of the fact that hate crimes and violence against LGBT persons exists, there can be little doubt. Research related to siblings provides clear evidence that gay, lesbian, and bisexual persons are more likely to report higher levels of overall lifetime victimization than their heterosexual siblings (Balsam, Rothblum, & Beauchaine, 2005). Herek, Gillis, and Cogan (1999) reported that of almost 2000 gay, lesbian, and bisexual individuals surveyed, one-fifth of the women and one-fourth of the men reported being the victim of a hate crime since the age of 16. More than one-half reported antigay verbal threats and harassment in the year before the survey.

The reality of hate crimes and anti-LGBT violence is well established, even as far-right conservative opposition to hate crimes legislation that includes sexual orientation and sexual identity remains vocal. As an example of far-right denialism of anti-LGBT bias, consider this passage from a website established by the organization Mission America:

> The new proposal [for hate crimes legislation] is based on the lie that homosexuals are an unchanging minority who are 'born that way,' which is not supportable by research or observed sexual practices. It also threatens the religious liberty of those who believe this is a harmful and sinful lifestyle, and want to continue to warn and help those involved, without being accused of 'inciting violence' or similar nonsense (Mission America, 2008).

More precise data on hate crimes and violence, as they pertain to lesbian and bisexual women of color, are vital because of the presumption—which may or may not be empirically true—that homophobia is more prevalent in African-American and Hispanic/Latino(a) communities. Kennamer, Honnold, Bradford, and Hendricks (2000, p. 522), for example, have concluded that "homophobia is a major part of the African American culture, driven by both religious forces and political forces." But "homophobia" cannot be adequately assessed by a single act or process, and it may be just as true that it simply manifests in different ways in different communities.

Some data, however limited, are available. A 1997 study found that over a third of gay, lesbian, and bisexual African Americans reported experiencing discrimination based on sexual orientation (Krieger & Sidney, 1997). In a much more recent survey of 860 lesbian, gay, bisexual, and transgender Asian and Pacific Islander Americans conducted by the National Gay and Lesbian Task Force, 98% reported some form of discrimination and/or harassment in their lives. Approximately three-quarters of the respondents (77%) experienced verbal harassment at least one time in their lives for being Asian/Pacific Islander or for being LGBT (74%). Nearly 1 in 5 (19%) reported physical harassment for being Asian/Pacific Islander, and 16% reported physical harassment for being LGBT. Eight-nine percent agreed or strongly agreed with the statement that "Homophobia and/or transphobia is a problem within the API [Asian/Pacific Islander] community," and 78% agreed or strongly agreed with the statement that "LGBT APIs experience racism/ethnic insensitivity within the white LGBT community" (Dand & Vianney, 2007).

Expansion of legal sanctions against LGBT hate crimes has broadened the umbrella of protection for LGBT persons in the United States overall in recent years (Yoshino, 2007). As of May 2007, hate crime laws in over 30 states covered crimes based on sexual orientation. In 10 states, hate crime laws cover gender identity or expression as well (Yoshino, 2007). However, the extent to which those laws have benefited LGBT individuals by *race* and *gender* is not generally known. More sensitive analysis, again, is required.

Safe in the Culture

If cultural communities provide zones of safety that allow racial minorities to negotiate—and at times, flee from—oppressive and discriminatory aspects of dominant culture, then the question of "safety" for lesbian and bisexual women of color can become particularly precarious. An earlier citation, in which a Latina lesbian struggles with a sense of being "a traitor to my race when I acknowledge my love for women," captures the conflict poignantly (Rust, 2003, p. 232). As Greene observed (2000b, p. 28),

> Because family and community are important buffers against racism and sources of tangible support, the homophobia in these communities [African American and Latino/a] often leaves lesbians and gay men of color feeling vulnerable and less likely to be out in the same ways as their White counterparts.

This represents a profound and potentially immobilizing tension, one that deserves to be much better narrated and understood.

Resistance and Visibility

Even within histories of lesbian organizing and rejection of both legal discrimination and psychological and cultural pathologizing, the role of lesbian and bisexual women of color is largely obscured: few know, for example, that Black lesbian Cleo Bonner was one of the initial national presidents of one of the first national lesbian

organizations, the Daughters of Bilitis (DOB), serving in that role from 1963 to 1966; or that Ernestine Eckstein, an African-American lesbian from New York, was one of the first lesbians to allow herself to be photographed for the cover of a magazine in which she was identified as a lesbian—the DOB's magazine *The Ladder*, in the summer of 1966 (Gallo, 2006).

Reclamation of such history is essential to the processes of identity articulation and assertion across cultural spheres. African-American lesbian activist Smith (1998) has stressed the importance for lesbians and gay men of speaking out; a failure to do so essentially leads to an assumption that the individuals are heterosexual, and thereby effaces LGBT identity. Critical to a better understanding of the lived experience and aspirations of lesbian and bisexual women of color is not merely the experience of discrimination and victimization in relation to employment, violence, and other issues, but an understanding, at the same time, of the ways in which individuals utilize their past experiences with oppression as a springboard from which they develop resources and resiliencies (Greene, 1994).

Cohler and Hammack (2007) have noted two competing narratives in the literature on adjustment and normality for, specifically, sexual minority youth. The first, which they term the "narrative of struggle and success," generally frames gay youth as victims of discrimination and harassment, with subsequent experiences of depression and anxiety, followed by "success" as realized through social practice in the larger LGBT community. The second and more recent narrative, the "narrative of emancipation," notes the fluidity of self-labeling among sexual minority youth, depathologizes sexual minority identity development and extends the notion of normality to embrace LGBT youth (Cohler & Hammack, 2007). While "struggle and success" remain critical features of the life trajectory for many LGBT persons, Cohler and Hammack's "narrative of emancipation" might find more resonance for some minority lesbian and bisexual women, in that it emphasizes both agency and a life-course framework, and the individual's capacity for resilience:

> The narrative of emancipation suggests that same-sex desire need not be the primary index of identity, the anchor of personal narrative. Rather, individuals with same-sex desire can lead lives very similar to heterosexuals; they need not be promiscuous, get AIDS, and live in a ghetto; they can even get married (Cohler & Hammack, 2007, p. 54).

