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"Trying to Figure Out Where We Belong": Narratives of Racialized Sexual Minorities on Community, Identity, Discrimination, and Health

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Abstract Lesbian, Gay, Bisexual, Trans, and Queer people of color (LGBTQ-POC) are regularly exposed to unique and contextual forms of prejudice and stigma, which have been linked to stress and increased likelihood of mental and physical health problems. In order to better understand the experiences of this multiply marginalized population, semi-structured interviews were conducted with 11 LGBTQ-POC to examine how they describe their experiences with identities, communities, discrimination, and health. Data consisted of verbatim interviews, which were guided by intersectionality theory and minority stress theory and analyzed using interpretive phenomenological analysis. Using *intersectionality theory*, this study addresses the simultaneity of oppressions and the ways in which having different combinations of marginalized identities may impact LGBTQ-POC well-being. Common issues discussed by respondents include disconnect from communities, relationships between identities, coming out, and stress and anxiety. The primary concepts introduced in this study include *positive intersectionality* and *come out stress.*

Keywords Homophobia · Racism · Marginalization · Stress · Positive intersectionality · Come out stress

Introduction

Lesbian, Gay, Bisexual, Trans, and Queer people of color (LGBTQ-POC) are challenged by social and psychological issues unlike those that affect White LGBTQ or heterosexual racial/ethnic minority individuals (Akerlund and Cheung 2000). In addition to everyday racism and heterosexism, this population experiences racism within LGBTQ (or "queer") communities and relationships, heterosexism within their ethnic community, and varying forms of oppression that interact in different contexts. Individuals' identities and inequalities are intersecting, rather than additive, and therefore they must be thought of as merging together and impacting how each identity is expressed and experienced socially (Crenshaw 1991). These experiences and expressions of sexual, gender, and ethnic and racial (also termed "ethnoracial" and "racialized") identities are fluid and are impacted by each other and the environment differently over time. For example, research shows that, although Black gay men may be regarded with disdain in Black Baptist communities (Ward 2005), they are perceived as more likable than Black heterosexual men by White individuals (Remedios et al. 2011). Using *intersectionality theory*, researchers can begin to address and understand the simultaneity of oppressions and the ways in which having different combinations of marginalized identities may impact well-being (Simien 2007). Research using an intersectional lens helps us to better understand racism, sexism, and heterosexism because LGBTQ-POC individuals are faced with "a fluid and contextual sexualization of race and a racialization of sexuality," rather than with each-ism individually Narváez et al. (2009, p. 65). Studies that attain a deeper understanding of these complex interactions and their effect on stress and health have the potential to educate healthcare providers and policy makers on the gravity of these experiences and contribute to public education on the relationship between mental and physical health. Based on a review of the growing literature on LGBTQ-POC, health and stress (e.g., Meyer 2010; Steele et al. 2009), discrimination and microaggressions (e.g., Liao et al. 2016; Nadal et al. 2011),

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identity (e.g., Kertzner et al. 2009; Jaspal and Cinnirella 2010), and community and social engagement (e.g., Meyer 2010; Liao et al. 2016) were highlighted as variables needing exploration. The present study investigated the details of the linkages between these variables in order to contribute to the scholarship and understanding of LGBTQ-POC.

Although some religious communities and ethnic groups offer affirming and safe space to LGBTQ individuals—for example, *Salaam*, a queer Muslim organization in Toronto (Grundy and Smith 2005)—LGBTQ-POC often face heterosexism within their ethnoracial communities. Some religious communities and ethnic groups disapprove of homosexuality and members of the community may openly refer to this lifestyle as sinful or unnatural (e.g., Reygan and Lynette 2014; Ward 2005). For example, Islamic holy scripture forbids and denounces homosexuality (Ali 2006), which may place gay Muslim men at odds with their sexual identity and cause them to feel inauthentic (Jaspal and Cinnirella 2010, 2014). African-Caribbean culture is noted for severe homophobic violence, evidence of which can be found in both religious and secular spheres (Gutzmore 2004). Through interviews with African-Caribbean and African-Canadian gay men living in Toronto, Crichlow (2004) revealed the many obstacles that these men face in their communities—including being excluded and silenced for bringing shame to their churches, families, and communities. Popular Jamaican music artists, largely influenced by Christian fundamentalism, have been accused of promoting violence against LGBTQ in their lyrics, which perpetuates this homophobia in popular culture (Gutzmore 2004; Williams 2000). LGBTQ Hispanic men have reported experiencing more instances of homophobia in their communities than non-Hispanic White men, which potentially leads to isolation and subsequently compromises the support they would otherwise receive from their families (Ceballos-Capitaine et al. 1990). Homophobia is also a large part of the hegemonic masculinity observed in Pacific Islander and Asian adolescents (Mayeda and Pasko 2012), and prejudice and restrictions on gender roles have been found among Japanese and Chinese American communities (Bridges et al. 2003). To contend with and avoid potential discrimination, some choose to conceal their sexual orientation and nonconforming gender identity, or manage and regulate how it is made visible to others in different contexts. Although stigma concealment may provide necessary comfort or safety, it can lead to fear of discovery, stress, and cognitive burden (Frost 2011). Concealing one's sexual orientation leads to low self-esteem and social isolation, which has been linked to increased risk of mental health problems, substance use, suicide, and high-risk behaviors (Bradford and Ryan 1989; Ceballos-Capitaine et al. 1990; Frost and Bastone 2007; Frost et al. 2007; Goffman 1963; Meyer 2003; Pachankis et al. 2015). In addition to the stress that may result from stigma concealment and living in heterosexist communities, the reluctance to come out to one's ethnoracial community may contribute to decreased likelihood to seek suitable healthcare and community resources, further increasing health risks (Frost 2011).

At the same time, there is mounting evidence of racism within the White LGBTQ community. In addition to overt racism, racial and ethnic minority individuals have reported experiencing different forms of discrimination in their LGBTQ communities (Balsam et al. 2011; Crichlow 2004; Nadal 2011; Teengs and Travers 2006; Ward 2005). Although some researchers have suggested that there has been a decrease in interpersonal racism, due to a decline in reported race-based assaults, others argue that, because North America is becoming more politically correct, racism now manifests as microaggressions (Nadal 2011; Sue et al. 2007). Microaggressions are subtle, commonplace statements or behaviors that are derogatory, hostile, and insulting, yet often done without the intent to harm. They also occur in the form of systemic, large-scale discrimination, occurring through community structure, social and health services, and one's environment (Sue et al. 2007). For example, LGBTQ organizations and bars in the USA have been noted for alienating ethnoracial minority individuals by neglecting to offer culturally specific services and events (Kudler 2007; Ward 2008). To better understand race relations in the Canadian LGBTQ community, Giwa and Greensmith (2012) conducted a series of interviews with LGBTQ-POC social service providers in Toronto. Participants reported feeling excluded from queer spaces, including Pride and gay bars, which are primarily targeted towards White LGBTQ. Beauty standards in the LGBTQ community, participants noted, are also White, and this norm permeates gay media, magazine publications, and everyday life, making LGBTQ-POC feel invisible and undesirable.