While implied aspirations of mainstream "normalcy" embedded in phrases, such as "need not be promiscuous," may be relevant to some and not to others, and are certainly ideologically contestable, the basic framework of polar narratives is nevertheless rich in analytical possibilities, and not only permits a fuller, more human understanding of lesbian and bisexual women of color and their lived experiences, but also points the way, as well, to the promotion of learnable strategies for self-preservation, survival, integrated self-assertion, and "success" in workplaces and other mainstream or shared venues and contexts. Ignoring reliance and individual/cultural survival may have the potential, in the end, of re-victimizing lesbian and bisexual women of color by encoding, within the parameters of research language, only narratives of subjugation, thereby reducing the lives of lesbian and bisexual women of color to a unidimensional portrait devoid of the actor and agency.

Research

What is most needed now is an articulate analytical and research agenda, one that resists conflation of multiple identities and which frames questions that are of specific, cultural relevance to lesbian and bisexual women of color. We make several recommendations to guide the interpretation of current research and to guide the formation of a new agenda.

1. Researchers and analysts should resist conflation of identities (sexual orientation, race and ethnicity, and gender) and interrogate current research through the lenses of race and gender. A healthy suspicion about whether large-scale studies of lesbians and gay men on any particular issue can result in meaningful conclusions about the "invisible" (nondelineated) lesbian and bisexual women of color within such studies is not simply warranted, but professionally responsible as well.
2. We should form precise research questions for clearly delineated communities and populations. Questions about the employment experience of African-American lesbians, for example, or Native American bisexual women's experience with violence and hate crimes can only be answered responsibly if the research populations are carefully described.
3. As a general (and admittedly highly complicating) rule, research should accept that assumptions about identity as a fixed and stable construction are highly problematic, especially when identity is mediated by multiple factors, such as race and gender. This point seems to contradict, at least on some level, the notion of clearly delineated research populations; it is, nevertheless, true, and must be accounted for. At the very least, researchers must accept the varying ways in which individuals prioritize personal identities and the labels and descriptors they attach to identity.
4. If the research community is to adequately address one of the problems identified at the beginning of this chapter—the difficulties of recruiting research participants for studies addressing lesbian and bisexual women of color—then one possible solution is to more vigorously recruit lesbian and bisexual women of color as professional researchers, and to provide them with the tools, resources, and publication opportunities they need to carry out and highlight their work. All other things being equal, potential research participants will be more likely to enroll in studies if there is a perception that the researchers involved are "safe" and culturally known to the participants.
5. In the relative absence of a large body of research texts that resist conflation, that recognize and affirm the fluidity of identity, and carefully delineate research communities and research questions, it is not inappropriate to consider mining more deeply, with a researcher's attempted objectivity, nonresearch texts, such as fiction, poetry, plays, memoirs, and essays that address the experience of lesbian and bisexual women of color in relation to employment, violence, community, or any number of other issues. Examples of works that are not based on primary research, but nevertheless narrate the experiences of LGBT people of color,

include Beam's *In the Life* (1986), Hemphill's (Ed.) *Brother to Brother* (1991), Lim-Hing's (Ed.) *The Very Inside: An Anthology of Asian and Pacific Islander Lesbian and Bisexual Women* (1994), Lorde's *Sister/Outsider* (1984), Mason-John's (Ed.) *Talking Black: Lesbians of African and Asian Descent Speak Out*, Moraga's *Loving in the Wars Years: Lo que nunca pasó por sus labios* (1983), Ratti's (Ed.) *A Lotus of Another Color: The Unfolding of the of the South Asian Gay and Lesbian Experience* (1993), Roscoe's (Ed.) *Living in the Spirit: A Gay American Indian Anthology* (1988), Saikaku's *The Great Mirror of Male Love* (1990), Silvera's (Ed.) *Piece of My Heart: A Lesbian of Color Anthology* (1991), Trujillo's (Ed.) *Chicana Lesbians: The Girls Our Mothers Warned Us About* (1991), and many others. Some of these works have become nearly canonic within the cultures of lesbian and bisexual women of color, shared among friends and within communities; they are rich sources of resonant narrative and narrative fields, within which research questions of the future can be explored.

Clearly, more—and better—research is needed. Unfortunately, the realities of sexism, heterosexism, homophobia, class, and race de-prioritize such research. As Smith (1998, p. 118) has written, "Racism in the lesbian, gay and women's movements and sexism and heterosexism among people of color are the 'last straws,' which we nevertheless confront again and again."

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Chapter 8
Religion, Spirituality, and Nonheterosexual-Identified Minority Women

Sana Loue

Introduction

Religion and spirituality are important dimensions of human existence. It has been asserted that it is spirituality that makes us human (Helminiak, 1996). Both religious practice and spirituality have been found to be associated with psychological well-being (Bergin, Masters, & Richards, 1987; George, Larson, Koenig, & McCullough, 2000; Levin, Markides, & Ray, 1996).

Although the concepts of religiosity and spirituality have often been used interchangeably in the context of research (O'Neill & Kenny, 1998), it is important to distinguish between the two. When distinctions have been made, there has been tremendous variability across studies with respect to the definitions that have been used. Studies have conceived of spirituality as a focus on God or other power that guides the universe, faith in mystical or transcendental experiences, and/or adherence to certain moral values and belief about relationships with people and a higher power (Mathew, Georgi, Wilson, & Mathew, 1996; Warfield & Goldstein, 1996). Spirituality has been defined as "a basic aspect of human existence . . . [encompassing] human activities of moral decision making, searching for a sense of meaning and purpose in life, and striving for mutually fulfilling relationships among individuals, society and ultimate reality. . ."(Canda, 1988, p. 238); "one's personalized experience . . . pertaining to a sense of worth, meaning, vitality, and connectedness to others and the universe" (Titone, 1991, p. 8); and "a striving for and infusion with the reality of the interconnectedness among self, other people, and the Infinite/Divine" (Ingersoll, 1994, p.102). Religion has been said to represent "the external expression of faith . . . comprised of beliefs, ethical codes, and worship practices that unite an individual with a moral community" (Joseph, 1988, p. 444). Spirituality and religion have been viewed as two dimensions of the same construct, with spirituality representing the inward, individual experience and religion its external manifestation (Fowler, 1981).

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Research findings suggest that, as is the case among sexual majority populations, religion or spirituality may be an important aspect of the lives of many sexual minority women. Results from a survey of 648 US readers of lesbian and gay publications indicated that 94% of the respondents had been raised in a religious Christian or Jewish household (Lee & Busto, 1991). In yet another study, researchers found that approximately one-third of 1925 lesbian participants maintained a current religious affiliation and 92% reported having been raised with a connection to a religious community (Bradford, Ryan, & Rothblum, 1994).

Organized Religion and Views of Minority Sexual Identity

Notwithstanding the apparent importance of religion and spirituality in the lives of women who are sexual minorities, Western religions and those that are monotheistic have been alleged to be generally intolerant of both homosexuality and homosexual behavior (Davidson, 2000; Lynch, 1996). Both Orthodox Judaism and Roman Catholicism view homosexual behavior as a sin (Nugent & Gramick, 1989; Schnoor, 2006; Umansky, 1997), while homosexual relations by a member of the Church of Latter Day Saints are punishable by excommunication (Schow, 1997). Many Islam-based societies and most multifaith regions with large Muslim populations penalize homosexual acts with severe physical punishment that, in its extreme, may include death (Brown, 2006). Various Buddhist texts have been interpreted as proscribing same-sex partner sexual relations (Jackson, 1995). A majority of Christian faiths continue to prohibit the ordination of gay, lesbian, and bisexual individuals, as well as marriage between two individuals of the same sex (Clark, Brown, & Hochstein, 1990), while Buddhism prohibits monks from engaging in all sexual relations (Corless, 2004).

However, the views of even Western monotheistic faiths (Murray & Roscoe, 1997) and those of some non-Western traditions (Corless, 2004; Jackson, 1995) are considerably more nuanced and complex than is often believed. Scholars have delineated four general approaches of religious communities/denominations to homosexuality, reflecting a more nuanced approach: Rejecting-Punitive, Rejecting-Nonpunitive, Qualified Acceptance, and Full Acceptance (Nugent & Gramick, 1989). It is important to note that the perspective of a specific religious community or denomination may vary across sexual minorities, chronological era, and geographic locale. For instance, attitudes toward self-identified lesbians may or may not be similar to those displayed toward male-to-female transsexuals.

The Rejecting-Punitive approach rejects both homosexual orientation and expression as evil and prohibited by religious doctrine. In contrast, the Rejecting-Nonpunitive perspective rejects the behavior, but not the person or his/her orientation. The Qualified Acceptance approach views homosexuality as acceptable but inferior to heterosexuality, while Full Acceptance recognizes equality between heterosexuality and homosexuality (Nugent & Gramick, 1989).

As one example of both a more nuanced approach and how a church's stance toward homosexuality may change over time, consider the views of the Roman

Catholic Church toward homosexuality. Traditionally, the Roman Catholic Church has condemned homosexuality, which it defines as "relations between men or between women who experience an exclusive or predominant sexual attraction toward persons of the same sex" (Catechism, 1995, §2357). Accordingly, sexual relations between persons of the same sex have been viewed as a sin, i.e., "humanity's rejection of God, and opposition to him" (Catechism, 1995, §386), and those who engaged in this behavior as sinners. This position derives from Sacred Scripture, most notably relevant portions of Genesis and Leviticus in the Old Testament of the Bible and Pauline passages found in Romans, Corinthians, and Timothy; Church tradition; and Catholic theology stemming from Thomas Aquinas' natural law perspective of sexual morality (Boswell, 1980; Westerfelhaus, 1998; cf. Hays, 1994). (The legitimacy of these interpretations as prohibitive of homosexuality has been subject to serious questioning. See, for instance, McNeill, 1994; Nelson, 1994). Aquinas' view has been explained as follows:

> [A] moral act is one consonant with right reason. Since procreation was the proper end of all venereal acts, signifying that coitus was necessary between man and woman, homosexual acts were *contra naturam*, by definition, and inconsistent with right reason. This right reason, though, would also include the problem arising where venereal pleasures between man and woman resulted in premature ejaculation, thus the meaning of the sexual act can be unnatural, lustful, and sinful with heterosexuals and homosexuals, depending on the act. Therefore a person can understandably have homosexual regards for another ... as one Christian might have for another in the love of Christ—but not when it leads to the attainment of forbidden pleasures (Carey, 1992, p. 111).

It has been argued that this position of the Roman Catholic Church has softened significantly since the Second Vatican Council, convened in 1962 by Pope John XXIII and concluded in 1965 under Pope Paul VI, through the adoption of a dual rhetoric in lieu of the previous singular one (Westerfelhaus, 1998). This dual rhetoric, consisting of a moral rhetoric and a pastoral rhetoric, apparently derives from a willingness to distinguish between the act (sexual act), agent (individual homosexual), scene (the physical location at which the act occurs), agency (the mechanism for the sex, such as the penis), and purpose (according to the Church, the expression of misguided love or selfishness) (Westerfelhaus, 1998). The moral rhetoric reflects the Church's position that the act of homosexual sex constitutes a sin, but that pastoral care within the teachings of the Church is to be provided to homosexual members (Cardinal Joseph Ratzinger, 1986) and followers are to accept the homosexual "with respect, compassion, and sensitivity" (Catechism, 1995, §2358). This message is reflected in the exhortation from bishops to clergy to "welcome homosexual persons into the faith community and seek out those on the margins. Avoid stereotyping and condemning" (National Conference of Catholic Bishops, 1997, p. 8).

Other faiths have adopted a similar approach. The United Methodist Church, for instance, has declared that "Homosexual persons no less than heterosexual persons are individuals of sacred worth," but also maintains that the "practice of homosexuality" is not to be condoned and is to be considered "incompatible with Christian teaching"(United Methodist Church, 2004, ¶5).

Empirical research further underscores the need to examine in a more nuanced and balanced manner the perspectives of churches and their clergy with respect to nonheterosexuality and nonheterosexuals. A survey conducted with 1458 clergy from 32 different denominations, including some who were primarily African American, and 53 other religious leaders revealed a diversity of beliefs and attitudes. Two-thirds of the respondents believed that sexual orientation is "largely a matter of biology" and almost two-thirds believed that it is not possible for individuals to change their sexual orientation (Clapp, 2007, p. 28). Although 56% of the clergy indicated that the Old Testament clearly prohibits homosexuality, 59% believed that those passages are not "binding on behavior today" (Clapp, 2007, p. 34). Further, 86% agreed with the statement, "The parable of the Good Samaritan stands as a reminder that homosexual persons are our neighbors and should be treated with love and respect" (Clapp, 2007, p. 34). While 21% disagreed or strongly disagreed that gays and lesbians would be welcomed and accepted in their congregations, 41% agreed or strongly agreed that they would find welcome and acceptance in the absence of any imposed conditions, such as involuntary celibacy or mandated efforts to become heterosexual.