Minority stress theory states that, because sexual and racial minorities are regularly exposed to prejudice and stigma, they are at greater risk for mental and physical health problems, through the increase of psychological distress (Krieger et al. 2008; Meyer 2003). Research shows that prejudice events, such as hate crimes, have greater mental health effects than assaults that are not hate-driven (Dunbar 2006; Herek et al. 1999). Noh et al. (2007) examined the effect of racial discrimination and emotional health among Korean immigrants in Toronto and found that perceived racism was associated with reduced positive affect and increased depressive symptoms. Individuals who experience a prejudice event are also more likely to report physical health symptoms 1 year later (Frost et al. 2013). It has been suggested that these minority stressors may affect health through chronic biological stress mechanisms and may be linked to poor cardiovascular health (Friedman et al. 2009), as well as an increase in health risk-taking behavior (Krieger et al. 2008; Littleton et al. 2013). Perceived racism has been shown to be predictive of a number of medical conditions, of ever having smoked, and alcohol dependency (Todorova et al. 2010). Discrimination against

sexual minorities is also linked to poor mental and physical health (Hatzenbuehler et al. 2010). Studies have shown an increased likelihood among these groups to experience heart disease, liver disease, migraines, asthma, disability, post-traumatic stress disorder (PTSD), depression, suicidality, lifetime mood and anxiety disorders, and alcohol and drug dependence, when compared to their heterosexual counterparts (Cochran 2001; Cochran and Mays 2007; Diamant and Wold 2003; Fredriksen-Goldsen et al. 2013; Gilman et al. 2001; McCabe et al. 2010; Sandfort et al. 2001; Steele at al. 2009).

Little research is currently available that measures the health and well-being of LGBTQ-POC. Using data from the 2004–2005 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), McCabe et al. (2010) examined the association between three types of discrimination (sexual orientation, racial, and gender) and substance use among Lesbian, Gay, and Bisexual (LGB) adults in the USA. These researchers found that LGB respondents reported twice as many substance use disorders as heterosexual respondents, and that those who reported experiencing all three kinds of discrimination were four times more likely to have had a substance use disorder in the past year than LGB who did not. Multiple variations of combined discrimination have shown to have a similar exacerbating effect on overall self-reported health among sexual minority adolescents (Grollman 2012). Research has also found that sexual risk-taking behavior and barriers to healthcare are associated with discrimination among racialized sexual minorities, placing this population at increased risk of contracting HIV and other sexually transmitted infections (Munro et al. 2013; Nakamura and Zea 2010).

Trans people are described by Serano (2007) as those who defy societal definitions of maleness and femaleness and identify with a gender (e.g., transgender, bigender, gender-fluid, genderqueer, etc.) that is not aligned with the gender they were assigned at birth, or whose presentation rejects the male/female binary altogether. They are confronted with discrimination (including, but not limited to, *transphobia*), heightened barriers to resources and housing, and violations of their basic human rights (Garofalo et al. 2006; Singh 2013). Trans people of color represent one of the most marginalized groups in society and this population is relatively invisible in research and neglected in healthcare and policy (Bauer et al. 2009, 2012). Experiences of transphobia and combined discrimination have been linked to increased depression symptoms among trans people of color (Jefferson et al. 2013), and trans people also appear to be at increased risk of low self-esteem and suicidality (Grossman and D'Augelli 2007; Whitman and Nadal 2015). The severity of these emotional and physiological responses to stress and trauma among minorities and the apparent compounding effects of different kinds of discrimination against the multiply marginalized further emphasizes the need for research that tends to the unique lived experience of individuals in this population.

The Present Study

Although research continues to yield new information on well-being among the LGBTQ-POC population, there remain several confounding factors and ethnic groups that have not been explored in research. Racialized sexual and gender minority individuals are among the most under-researched and underserved populations in health and psychology. They are multiply oppressed and many are in a perpetual state of negotiation between conflicting identities and values, which leads to stress, mental health problems, substance abuse, suicide, and high risk behaviors (Clements-Nolle et al. 2001; Frost and Bastone 2007; Jaspal and Cinnirella 2010; McCabe et al. 2010; Meyer 2003). Existing quantitative scales fail to capture important aspects of a self-system and are incapable of accounting for how identities change and interact with each other within different contexts. Open-ended interviews are ideal for assessing identity interactions, as they provide participants the opportunity to contribute new perspectives and explain how these interactions vary and are impacted by power relations (Bowleg 2008). This method of research has given researchers insight into various components of identity that cannot be examined individually or adequately understood through quantitative measures (Narváez et al. 2009). Using the lens of minority stress theory and guided by the intersectionality framework, the present study aimed to attain a deeper understanding of the experiences of those who identify as both LGBTQ and racialized. Specifically, this study was designed with the following objectives: (1) To examine how respondents describe the relationships between their identities and communities; (2) To explore under-researched microaggressions that may affect LGBTQ-POC; (3) To learn more about how multiple marginalization and discrimination affect stress and health in the LGBTQ-POC community. Through research and activism, the LGBTQ has claimed the rights and benefits of marriage, family, and safety, and has effected great change in policy in both Canada and the USA (Grundy and Smith 2005); however, people of color are not wholly positioned to gain from this progress. By contributing to the literature on the need of LGBTQ-POC, the present study acts to inform healthcare providers and policy makers on the gravity of these experiences and contribute to efforts in educating the public on the relationship between mental and physical health.

Methods

Participants

Participants were 11 English-speaking individuals who identified as LGBTQ and as an ethnic/racial minority. Demographics variables are displayed in Table 1. Participants ranged from 18 to 42 years of age ($M = 27.00$). When asked about their sex-at-birth, no participants reported

Table 1 Participants' demographic characteristics and profile

	Age	Sexual orientation	Gender identity	Ethnic/racial identity	Family religion	Source of income	Education
Deena	18	Bisexual	Cis woman	South Asian/Indian	Hinduism	Parental assistance	Some college/university
Rowan	22	Queer	Cis woman	Black/Afro-Caribbean/ African-Canadian	None	Retail work	Completed college/university
Elliot	33	Gay/queer	Trans man	East Asian	Buddhism	Social work, sex work	Completed college/university
Manny	30	Gay	Cis man	Latino/Hispanic	Christianity	Government and policy work	Completed college/university
Tate	25	Queer	Trans woman	East Asian/White	Christianity	Scholarships, parental assistance	Some graduate school
Teona	23	Lesbian	Trans woman	Indo-Caribbean/Latina	Islam	Government and policy work	Completed college/university
Kai	28	Queer	Trans/ genderqueer	East Asian	None	Sex work	Completed college/university
Tashel	25	Queer	Cis woman	Black/Afro-Caribbean/ African-Canadian	Christianity	Telemarketing, sex work	Completed college/university
Sarah	25	Bisexual	Cis woman	Mixed race	None	Social assistance, parental assistance	Some college/university
Gabriel	30	Queer	Cis man	Mixed race/East Asian/ West Indian	Christianity	Scholarships	Completed graduate school
Sherry	42	Straight	Trans woman	Aboriginal/First Nations	None	Disability Support Program	Completed elementary school

being born intersex. Genders of participants were as follows: four cisgender (i.e., expressing the gender that corresponds with the gender assigned at birth) women, three trans women, two cisgender men, and one trans man, and one trans/ genderqueer person. At the time of the study, eight participants were not practicing any religion, one was Hindu, one was Christian, and one was Muslim. Three participants reported having no stable income. All remaining participants reported an annual income under $30,000. Seven participants were born in Canada. Of those that were not, one had been living in Canada for 3 years, one for 5 years, one for 13 years, and one had been living between Canada and the USA for a year and a half. All participants had at least one biological parent who was born outside of Canada.

Recruitment

Interviews took place in an urban area of an Eastern Canadian city. The majority of participants were recruited through a local health center and through posts in online classifieds. Participants were also recruited through word-of-mouth advertisements via groups and organizers in the city who cater to specific ethnic minorities. Individuals who were interested in participating in this research contacted the researcher to receive more information about the study, determine eligibility, and to organize an interview date and location.

Participants were eligible if they were able to read, speak, and understand English, were least 18 years of age, identified as non-White or of non-European decent, and identified as a sexual and/or gender minority (including, but not limited to the following: lesbian, gay, bisexual, queer, and/or trans). Biracial individuals who had one White parent also qualified for eligibility. Newcomers of European decent were not eligible for this study.

Procedure

Informed consent was obtained from all individual participants. A list of LGBTQ-related resources in the area and crisis helpline contact information was provided with the participant copy of informed consent. Participants then completed a demographics questionnaire, which asked questions concerning age, sex-at-birth, gender, race/ethnicity, religious upbringing and denomination, current religion and denomination, sexual identity/orientation, annual income, number of dependents, highest education achieved, sources of income, whether or not the participant was born in Canada, for how long the participant had lived in Canada, whether or not the participant's parents were born in Canada, and where the participant's parents were born. Next, participants completed the Identity Salience Task (Thoits 1995), which was followed by the interview questions. Interviews were semi-structured, with the interview guide consisting of 34 questions. Interview duration ranged from 1 to 3 h. At the end of the interview, participants received $35 as remuneration for their participation in the study. Interviews were conducted, transcribed verbatim, and analyzed by the author.

Identity Salience

To help participants begin thinking about their various identities and the relationships between them, they were given an identities worksheet. The Identity Salience task was developed by Thoits (1995) in a study of identity, stress, and

mental health outcomes. Salience is defined by Thoits as the perceived importance of self-descriptive roles. Respondents listed up to 12 self-descriptive identities, roles, or traits in response to the question, "Who am I?" This prompt was changed for the present study from, "I am a(n)…" This list would include their gender, race/ethnicity, and sexual orientation, as well as up to nine other items. They were then asked to order these items in three categories: first most important, second most important, and third most important. Finally, participants were asked to identify any of the previously self-elicited items which they do not always regard positively (e.g., Meyer et al. 2006).

Measures

Interview questions could be divided into the following five topics: (1) Health and Stress, (2) Discrimination and Microaggressions, (3) Identity, (4) Community and Social Engagement, and (5) Life History.

Health and Stress

Six open-ended questions in this study asked about general health and stress. Participants were asked about any physical or psychological diagnoses they felt comfortable discussing, and for their own perceptions of their health. Examples include, "Has a doctor ever told you that you have a physical illness or condition that you are comfortable telling me about?" and, "In general, how would you describe your health?" These questions were included to facilitate discussion about health and stress in order to meet the third objective of this study to learn about how LGBTQ-POC describe their own health, as well as stress and health in their community. For trans participants, this portion occasionally included discussions of the transition process and the effects of hormone replacement therapy on the body.

Discrimination and Microaggressions

These questions were designed to address the first and second objectives of this study to examine microaggressions and the interactions between respondent identities and communities. Participants were asked to discuss situations in which they may have been harassed, judged, treated unfairly, or felt unsafe (e.g., "How often are you treated with less respect than others?"). Participants were asked whether or not they felt their experiences of discrimination were related to their identity as a minority, and why they believed they were treated this way (e.g., age, gender, disability, etc.). For example, "What were the insults or name-calling related to?" and "Why do you think you were treated [this way]?" Participants were asked about discrimination in their communities. For example, "As a racialized person, do you sometimes feel at disadvantage in the queer community?" Some items were adapted from the Everyday Discrimination Scale (Williams et al. 1997).

Community and Social Engagement

These questions were designed to address the first and second objectives to examine microaggressions and the interactions between respondent identities and communities. This portion of the interview inquired about participation in social groups and their interactions with similar others. Examples include, "In the past 12 months have you attended meetings or participated in some other way in any political or activist associations?" and, "Are any of these groups attended by other ethnoracial or sexual minority individuals?" Participants were asked about their experiences in and connectedness to the LGBTQ community in their city, online, and in other cities. Questions also asked about positive and negative experiences in the LGBTQ community. Examples include, "Do you feel you are a part of the LGBTQ community in [city of residence]?" and, "Is participating in LGBTQ events and activities a positive thing for you?" Interviews with trans participants included discussion of trans-friendly spaces in the LGBTQ community and experiences with transphobia. Some questions were adapted from the Connectedness to the LGBT Community Scale (Barrett and Pollack 2005).