An interview-based study involving 62 Protestant clergy of diverse denominations across the United States found that clergy who framed the discussion in abstract terms of homosexuality were less welcoming than those who spoke about homosexual people (Olson & Cadge, 2002). The authors of the study concluded:

> [A]ll but one of the seven United Church of Christ ministers in the sample discussed "gay and lesbian people" . . . "gay and lesbian folk" . . ., or the "place of gays and lesbians in the community" . . . The American Baptist clergy, on the other hand, spoke more vaguely and abstractly about "homosexuality . . .," "homosexual churches . . .," or the "homosexual issues" . . .. Differences in how United Church of Christ and American Baptist clergy talk about sexuality and homosexuality suggest, tentatively, that clergy in progressive denominations such as the UCC that welcome homosexual people into all aspects of church life (including ordination and marriage) are more likely to talk about homosexual *people* than are clergy in denominations such as the American Baptist Churches, which consider homosexuality incompatible with Christian teachings (Olson & Cadge, 2002, p. 164, italics in original).

Nevertheless, researchers have found that the distinction between the person and the behavior may not necessarily produce greater understanding or compassion. A study conducted with 155 undergraduate students at a Christian university found that those students who emphasized the person-behavior distinction held more negative views toward lesbian women and more accepting attitudes toward gay men (Rosik, Griffith, & Cruz, 2007). Additionally, increased frequency of church attendance and higher levels of religiosity have been found to be associated with higher levels of condemnation and disapproval of homosexuality (Olson, Cadge, & Harrison, 2006; Robinson, Gibson-Beverly, & Schwartz, 2004; Scott, 1998). These findings may be explainable, at least in part, by the distinction between intrinsic and extrinsic faith. Intrinsic faith, which is the conceptualization of religion as the central organizing value of an individual's life, has been found to be associated with increased levels of homophobia and restricted sexuality (Allport & Ross, 1967; Herek, 1987, 1994;

Rowatt & Schmitt, 2003; Wilkinson, 2004). In contrast, extrinsic faith, which serves other personal or social goals, has been linked with both homophobia and racial prejudice.

It is important to recognize that the official views of a denomination or Church may not reflect the views of the Church's individual members or of individuals who self-identify as practitioners or believers of that faith. Another study focusing on 2400 clergy and 1600 congregants in two mainline Protestant denominations, the Evangelical Lutheran Church in America (ELCA) and the Episcopal Church (EC), reported significant variation among both the clergy and the congregants (Djupe, Olson, & Gilbert, 2006). Among ELCA respondents, 82.8% of the surveyed clergy agreed or strongly agreed with the statement, "Homosexuals should have all the same rights and privileges as other American citizens," compared with 47.9% of ELCA Church members. Among respondents from the EC, 86.6% of clergy agreed or strongly agreed with the same statement, compared with 74.1% of Church congregants. Clergy appeared to greatly underestimate the extent of members' support of gays and lesbians. ELCA clergy believed that only 32% of their congregants would support such a statement, in comparison with the almost 50% that did. Similar underestimation occurred among EC clergy (Djupe et al., 2006).

This dissonance in values is evident not only in the struggle of individuals, churches, and entire denominations to achieve consensus with respect to their level of recognition or acceptance of homosexual orientation and sexual minority individuals as congregants and participants in all aspects of lay religious life, but also in debates surrounding the ordination of sexual minority persons (Goodstein, 2006; Grossman, 2006). Some scholars have advocated for the ordination of homosexual clergy only on condition of complete celibacy, a condition not imposed on their heterosexual colleagues (Hays, 1994). In the midst of such congregational and churchwise debates and angst, some clergy have hidden their identity in an effort to retain their posts, while others have been removed from their Church's clergy roster once their same-sex partner relationships became known (Hill, 2001). These outcomes not only reflect the deep rifts in congregations and Churches, but further accentuate the schism that already exists (Ullestad, Mocko, Hill, Martin-Schramm, & Kolden, 2001). Not surprisingly, the debates surrounding homosexuality have been characterized as "the most divisive issue the churches of America have encountered, or evaded, since slavery" (Coffin, quoted in Nelson, 1994, p. 77).

Minority Churches and Homosexuality

Many Black denominations have also condemned homosexuality and marginalized gay and lesbian congregants (Fullilove & Fullilove, 1999; Sanders, 1998), including the African Methodist Episcopal; African Methodist Episcopal Zion; Christian Methodist Episcopal; National Baptist Church, USA, Inc.; National Baptist Church of America; National Progressive Baptist Church; and the Church of God in Christ (Griffin, 2006). In fact, Black Churches have been accused of playing a major role in

the perpetuation of homophobia within Black communities and the use of violence against gays and lesbians (Anderson, 1998). One scholar explained her view as an ordained minister in the Church of God (Anderson, Indiana) of gays and lesbians:

> As a pastor of a local church, my policy is not to seek out and condemn gays and lesbians, but rather to advocate and encourage heterosexual monogamy as the optimal structure for family life both inside and outside the church . . ..[A]ny person who desires to become actively involved as a member of our church "in good standing," especially in a leadership capacity, is expected to conform to the church's moral teachings with respect to sexual conduct" (Sanders, 1998, p. 181).

Sanders premises this view on a reading of scripture and "the observation that in the African-American community in particular, and also in society at large, the ethic and practice of sexual freedom have seriously undermined the stability of families and their parenting structures during the past three decades" (Sanders, 1998. p. 182). Sanders argues further that a rejection of the institution of marriage will ultimately bring about the demise of the extended family and that "loving well" requires the establishment and maintenance of a heterosexual marital relationship. Notably, Sanders does not adhere to the biblical passages that have been relied upon to challenge the legitimacy of women's roles in church leadership (Griffin, 2006).

Horace Griffin, an African-American Christian pastoral theologian and seminary professor, has pointed out the inherent contradiction in the rejection by African-American churches of biblical passages alleged to condone the existence of slavery, and their willing acceptance of and almost enthusiastic reliance on those portions of the Bible that supposedly condemn homosexuality (Griffin, 2006).

It has also been suggested that the animosity of many Black Churches toward gays and lesbians results from their conceptual dependence on White theology (Anderson, 1998) and the internalization of racist sexual portrayals of uncontrollable and uncontrolled Black sexuality that demands salvation through Christianity (Griffin, 2006; Roberts, 2001). Such a position reflects an inherent contradiction with their more liberal perspective on issues related to social justice (Dyson, 1996). Accordingly, it has been argued that Black Churches must formulate a Black theology of sexuality and homoeroticism and serve as a center for sexual healing (Dyson, 1996).