Identity

These questions addressed the first objective of the study to examine the interactions between identities and communities. This section addressed conflicts and benefits of intersectionality and experiences with disclosing and withholding information about sexual identity. This included questions about stigma concealment and presentation. Examples include, "Do you have aspects of your life that conflict with your queerness?" and "Does being a part of an ethnic or racial community make you want to look or act less queer?"

Life History

Life History was placed approximately halfway through the interview so that, having established trust and common experience with the interviewer, participants would feel comfortable guiding the interview and presenting novel issues that may have otherwise not been discussed. They were asked a general question pertaining to impactful or unusual events, experiences, and relationships, and invited to discuss both positive and negative events that they felt have made some impression on their identity and/or health. This portion of the interview also provided participants an additional opportunity to elaborate on issues concerning social support, communities, discrimination, trauma, and health, and describe the contextual interactions between these variables and their multiple identities.

Data Analysis

Data consisted of full verbatim interview transcriptions, which were analyzed using interpretive phenomenological analysis (IPA), a method of identifying and analyzing patterns within and between participant interviews (Smith 1996). IPA is different from thematic analysis and grounded theory, as it is neither theory-driven nor does it necessarily seek to propose theories with research findings. This approach is ideal for this study because of its pursuit to gather accurate and holistic information about the phenomenon in question and its consideration of contextual and intersecting factors in order to understand the meaning that participants ascribe to their lived experiences (Patton 1990). This process involves searching data for common and shared experiences between participants, and is inductive, rather than theory-driven. Analysis began with a close reading of the interview transcripts, during which time notable comments and quotes from participants related to the key objectives were identified. Themes were drawn from these quotes, and these themes were gradually clustered into larger overarching themes, while ensuring that themes accurately represented participant experiences. Interviews were coded using NVivo[10] software.

Results

The qualitative analysis resulted in four main themes that were commonly discussed and were relevant to the topic of interest. These included feelings of *disconnect from communities*, *identity relationships*, *coming out*, and *stress and anxiety in the LGBTQ-POC community*. An intersectionality framework guided the interviews and analysis, and varying intersections and contexts were discussed. Further, minority stress theory was used to connect the former three themes with the theme of *stress and anxiety in the LGBTQ-POC community*.

Disconnect from Communities

Eight participants discussed feeling separated in some way from their racial or ethnic community because of their sexual identity. Three participants said that they wish to be more connected to their culture or background. Five individuals described specific efforts made to form this connection; for example, by seeking out various gay-affirming communities, or simply through displaying behaviors and values believed to be idiosyncratic to their culture. For example, Tate, a queer, mixed-race trans woman, said:

> "I was raised by my mother, primarily, so I have a lot of the Chinese things raised into me and value systems and ways of being in life. But…I also joke a lot about, like, 'Oh, this is one of my Chinese habits acting up,' or, like, 'I'm so Chinese right now.' It's, I guess, one of the ways I try to resist the Whiteness that's imposed on me, as well as try to connect back to my roots periodically."

On the other hand, participants also reported feeling disconnected from the mainstream LGBTQ community due to their identity as a racial/ethnic minority, explaining, "sometimes we're just not included in things because we're not White," (Kai, a queer, East Asian, genderqueer person). Six participants said that they feel discomfort in the local LGBTQ community and often avoid participation due to past experiences with racism and exclusion. Five participants said that they have no connection to a White LGBTQ community and that they are immersed in their own LGBTQ-POC community. Gabriel, a queer/gay-identified, East Asian/West Indian cis man, recalled a time when he had to negotiate between his ethnic culture and members of his LGBTQ community:

> "This is a lot to why people say Jamaicans are so homophobic, because the music is really homophobic and people get physically assaulted for being queer or trans—which is fine and I understand that. I was so upset, because…the White people, they were like, 'We need to boycott this band, we need to boycott [the artist],' and I'm just like, 'Well, actually, this is really messed up because it's like, first of all, yes, that song was wrong and he's apologized for that song. That song was fifteen years ago, so why are you still–?' You know? …It's weird. So then you find yourself—I find myself kind of defending Jamaicans to queers and then defending queers to Jamaicans, almost."

Multiple respondents said that LGBTQ feels like a "White" (Manny, Tashel, Gabriel, Elliot) or "North American" (Tashel) community and identity. Two participants attributed this association to portrayal of LGBTQ in the media—including representations in queer media. For example, Elliot, a queer/gay-identified, East Asian trans man, said:

> "I went to see this film at the queer film festival last night. And they had a picture of, like, a poster that they show before the film. And the only couple that they showed, everyone else was kind of not holding hands or anything. But the only couple that they had shown that was holding hands were these two White, gay—I'm assuming—cis, gay males. That's definitely sending a message, even though they did have very diverse other individuals, like all across the board. But that says something, I think."

Of all participants, four said that they feel disconnected from both their LGBTQ and racial/ethnic communities. Eight respondents mentioned general apprehension or

"mistrust" of people, based on past negative experiences concerning their marginalized identities.

Identity Relationships

Identity relationships was also a reoccurring theme in this study. Seven participants felt that each stigmatized identity contributes to everyday challenges, acting as compounding "stabs" (Rowan) against an individual. They described situations in which their intersectionality has caused problems in personal relationships and everyday encounters. Tashel, a queer Black woman, explained her mother's grievances with her several marginalized identities and how she encourages her to conceal them:

> "I guess, for her, having a daughter that has certain conditions freaks her out. Also, having a daughter that doesn't [removed for confidentiality] freaks her out. And having a queer daughter that doesn't [removed for confidentiality], that has medical conditions freaks her out. Right? So for her, it's a whole bunch of stuff, and she's always pressuring me to try some treatment or do something."

Five participants said that they choose to present themselves in ways that conceal their sexual identity in some or all contexts; four of these participants said that this is directly because of their identity as an ethnic/racial minority. Deena, a bisexual, South Asian/Indian cis woman, explained that she chooses to "assimilate" and "look normal" because "there's already a difference of culture, so adding another layer to that, it might not be in my best interest." She added:

> "My skin color is a big part of it, but now I'm queer, right? So that would be another part that people can take advantage of… It's a cultural thing—because, first, you look a certain way and then, on top of that, you're a sexual minority."

Conversely, five participants said that their marginalized identities support each other; that being able to identify as queer and racialized empowers them and allows them to comfortably claim other stigmatized identities, such as "crazy" (Tashel), "disabled,…neuro-diverse" (e.g., Autistic; Tate), and "poor" (Kai). Tashel explained how this intersectionality has had a positive effect on her life:

> "I definitely think that's a key part of my identity and it also really helps me feel good about the other parts of who I am. I feel like it gives me—Like, that part of my identity has lent me some strength in my life that I can use when tackling some of the things I don't feel so great about."

These participants addressed the conflict that can occur between feeling both hindered and empowered by these identities. Elliot said:

> "Um…It is harder [to be queer and racialized]—I think you have to do a lot more work, and there is a lot more trying to figure out where we belong. Like…It's not a given that you would just be like, 'There I am on that poster. I'm supposed to be here. Great.' But, um, but also it's really cool, because it's like you have—I think it's complicated, and…I don't think I would want it any different. I don't know if I would not want it. It's just part of identity—Like, identity to me is so many things; It's not just one thing. So, I think it can be really good."

Coming Out

Another common theme discussed by participants was the inability to disclose sexual orientation to family due to cultural homophobia. Of all participants, seven had at least one parent who was not aware of their sexual identity and four participants reported being out to both parents. Of the four participants who were both queer and trans-identified, three were concealing both of these identities from their parents. Tate, who has one Chinese parent and one White parent, chose not to disclose her sexual or gender identity to either parent.

When asked for the reasons for not disclosing their sexuality to their parents, participants explained that their parents would likely "threaten" (Rowan, Tate) or "disown" (Rowan, Gabriel) them. Rowan, a queer, Jamaican cis woman, recounted a conversation she had had with her mother:

> "I think she saw, like, an ad on Yahoo News and it was two guys kissing…and she was just, like, 'Ew! Look at my screen.' And I'm just like, 'What?' And I look at the picture and it's just two guys kissing and that pissed me off and I was like, 'You have way too much hatred. All of that just needs to stop… It's just kissing—who cares? What if it was me in the picture with a woman?' And she just looked at me and said, 'Don't ever say that in your life. I will kill you.' And I believe her."

Anger (4) was a common reaction that respondents expected from their family members, as well as disappointment (3), confusion (2), shame (2), sadness (3), heartbreak (2), and feelings of betrayal (2). Deena was concerned that if she came out to her younger brother, he would begin to also think he was queer, and that her mother would hold her responsible.

Gabriel said that when he did disclose his sexuality to his parents, they told him that he would contract HIV.

All participants ($n = 11$) believed that the value and pressure placed on coming out in the LGBTQ community does not

take into account the racial and ethnic experience. Participants said that the culture of coming out in the LGBTQ community asserts that one must come out in order to be "true to oneself" (Deena) and "authentically queer and authentically trans" (Elliot). This culture also posits that closeted sexual minorities are "two-faced," "fake" (Tashel), and "lying to themselves" (Gabriel). Campaigns that promote the importance of coming out, such as National Coming Out Day, are considered to be "awkward" (Sarah), "isolating" (Elliot), and "selfish" (Rowan) and Tashel said that they make it difficult to feel "supported by the community."

Participants listed several reasons that coming out as a racial or ethnic minority can be especially difficult. They described this experience as "stressful," (Deena) as it poses a threat to "safety" (Elliot, Sarah, Tashel, Rowan, Tate) and "comfort" (Deena, Tashel). Tashel explained how these experiences can be different for racialized people and that these differences are often ignored in mainstream culture:

> "When I was first coming out, my friends were pressuring me in a way and pushing me to come out to everyone right now. I was like, 'Whoa…I need a roof over my head. I need to be strategic about this.' And I feel that in the mainstream community, there's so much pressure to be out and be, you know, almost the poster child for queerness or whatever. And I feel like that isn't really realistic for me or realistic for a lot of people I know that are racialized, because our communities are different. No matter what people say to be politically correct, our communities are different. I don't accept that people say, 'Oh, there's no such community that is less or more homophobic.' I don't think that's the issue. I think it's the way that communities react to queerness that is very different, regardless of their level or scale of homophobia—whatever that is. Different communities react differently."

Three participants identified this as an issue of "White privilege" (Rowan, Manny, Kai) because White LGBTQ generally face fewer obstacles and prejudices, and are less likely to have to confront aggressively homophobic cultures (e.g., Jamaican, Ghanaian, Chinese).

Kai described difficulty with feeling pride for a secret identity as another issue that those with more privilege do not understand, and compared this to experiences with sex work:

> "I think there's definitely this part where… maybe some racialized people don't feel the pride that many White queers feel as a queer person, because they're not in the condition where they can come out to their parents. I think the same sort of applies to, in my case, being a sex worker; where many White, typically beautiful sex workers are so proud of being a sex worker and out about being a sex worker, whilst my parents would f*****g kill me and disown me, if I do so, right? So I cannot feel proud about it. So essentially there is this dynamic where I feel the proud-and-out people are like, 'How come you're not proud of being who you are?' and sort of see that as a shame for the community. Like, if there's one sex worker who's not proud, they're like, 'How come you're not proud? Because we're all so proud.' So I feel the same with the coming out thing."

Gabriel asserted, though, that LGBTQ-POC should not allow this come out culture to cause them to feel inauthentic or undeserving of the queer identity. Queers, he explained, must do what is best for them in their specific circumstances:

> "It's always like, if you come out, it's this huge thing and, like, 'You should reveal yourself to the world!' But some people are just not in a space to do that. Like, they can't…Like, I was ready to be kicked out of my house when I was coming out…Like, I feel like…being a good queer, maybe, is just having an awareness around what your basic needs are and making decisions around that."

Stress and Anxiety

Most respondents (diagnosed, $n = 3$; undiagnosed, $n = 5$) mentioned experiencing stress and anxiety regularly. Stress and anxiety were attributed to unemployment and finances (7), coming out (7), police encounters (e.g., racial profiling; 2), social events (2), changing pronouns (2), romantic relationships (1), transitioning (1), internalized racism and trans-misogyny (1), inaccessible spaces for disabled bodies (1), loneliness (1), and family health (1). Four participants felt that stress and anxiety have affected their health. Kai explained that their stress over financial issues caused depletion in energy that they would have otherwise used to take care of their health. Further, this participant said that they often choose to not make healthy food purchases because they have to engage in sex work in order to afford these items.

During the time she was preparing to come out to her parents, Tashel said that she experienced notable hair loss. Two participants said that, in general, they suffer digestive problems when dealing with anxiety episodes, and another said that she is medicated for anxiety attacks that occur regularly due to her financial situation.