Regardless of the basis for their rejection of homosexuality and homosexuals, the role of the African-American church in fostering and perpetuating this response has been particularly impactful because of the church's positioning with the larger African-American communities. The church has been at the center of African-American life since the time of slavery, serving as a house of worship, an educational resource, a source of stability and hope, and a refuge from hostility and oppression (Frazier, cited in Lincoln & Mamiya, 1990, p. 272; Griffin, 2006). The hostility and rejection has deprived African-American lesbians of a voice even more so than African-American gay men (Griffin, 2006; cf. Comstock, 2001). Griffin (2006, p. 130) explained,

> When we consider the shameful sexist history of black churches, it is not so surprising that black lesbians would have difficulty in giving voice to their presence. Since black churches have always allowed men opportunities to hold whatever position they desired

> in churches, the invisibility of gay men allowed them to "pass" as heterosexual and hold any office in the church. Thus, gay men can be found in all denominations and throughout black Christendom from the highest offices as bishops and ministers to the lay positions as trustees and deacons. Black men's exclusion of women from most positions throughout black church history has not allowed for lesbians, and heterosexual women for that matter, to excel and be granted power.

Some pastors have welcomed gay men and lesbian women into their congregations. In some cases, the clergy have been pleasantly surprised to find that their actions have resulted in increased membership of not only gay and lesbian individuals, but also heterosexuals who are concerned about justice (Clapp, 2007). Such efforts, however, have frequently heralded unintended consequences, such as a loss of congregants and finances (Banerjee, 2007).

Although many Black Americans have condemned homosexuality as much as their White counterparts have, they have, in general, been more opposed to antigay discrimination and more supportive of civil liberties for gay and lesbian individuals (Lewis, 2003). This has not been extended, however, to the acceptance of gay marriage, to the adoption of children by gay men and lesbian women, or to the ordination of African-American gay and lesbian individuals (Griffin, 2006; Rodriguez, 2000).

The Impact of Religious Teachings on Sexual Minority Individuals

Religious influences have been found to have both negative and positive effects in the lives of LGBT individuals. A survey study with 85 predominantly Christian self-identified nonheterosexuals found that individuals' levels of self-esteem and stress over their sexual orientation were significantly correlated with past attendance at a conservative church and the church's level of (non)acceptance of homosexuality (Yakushko, 2005).

It has been suggested that sexual minority individuals, regardless of their ethnicity/skin color/race, are often forced to deny their sexuality in order to remain within their religious community or to reconcile themselves to living life as a sinner (Baldwin, 2002; Ritter & O'Neill, 1995). Denial may take the form of passing. Although African Americans have decried attempts of lighter-skinned African Americans to pass as White, while understanding the reasons underlying these efforts, passing as heterosexual has come to be expected of gay men and lesbian women if they wish to remain within their churches. Four forms of passing have been observed among nonheterosexual African-American churchgoers (Griffin, 2006).

Guilty passing refers to gay men and lesbian women who may feel guilty and deserving of the anger and rejection that is directed toward them by their heterosexual counterparts in their churches. They may or may not participate in church activities that equate homosexuality with immorality and sin. The second type of passing, called *angry passing*, refers to the behavior of gay men and lesbian women who publicly deny their own same-sex orientation and pass as heterosexual by

participating in condemnations of homosexual behavior or homosexual and lesbian persons. Silent passing encompasses those homosexual and lesbian individuals who publicly deny or remain silent about their same-sex orientation and pass as heterosexual. The fourth form of passing, *opportunistic passing*, relates to gay and lesbian individuals who have accepted their sexual orientation but feel that they cannot disclose it and cannot speak out against the homophobia and heterosexism of their churches (Griffin, 2006).

Attempts to abandon same-sex orientation completely may include efforts to become heterosexual through the practice of celibacy; through prayer, fasting, or counseling (Piazza, 1994); or through reconstruction of identity as a heterosexual. Alternatively, individuals may reject their religious identity in an effort to resolve their cognitive dissonance. This can be accomplished by distancing oneself from one's religious community and practices (Mahaffy, 1996), an abandonment of faith (Lease, Horne, & Noffsinger-Frazier, 2005), or by becoming involved in a religion that does not view homosexuality negatively (Ellison, 1993).

Often, unsuccessful attempts to reconcile both sexual and spiritual identities may lead to negative mental health consequences, including increased levels of shame and psychological distress, internalized homonegativity, or suicide (Allen & Oleson, 1999; Miller, 2000; Rodriguez, 2000; Schuck & Liddle, 2001; Shidlo, 1994; Szymanski, Chung, & Balsam, 2001). Individuals' successful reconciliation of the conflict between spiritual and sexual identities often occurs only following consistent engagement with their internal conflict (O'Brien, 2004) or their differentiation between religion and spirituality (Love, Bock, Jannarone, & Richardson, 2005). (Successful integration is discussed further in the section below, entitled "Movements of Inclusion.")

Family members of sexual minority individuals may be similarly conflicted. Research suggests that some family members have been devastated by negative religious doctrine about homosexuality (Lease & Shulman, 2003). Reconciliation of such conflicts was facilitated through an emphasis on religious teachings about acceptance and unconditional love.

Nonheterosexual employees of relatively conservative churches may experience particular distress as a result of the conflict between who they are and the dictates of their religion and their religion-based employer. In-depth interviews conducted with five gay and lesbian Catholic elementary school teachers revealed conflict between their church and their homosexuality, a fear of losing their jobs if their sexual orientation were to become known to others, and a need to work harder than their heterosexual counterparts in order to decrease the possibility that they would be terminated from their employment (Litton, 2001). Individuals adapted any number of strategies in their attempts to avoid and/or survive harassment and distress, including talking and acting in a way that might lead others to believe that they were heterosexual (passing), avoiding the disclosure of any information about themselves that might lead others to believe that they were not heterosexual (covering), or disclosing their sexual identity to only a few trusted colleagues (being implicitly out) (Litton, 2001).

It is not surprising, in view of the full or partial rejection/nonacceptance of nonheterosexuality and/or nonheterosexuals, that many nonheterosexuals would be less active in religious activities than their heterosexual counterparts. Sherkat (2002) found from his examination of data from the 1991 to 2000 General Social Surveys that gay men, while not as active in religious activities as heterosexual females, were more active than heterosexual males. Lesbian and bisexual women were found to have the lowest levels of religious participation of any of the groups. Sherkat attributed this relatively low level of religious participation to a lack of affinity with many gay-affirming denominations, such as goddess worship, and a rejection of traditionally patriarchal systems of leadership and focus within many churches. A survey study conducted with a multiethnic/racial sample of 605 self-identified nonheterosexual adults and 649 of their siblings similarly found that lesbian and bisexual women were the least religious group (Rothblum, Balsam, & Mickey, 2004). Yet another study involving 568 lesbian women of color found that 44% were spiritual, but were not affiliated with any formal religion (Morris, 2000). Only 7% attended religious services on a weekly basis, while 29% rarely worshipped in a church, synagogue, or mosque, and fully 42% never attended services. African-American women had the highest rate of weekly participation and the lowest rate of nonattendance (Morris, 2000).