Respondents (3) explained that anxiety is common in the queer community because of the challenges specific to sexual minorities, such as rejection from larger society, "barriers" from resources (Tate, Gabriel), and expectations within the LGBTQ community. Gabriel said:

> "I know a lot of friends that are anxious…I think you have to be, in some way. I think you have to be on your s***. It's hard—it's hard to survive and make money and make a living and always have to be doing different things. I think—especially for younger queers—I think anxiety is a big thing, because, you know, you're just coming into yourself. You're learning about this political community. It's hard…You're afraid you're going to f*** up. I did; I felt that [I might] say something politically incorrect and get called out, and all that stuff. So, like, watching and wondering who is talking about you."

In regards to these pressures, Elliot added that LGBTQ individuals must work on being kinder to themselves, because of the difficulties that come with a queer identity: "I think being queer is—it's pretty gutsy, to begin with. And so, I just think we should all be easier on ourselves."

Discussion

Although researchers have begun to identify broad issues concerning some LGBTQ groups and ethnicities, there is still a great deal that remains unknown about specific issues that affect sexual and gender minority people of color. The purpose of the present study was to examine how LGBTQ-POC describe their identities and communities, to explore microaggressions that may affect racialized sexual and gender minorities, and to learn more about how these issues are related to stress and health in this population. To address these objectives, respondents were asked to discuss their identities, oppressions, relationships, views on the LGBTQ community, and experiences with health, stress, and discrimination. From an intersectionality perspective, participant identities cannot be considered additive; each individual's experiences with stress and discrimination in the context of their combination and interaction of identities is unique. Minority stress theory suggests that each of the challenges discussed in this study contribute to the issues of stress and poor health reported by the participants. Using this approach, this study reveals new information about resilience and provides qualitative evidence to substantiate previously addressed issues concerning community conflict and well-being. The primary concepts introduced and discussed in this study are *positive intersectionality* and *come out stress*. While *come out stress*, the pressure from the LGBTQ community to disclose sexual and non-conforming gender identity, may pose an additional stress for racialized individuals, the *positive intersectionality* narrative may empower the multiply marginalized and contribute to resilience (see Table 2).

Exclusion, Segregation, and Stress

The majority of respondents expressed feeling everyday anxiety and experiencing some effect of this on their health. Many studies have identified anxiety among LGBTQ and racialized people (Meyer 2003; Williams et al. 2003), yet there are few studies that investigate, in depth, the experiences that LGBTQ-POC have with anxiety and their multiple oppressions, or how they perceive this stress and anxiety in their communities. Respondents who believed that anxiety is common in the LGBTQ community provided explanations that were consistent with Goffman (1963), who proposed that stigmatized individuals experience anxiety because they approach social situations with the expectation that they will be rejected. Goffman suggested that marginalized individuals correctly perceive that they are not accepted by others and learn to anticipate this treatment. This is congruent with participant responses regarding feelings of general mistrust for other people. Participants, Gabriel and Elliot, mentioned that much of this anxiety comes from expectations in the community to uphold a certain image and lifestyle. Research is needed to further examine these pressures that racialized LGBTQ place on themselves and each other in the community and how this impacts distress and mental health. Stress and anxiety were also connected to the other themes that emerged, including issues concerning identity, community, and coming out.

Several respondents reported feelings of disconnect from both the larger LGBTQ community, as well as their ethnoracial community. Although it has been suggested that LGBTQ-POC may come to rely more heavily on their racial/ethnic communities than on their LGBTQ communities (Jaspal and Cinnirella 2014; McQueeney 2009), most respondents in this study did not reflect this; on the contrary, they were largely removed from their ethnoracial communities. This could perhaps be partially attributed to the fact that the sample was collected in a Canadian urban area, where there are fewer barriers to LGBTQ-POC

Table 2 Primary emerging concepts based on LGBTQ-POC experience

Emerging concepts	Corresponding examples
Positive intersectionality	"…It also really helps me feel good about the other parts of who I am. I feel like it gives me—Like, that part of my identity has lent me some strength in my life that I can use when tackling some of the things I don't feel so great about."
Come out stress	"And I feel that in the mainstream community, there's so much pressure to be out… And I feel like that isn't really realistic for me or realistic for a lot of people I know that are racialized, because our communities are different. No matter what people say to be politically correct, our communities are different."

communities and organizations. Additionally, the present study appeared to include mostly individuals who were at least somewhat informed on race relations and for whom queerness is political and radical. Nonetheless, the efforts made by participants to connect to their cultures, such as exhibiting certain behaviors or pursuing non-stigmatizing ethnic groups, suggest that finding a connection or bond to their ethnicity remains a high priority. At the same time, respondents did not feel included in or connected to the larger, mainstream LGBTQ community. They discussed feeling that queer culture is not congruent with their ethnic cultures (e.g., having to defend their culture to their sexual minority group) and that experiences with racism and exclusion have caused them to withdraw from the primarily White LGBTQ community. This supports research by Giwa and Greensmith (2012), who found that gay and queer racialized men in Toronto identified racism as a major deterrent for people of color to engage with White LGBTQ communities. Feeling separated from communities may pose a risk to LGBTQ-POC, as there appears to be a positive association between community connectedness and well-being among sexual minorities (Kertzner et al. 2009). To negotiate this simultaneous divide, many respondents involved themselves in strictly LGBTQ-POC spaces, rather than participating in either ethnoracial communities or mainstream LGBTQ communities. This generally allows LGBTQ-POC to escape racism in primarily White spaces, as well as the heterosexism expected of certain ethnic/racial communities. The respondents who were involved only in LGBTQ-POC communities had fewer encounters with microaggressions and everyday racism, and received consistent support from a non-stigmatizing environment, which may contribute to overall improved well-being. This continued segregation, however, exacerbates the whitewashing of the larger LGBTQ community and further erodes progress towards realizing full integration.

The Come Out Stress Paradox

One notable theme that emerged in the present study is the pressure to "come out" and disclose sexuality to family members uniquely felt by people of color (referred to here as *come out stress*). This pressure appears in this study as a systemic microaggression in the queer community. Coming out is commonly valued as a vital step towards an authentic queer life (Rasmussen 2004). Queer scholars have proposed that concepts of "coming out" and "the closet" are based in White, middle-class conceptualizations of sexuality and identity, and that these notions cannot be applied outside of this context (Ward 2008). Campaigns such as National Coming Out Day celebrate coming out and encourage closeted sexual minorities to promote awareness about the community. This emphasis on coming out in LGBTQ culture creates an in-out binary. For example, LGBTQ film often focuses on the coming out experience with storylines that propagate the common belief that to be an actualized and active queer, one's sexual orientation must be liberated from secrecy and evolved into an entirely public identity (Cover 2000). This *come out stress* causes LGBTQ-POC to feel less authentic and further separates them from the mainstream queer community. For many respondents, being entirely out was not an option because they belonged to cultures with conservative or homophobic values. Participant experiences are in line with previous research that suggests reluctance to be fully out because disclosure of sexual identity can result in social rejection and threats of disownment (e.g., Jaspal and Siraj 2011). Indeed, it seems that LGBTQ-POC are less likely than White LGBTQ to engage with their communities and be entirely out (Rosario et al. 2004). This relates to the trouble that LGBTQ-POC often have connecting to the White, mainstream LGBTQ community and contributes to their overall stress and isolation. This is made especially complex by the emphasis on *pride* in the LGBTQ community. As Kai explained, being private about one's sexual identity may be misinterpreted by others as feeling ashamed, and that not being able to come out can prevent a person from feeling proud. Research indicates that being out is associated with reduced anxiety and higher self-esteem (Jordan and Deluty 1998; Whitman and Nadal 2015). Results from the present study suggest that further research is needed to explore how *come out stress* plays into the relationship between coming out and self-esteem and the effect that *come out stress* has on LGBTQ-POC well-being. This study and others (e.g., Jaspal and Cinnirella 2010; Jaspal and Siraj 2011) show that coming out is often not a viable option for LGBTQ-POC, yet little is being done in the mainstream to acknowledge these realities and redefine the coming out process for LGBTQ-POC. Queer organizations should conduct advocacy work that educates mainstream LGBTQ on the complexities of this issue for people of color. These organizations should also effect policy that dismantles the culture of coming out in the LGBTQ community and modifies come-out campaigns to account for the racialized experience.

In light of this clash between communities, it is understandable that multiply marginalized people may have conflicting feelings about the interactions between their identities. LGBTQ-POC must work to find balance and harmony between their communities and identities. As described by participants and supported by past research, identities may work against each other and add compounded stress and obstacles (e.g., Balsam et al. 2011; Bowleg 2008).

Code switching, described by Cross (2012), occurs when ethnoracial minority individuals alter their behavior or appearance when interacting with White individuals, in order to escape conflict or advance themselves in a prejudiced system. To avoid unnecessary complications and discrimination, respondents in this study tried to conceal the aspects of their identities that are not immediately visible to others, such as sexuality, HIV status, mental illness, disability, and sex work.

Research on self-concept differentiation, the degree to which one has differing identities in varying contexts, has revealed that this inconsistency is a sign of self-fragmentation and is associated with poor adjustment and emotional distress among college students and middle-aged women (Donahue et al. 1993). More recently, Yampolsky et al. (2013) discovered, through qualitative interviews, that multicultural individuals who compartmentalize their different identities are less likely to exhibit narrative coherence (the ability to effectively understand and communicate one's life and oneself). According to this research, LGBTQ-POC who engage in stigma concealment will be more likely to experience poor mental health. This was best exemplified by Kai, the interviewee who reported the most experiences of general poor health and sickness behavior, who said, "I definitely feel like my life is compartmentalized. Like, when I'm on the phone with my parents and they think I'm someone else and I am everything that I'm not." Research has shown that outness and queer community involvement predict lower suicidality among racialized sexual minority women (Morris et al. 2001). This presents a paradox for LGBTQ-POC, who must prioritize their safety, perhaps at the cost of their health. Future research should further investigate how queer people of color manage to connect with and balance their communities and identities, as these strategies could be critical to health and well-being.

Positive Intersectionality as a Protective Narrative

Although many participants felt the negative effects of this multiple marginalization and displayed efforts to conceal their other identities in specific contexts, they also shared a positive outlook on their intersectionality. Positive marginality is the view that one's stigmatized identity can also be embraced as a positive aspect of the self, and that the self is a member of a larger marginalized group with similar others who have the power to work for change (Unger 2000). This narrative has received support from research by Meyer et al. (2011), who found that in describing positive marginality, individuals also developed "resilience and resolve" in response to their oppressions (p. 212). According to Meyer (2010), resilience as a response to lifetime discrimination is in opposition to the tenets of minority stress theory. To test this resilience perspective, Moradi et al. (2010) examined the perceived heterosexist stigma, internalized homophobia, and comfort of sexual orientation disclosure among White LGB participants and LGBTQ-POC, and found no difference in these variables between the two groups. Further, although racialized sexual minorities experience more stressors and have fewer resources available to them (Meyer et al. 2008b), research has shown that they do not necessarily have lower self-esteem or more mental disorders compared to White sexual minorities and White heterosexuals (Meyer et al. 2008a; Whitman and Nadal 2015).

Results from the present study suggest that not only do LGBTQ-POC demonstrate the positive marginality narrative, they also exhibit *positive intersectionality*, in which they are able to identify ways their marginalized identities support one another. In other words, embracing one marginalized identity can lead to the empowerment and acceptance of other marginalized identities, which in turn improves and preserves well-being. This *positive intersectionality* narrative may provide one explanation for the resilience observed among some racialized sexual minorities. Some of the respondents in this study who engaged in stigma concealment were among those who discussed this view that identifying as queer and racialized enabled them to identify with other stigmatized identities. This positive perspective may counteract the negative effects that appear to result from discrimination and *come out stress*. The fact that only approximately half of the participants exhibited this narrative indicates that there is still a great deal to explore in terms of the factors and contexts that predict and promote *positive intersectionality* and resilience among LGBTQ-POC. A deeper understanding *of positive intersectionality* may equip researchers, service providers, and healthcare providers with an additional way to promote and predict well-being.

Limitations and Future Directions

This study contributed to LGBTQ and intersectionality literature in a number of ways; however, a few limitations should be noted. Due to lack of response from the community during the recruitment period, the sample is relatively small and there are several LGBTQ-POC identities that could not be included in this study. This study did not include all ethnoracial categories and, as a result, the data does not represent all cultural experiences. These factors limit the generalizability of these findings. Second, although an interview with a First Nations participant was included in the data, the complexities and history of the oppressions that First Nations and Aboriginal peoples are faced with were not adequately addressed in this study. Although Two-spirit individuals encounter a great deal of prejudice that stems from colonial history and ongoing practices, this sexual/gender identity is often accepted and celebrated in First Nations culture and interview questions concerning cultural homophobia may not have been applicable. Future research should aim to include more ethnicities and cultural backgrounds to fill all LGBTQ-POC identity cells. Future studies should also explore trans issues separately, as this population is subjected to several layers of oppression (Jefferson et al. 2013; Logie et al. 2012).

Conclusion

This study explored some of the intricacies of the contextual experiences of LGBTQ-POC in urban Eastern Canada.