Some nonheterosexual individuals may seek to reconstruct their sexual identity and "convert" to heterosexuality in an attempt to resolve both their inner conflict and their sense of isolation and rejection (Cates, 2007; Ford, 2001; Tozer & Hayes, 2004). Some may do so through participation in Exodus International, "a Christian referral and resource network found in 1976 ... to proclaim that freedom from homosexuality is possible through repentance and faith in Jesus Christ as Savior and Lord" (Exodus International, 1999) or one of its affiliated groups (e.g., Courage [Roman Catholic], JONAH [Jewish], Transforming Congregations [United Methodist], oneBYone [ministry of the Presbyterian Renewal Network]) (Keysor, 1979). A reconstruction of identity requires an extraordinary metamorphosis: the adoption of a new universe of discourse, the reconstruction of one's biography, the adoption of a new explanatory model, the acceptance of a transformed self, a shift in reasoning, and strong affective bonds (Ponticelli, 1999).

Others may try to become heterosexual in orientation and/or change their behavior to conform to heterosexuality through conversion therapy, also known by the terms reparative therapy, reorientation therapy, and transformational ministry, which purports to facilitate an individual's transition from a nonheterosexual to a heterosexual orientation. Although there is inadequate empirical evidence to support the efficacy of this approach (Haldeman, 2002), it appears that this intervention may assist some individuals to achieve a level of "heterosexual functioning" (Spitzer, 2003). Whether such interventions ethically should be available to those who seek such a transition continues to be a source of debate among mental health professionals, with some arguing that individuals should not be forced to accept a lesbian, gay, or bisexual identity that contravenes their moral values (Throckmorton, 1998; Yarhouse, 1998; Yarhouse & Throckmorton, 2002), and

others asserting that this intervention serves to foster a heterosexual bias, strengthen self-hatred (Begelman, 1975), and transform a state of being that is essentially immutable (Haldeman, 1994; Martin, 1984; Stein, 1996). However, the imposition of this perspective on unwilling or unknowing individuals may result in serious emotional-psychological injury (Moor, 2001). (For a history of reparative therapies, see Drescher, 2001).

Movements of Inclusion

Movements of inclusion provide and promote an alternative strategy to address the cognitive dissonance that may exist between one's religious identity and one's sexual identity—identity integration. Such movements not only welcome lesbians and gays into their congregations, either implicitly or explicitly, but also recognize and address their spiritual needs. This is accomplished through gay-positive and Christian-positive, or other religious-positive messages rooted in positive reinterpretations of the relevant scriptures and texts (Englund, 1991; Thumma, 1991).

Liberation Theology

Liberation theology has provided a theoretical basis for an examination of sexuality in general and sexual orientation in particular (Althaus-Reid, 2006b; Bardella, 2001). While a detailed discussion of liberation theology is beyond the scope of this chapter, a brief summary is necessary in order to understand how this perspective may serve as a foundation for such an examination.

Liberation theology emerged as a theological movement in the late 1950s and early 1960s in Christian churches in Latin America, most notably the Roman Catholic Church (Goizueta, 2005). The development of this movement has been attributed to three significant shifts that were occurring at that time: (1) the interpretation of Third World poverty through the lens of dependency theory, i.e., the poverty that existed in less economically developed countries was a direct result of their dependence on more economically developed nations; (2) the rapprochement that occurred between the world and the church as a result of the Second Vatican Council and the second General Conference of the conference of Latin American bishops in 1968; and (3) the growth and growing influence of Latin America's "base ecclesial communities."

Liberation theologians utilized these events as the basis for the formulation of a Christian theological vision that was rooted in the everyday experiences of Latin-American Christians, including poverty and the struggle for justice. This approach received official support through the Second Vatican Council's Constitution on the Church in the Modern World and the later General Conference of the conference of Latin American bishops. The bishops concluded that the poverty in which many were living was contrary to the will of God. This was interpreted as an endorsement

of the developed grassroots movement involving the application of the gospel by poor Christians to civic and political activity (Goizueta, 2005).

Gustavo Gutierrez, a Peruvian priest and one of the foremost liberation theologians, identified three dimensions of liberation: (1) liberation from all forms of social, political, and economic oppression; (2) rejection by the poor of their suffering as a mandate of God, the development of an understanding of their poverty as rooted in social, historical, and human causes, and acceptance of their responsibility to act as agents of change; and (3) liberation from sin and death, as a gift from Jesus Christ. The first two forms of liberation require human action; the third can only be brought about by Jesus Christ.

Within this framework, theological reflection has sought to "unveil the construction of heterosexuality in theology as part of a liberative praxis" and to address the oppression of sexual minorities (Althaus-Reid, 2006a). The role of liberation theology in this regard has been stated as follows:

> [A]ny courageous Liberation Theology has to take seriously, once and for all, the integral defense of our lesbian, gay, bisexual and transsexual sisters and brothers. Liberation Theologies should enter into an open, sensitive, respectful and continuous dialogue with LGBT theologians and their work. We need to pursue the critical analysis of Christian homophobia, heterosexism and erotophobia from historical, psychological, anthropological, sociological, biblical and properly theological perspectives. We should then propose an open ethic in favour of an abundant, loving and pleasurable life for an ever increasing diversity of ways of living in harmonious communities (Maduro, 2006, p.28).

Liberation theology has served as an important springboard from which African-American lesbian women and gay men have challenged the position of Black Churches on homosexuality. They have posed their question as follows:

> If the majority Christian culture today recognizes that earlier Christians should not have adhered to certain biblical passages on slavery and should not have supported racial oppression, how does the same Christian culture justify the present adherence to a few biblical passages that allegedly depict gays as immoral and, as a result, deserving of denigration and unequal treatment? (Griffin, 2006, pp. 46–47).

Other Judeo-Christian Perspectives

Various churches and denominations have been developed in an effort to address the religious and spiritual needs of nonheterosexual-identified individuals. Dignity is a group dedicated to serving Catholic nonheterosexuals. However, it is not allowed to hold services in a Roman Catholic Church, and Catholic priests are not permitted to officiate (Heermann, Wiggins, & Ritter, 2007). The United Church of Christ, Integrity (of the Episcopal Church), and Lutherans Concerned have all assumed a positive stance toward homosexuality (Brumbaugh, 2007).

The Universal Fellowship of Metropolitan Community Churches (UFMCC) was established in Los Angeles, California, in 1968 by Troy Perry as a Christian church, "universal enough to reach out to all God's children," including those who are gay, lesbian, and bisexual (Warner, 2002). Perry established the church after he had been

defrocked by the Pentecostal Church of God of Prophecy in Santa Ana, California, after he disclosed his sexual orientation.

In order to refute those portions of scripture traditionally relied upon to condemn homosexuality and homosexuals, Perry:

> first assimilated the Levitical prohibition of homosexual relations to the Old Testament law from which Jesus freed the faithful: rules and regulations concerning diet, dress, slave-holding, and myriad other matters . . .. He then elevated above Paul's evident homophobia three other lessons from the New Testament: Jesus's message of love, the silence of the gospels themselves on the subject of homosexuality, and Jesus's own personal life as an unmarried peripatetic who kept company with 12 men (Warner, 2002, p. 284).

In order to appeal to the heterogeneous congregation, Perry integrated elements of Catholic, Episcopal, and Lutheran liturgical forms with gospel hymns and preaching style of current charismatic fellowships. Beginning in 1972, UFMCC officially committed itself to gender equality and later adopted gender-neutral language in its bylaws, policies, and worship services.

The UFMCC currently comprises more than 300 churches in 16 countries and the United States (Lukenbill, 1998; Singer & Deschamps, 1994). The Metropolitan Community Church of New York (MCC/NY) is one of the churches within the UFMCC (Rodriguez & Ouellette, 2000). The MCC/NY is a gay-positive Christian church that ministers to an ethically and racially diverse lesbian, gay, bisexual, and transgender community in New York City. Such an environment appears to play an important role in helping individuals to achieve identity integration. A study conducted with church members found that greater integration of sexual and religious identities was associated with greater role involvement in the church, more attendance at worship services, participation in ministries, and attendance for more years. Lesbians were less likely to report identity conflicts than were gay men and were more likely to report integration of their identities.

Dr. James Tinney, a Black gay Pentecostal minister, founded the African-American gay/lesbian church, Faith Temple, following his excommunication from his Black Pentecostal denomination, the Church of God in Christ (Miller, 1989). The Washington, D.C. Church describes nondenominational, charismatic, Liberationist church where:

- People dare to believe God for the impossible;
- People experience the transforming power of Jesus Christ;
- Everyone is welcomed no matter their background; and
- People are built up, not torn down (Faith Temple, n.d.).

Years later, Carl Bean founded Unity Fellowship, a congregation comprised primarily of African-American nonheterosexual-identified individuals. The Unity Fellowship Los Angeles states as its mission:

> The primary work of the UFCM is to proclaim the SACREDNESS OF ALL LIFE, thus focusing on empowering those who have been oppressed and made to feel shame. Through an emerging international network, the UFCM works to facilitate social change and improve the life chances for those who have been rejected by society's institutions and systems. Although its pivotal work focuses on the urban weak and powerless, the scope of its work

> is inclusive and has significance for all people ... **REMEMBER: LOVE REQUIRES ACTION!** (Unity Fellowship Church Los Angeles, 2004). (emphasis in original).

This mission is effectuated through a variety of activities that include the creation of HIV/AIDS outreach ministries; establishment of training, education, health, and human services; development of organizations to address gaps in human services; establishment of ministries that empower everyone and, particularly, those who are disenfranchised; initiation of projects designed to strengthen community leadership; and provision of outreach information, education, and empowerment. The mission statement of Unity Fellowship New York similarly addresses issues of sexual orientation, stating in its mission:

> UFC-NYC is a Social Justice Ministry, which focuses on freedom of oppression from racial, sexual, religious and social-economics. This mission is carried out through the valuing each person's heritage, the teachings of Jesus Christ, as deity and man, and social ministries which outreach to those who are hungry, and in need (Unity Fellowship Church in Christ NYC, n.d.).

Yet another congregation that was established to minister to African-American gay/lesbian/transgender-identified individuals includes Chicago's Church of the Open Door, which is affiliated with both the United Church of Christ and the Unitarian Universalist Church.

Participation in religious rituals in a gay-affirming environment may serve several important functions. First, it constitutes a response to the rejection of other churches. Second, rituals such as communion may serve as a demonstration of love, belonging, acceptance, and a tolerance of religious diversity (Brumbaugh, 2007). Additionally, it may be seen as a celebration of individualistic spirituality, the affirmation of a same-sex partnership, and an act of social justice.

Efforts have also been made to address the needs of lesbian and gay clergy candidates who have been denied recognition/ordination by their denominations. The Extraordinary Candidacy Project (ECP) was established by members of the ELCA in 1993 (Hill, 2001).The ECP maintains a listing of pastors, associates in ministry, diaconal ministers, and deaconesses who are available to serve congregations and who have been denied commissioning or ordination or have been removed from the ELCA roster because of their sexual orientation.

Nontraditional Spiritual Paths

There has been some suggestion in the literature that shamanism may provide an alternative spiritual path to lesbian and bisexual women who have been rejected by their Judeo-Christian places of worship or who do not feel an affinity for those beliefs (Ritter & O'Neill, 1995). Shamans are able to enter an ecstatic state and trance and, as such, enter an "out of body" state during which they may journey to heaven or hell (Bowker, 1997). These ecstatic states may be induced through drumming, concentration on a particular object, or the use of alcohol, tobacco, or hallucinogens. In this ecstatic state, the shaman may neutralize spirits that are

perceived as harmful to the community by incorporating them into his/her own body (Bowker, 1997). As such, shamans are heavily engaged in the healing of both individuals and communities (Smith, 1991).

Various Goddess faiths are appealing to women in general because of the identification of Judaism and Christianity with patriarchy and the domination and control of women (Daly, 1985; Starhawk, 1982). In contrast, Goddess spirituality emphasizes the interconnectedness of all creation, equality, shared power, and the empowerment of the feminine, as well as regeneration, life, and bounty. The Divine Feminine manifests across diverse cultures and eras and is reflected in the Egyptian Goddess Isis, the Indian Goddess Kali, and the Christian Virgin Mary (Eisler, 1995).

Numerous writers have emphasized the process of loss, ultimately leading to transformation and spiritual awakening. Garanzini (1989) has noted that pastoral care of lesbian and gay men must be cognizant of their losses and separations, which includes the relinquishment of the myth of heterosexuality. Whitehead and Whitehead (1986) speak of a path that begins with disorientation and a sense of loss, but that ultimately culminates in transformation. The path for lesbians consists of several steps: the coming out to oneself, the development of a bridge between the gay/lesbian self and others and, finally, the public integration and witnessing of oneself as both homosexual and Christian. Schneider (1984, 1994) similarly contends that lesbians cannot resolve the loss of their heterosexual identity in the absence of public integration of their lesbian identity. This integration may lead to a new identity, a reformulation of the loss, a reframing of one's grief as unifying rather than alienating, and the development of a sense of connection to and continuity with all things.

Discussion

This review underscores the importance of including a religious history in the initial assessment of individuals beginning counseling or therapy (Benner, 1989; Dombeck & Karl, 1987; O'Rourke, 1997). This history may include information about the individual's religious background and the meanings that the individual attaches to various religious symbols, beliefs, and rituals. In the context of group work, relevant spiritual issues may be explored through sensitive discussions that focus on participants' views regarding connections between people and/or a divine presence and responsibility toward others.

A variety of strategies have been offered for use in the therapeutic context to assist nonheterosexual-identified minority individuals in their efforts to address feelings of loss, rejection, and depression associated with a conflict between their sexual and religious/spiritual identities and/or the perspective of their place of worship/denomination. These strategies include bibliotherapy in religion and homosexuality (Lynch, 1996), identification of positive images of spiritual leaders and paths (Frame, 2003), reframing of losses to promote spiritual transformation (Ritter & O'Neill, 1995), and focusing on the inherent goodness of body (Heyward, 1984).

Nevertheless, the inclusion of spiritual issues in the therapeutic exchange raises significant ethical issues for the therapist or educator (Lindgren & Coursey, 1995; Sheridan & Bullis, 1991; Titone, 1991). Therapists, counselors, and HIV educators utilizing spiritual beliefs as a strategy in such efforts must examine and address their own spiritual and religious issues and conflicts outside of the counseling/education context (American Psychiatric Association, 2000). Discussions of spiritual issues with clients must be done in a manner that does not seek to have clients redefine or reinterpret their religious beliefs.

In the research context, increasing attention has focused in recent years on the effects of religious and spiritual beliefs, practices, and experiences on health behaviors and outcomes, most notably in the areas of the prevention and treatment of HIV/AIDS (Bosworth, 2006; Cotton et al., 2006; Fitzpatrick et al., 2007), substance use (Galanter, 2006; Miller & Bogenschutz, 2007), and mental illness (Fallot, 1998). This review argues for both an increased recognition of the importance of religion and spirituality in the lives of research participants and a nuanced approach to the ascertainment of their various dimensions.

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Portrait 3
An Interview with Dominique

Dominique is male-to-female, questioning. She discusses in this interview her spiritual beliefs and their importance to her survival, despite the hardships that she has faced.

I believe in a universal Creator, a belief in life after death, and that every person has a soul. I was raised Catholic and even though I have held onto some of the tenets, some of the stories, I identify more as Christian instead of a particular denomination.

I put my faith in Christ. My source of inspiration is a biblical story.

I think immediately of the Good Samaritan. I identify as human and I consider myself a compassionate person. I observe in the world today a lack of compassion for our fellow man, kind of an overall indifference to the pain of people's daily lives; unless it directly affects somebody, they don't take time to care.

I see myself like the Good Samaritan. I identify as a healer with a great capacity to nurture and care for people. I have a sense like a calling to some type of ministry, helping people. I am searching for some nonprofit organization or volunteer organization where I can start to begin ministering.

I believe in an all-knowing, all-loving Being. I embrace the Trinity of the Father, Son, and Holy Spirit. I am constantly being tried, living and identifying as a transgender person. I encounter a lot of people who are quick to judge based on my image. According to them, say if they are more conservative in their views, I am not part of overall Creation in that I am deviant, my identity is freakish and abnormal.

For me, it is faith that gets me through. It has to do with a level of trust. I have been through times when I felt separated from God or abandoned. I continue to struggle with doubts. I feel helpless like I am not, I am thinking now of the poem about the footsteps, that really seems to resonate with me, that story. What gets me through is a belief that God's love transcends everything that is negative and painful as it affects me and as I see it affects other people, as I see the injustice in the world. I take comfort in the belief that there will be atonement or justice for those being hurt, those who are being abused, those who are not represented. I am frustrated sometimes that I can't do more personally to bring forth that justice. I struggle to let go of the anger and resentment and reside in a space where I know God will take care of me; if it is not addressed in this lifetime, it will be addressed in the next. I guess I do not understand His plan, the greater plan for human rights, just to believe.

It is very hard, lately it's been very hard, trying as I present myself as a transgender person to the world and as I identify as a healer in the energetic sense, someone to be empathetic. I guess that this is kind of trite but it's trying to find meaning to obstacles and suffering and pain as someone who is often nonvalidated as a transgender person. I need to find meaning in the suffering and to find my greater purpose here in this lifetime.

I thought I had found it four or five years ago, as simply to make people happy. I mean affecting people through my art, my talent, my love for music, particularly singing because it's more than me singing. When I sing, a lot of spirit sings so I am praising God and I realize I have been able to move people through my performance. I think that it is still there but I think it is more multi-faceted and deeper. I do not know in what capacity or where to begin, if I am my own power or to get connected with people to get support so I can carry out my ministry. I am thinking to affect people's lives for the better. I know that I am already doing that now just by having courage and making the effort to dress up daily and identify as a woman and let people know that transgender people are more alike than different, that everyone at all levels is worthy of respect, validation, and love.

I talk to God the Father. I know that there seems to be a need to be very emotionally attached to a male figure because my father wasn't there when I was little, my parents separated. The image of a loving Father who is not afraid to touch me, to be physical with me, to embrace me. I think of the passion of Christ, the image of Christ on the cross enduring the ultimate rejection and sacrifice and ultimately through that sacrifice for a greater purpose that I will have eternal life, a transition. I will leave this realm as we know it and I will enter a state where I am completely loved and completely free to be me, completely understood.

How to make the most of life, seize the day, give to others to give to myself. I realize the power in giving and forgiveness and how it can be transformative.

I am just thinking a lot. I see myself as someone who is actually challenging the beliefs of others whether they are fundamentally moral or religious beliefs, specifically in the terms that transgender people are not deviant and are God's creation and are equal to everyone else as part of the human race and worthy of being recognized and not feared.

Index

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