Intersectionality theory and minority stress theory are valuable in health and policy research, as they highlight the unique lived reality of those whose experiences are immeasurable and invisible in most research and whose needs are neglected in society. The findings of this study addressed the importance of feeling connected to both ethnoracial and LGBTQ communities for LGBTQ-POC and the value of queer spaces specifically for racialized individuals. Results revealed a potentially effective resilience strategy for LGBTQ-POC, termed *positive intersectionality*, and highlight the need for the eradication or modification of come out culture in the larger LGBTQ community.

Ethical Approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

References

Akerlund, M., & Cheung, M. (2000). Teaching beyond the Deficit Model. *Journal of Social Work Education, 36*, 279–292.

Ali, K. (2006). *Sexual ethics and Islam: feminist reflections on Qur'an, Hadith, and jurisprudence*. London, UK: Oneworld Publications.

Balsam, K. F., Molina, Y., Beadnell, B., Simoni, J., & Walters, K. (2011). Measuring multiple minority stress: the LGBT People of Color Microaggressions Scale. *Cultural Diversity & Ethnic Minority Psychology, 17*(2), 163–74.

Barrett, D. C., & Pollack, L. M. (2005). Whose gay community? Social class, sexual self-expression, and gay community involvement. *Sociological Quarterly, 46*, 437.

Bauer, G. R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K. M., & Boyce, M. (2009). "I don't think this is theoretical; this is our lives": how erasure impacts health care for transgender people. *Journal of the Association of Nurses in AIDS Care, 20*(5), 348–361.

Bauer, G. R., Travers, R., Scanlon, K., & Coleman, T. a. (2012). High heterogeneity of HIV-related sexual risk among transgender people in Ontario, Canada: a province-wide respondent-driven sampling survey. *BMC Public Health, 12*(1), 292.

Bowleg, L. (2008). When Black + lesbian + woman ≠ Black lesbian woman: the methodological challenges of qualitative and quantitative intersectionality research. *Sex Roles, 59*, 312–325.

Bradford, J., & Ryan, C. (1989). *National lesbian health care survey: final report*. Washington, DC: National Lesbian and Gay Health Foundation.

Bridges, S. K., Selvidge, M. M. D., & Matthews, C. R. (2003). Lesbian women of color: therapeutic issues and challenges. *Journal of Multicultural Counseling and Development, 31*, 113–130.

Ceballos-Capitaine, A., Szapocznik, J., Blaney, N. T., Morgan, R. O., Millon, C., & Eisdorfer, C. (1990). Ethnicity, emotional distress, stress-related disruption, and coping among HIV seropositive gay males. *Hispanic Journal of Behavioral Sciences, 112*, 135–152.

Clements-Nolle, K., Marx, R., Guzman, R., & Katz, M. (2001). HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: implications for public health intervention. *American Journal of Public Health, 91*(6), 915–921.

Cochran, S. D. (2001). Emerging issues in research on lesbians' and gay men's mental health: does sexual orientation really matter? *American Psychologist, 56*, 931–947.

Cochran, S., & Mays, M. (2007). Physical health complaints among lesbians, gay men, and bisexual and homosexually experienced heterosexual individuals: results from the California Quality of Life Survey. *American Journal of Public Health, 97*(11), 2048–2055.

Cover, R. (2000). First contact: queer theory, sexual identity, and "mainstream " film. *International Journal of Sexuality and Gender Studies, 5*(1), 71–89.

Crenshaw, K. (1991). Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*, 1241–1279.

Crichlow, W. (2004). *Buller men and batty bwoys: hidden men in Toronto and Halifax Black communities*. Toronto, ON: University of Toronto Press.

Cross, W. E. (2012). The enactment of race and other social identities during everyday transactions. In C. L. Wijeyesinghe & B. W. Jackson (Eds.), *New perspectives on racial identity development: a theoretical and practical anthology* (2nd ed.). New York, NY: New York University Press.

Diamant, A. L., & Wold, C. (2003). Sexual orientation and variation in physical and mental health status among women. *Journal of Women's Health, 12*(1), 41–49.

Donahue, E. M., Robins, R. W., Roberts, B. W., & John, O. P. (1993). The divided self: concurrent and longitudinal effects of psychological adjustment and social roles on self-concept differentiation. *Journal of Personality and Social Psychology, 64*(5), 834–846.

Dunbar, E. (2006). Race, gender, and sexual orientation in hate crime victimization: Identity politics or identity risk? *Violence and Victims, 21*(3), 323–337.

Fredriksen-Goldsen, K. I., Kim, H. J., Barkan, S. E., Muraco, A., & Hoy-Ellis, C. P. (2013). Health disparities among lesbian, gay, and bisexual older adults: results from a population-based study. *American Journal of Public Health, 103*(10), 1802–9.

Friedman, E. M., Williams, D. R., Singer, B. H., & Ryff, C. D. (2009). Chronic discrimination predicts higher circulating levels of E-selectin in a national sample: the MIDUS study. *Brain, Behavior, and Immunity, 23*, 684–692.

Frost, D. M. (2011). Social stigma and its consequences for the socially stigmatized. *Social and Personality Psychology Compass, 5*(11), 824–839.

Frost, D. M., & Bastone, L. M. (2007). The role of stigma concealment in the retrospective high school experiences of gay, lesbian, and bisexual individuals. *Journal of LGBT Youth, 5*(1), 27–36.

Frost, D. M., Parsons, J. T., & Nanin, J. E. (2007). Stigma, concealment and symptoms of depression as explanations for sexually transmitted infections among gay men. *Journal of Health Psychology, 12*(4), 636–640.

Frost, D. M., Lehavot, K., & Meyer, I. H. (2013). Minority stress and physical health among sexual minority individuals. *Journal of Behavioral Medicine, 38*(1), 1–8.

Garofalo, R., Deleon, J., Osmer, E., Doll, M., & Harper, G. W. (2006). Overlooked, misunderstood, and at-risk: exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *Journal of Adolescent Health, 38*(3), 230–236.

Gilman, S. E., Cochran, S. D., Mays, V. M., Hughes, M., Ostrow, D., & Kessler, R. C. (2001). Risks of psychiatric disorders among individuals reporting same-sex sexual partners in the National Comorbidity Survey. *American Journal of Public Health, 91*, 933–939.

Giwa, S., & Greensmith, C. (2012). Race relations and racism in the LGBTQ community of Toronto: perceptions of gay and queer social service providers of color. *Journal of Homosexuality, 59*(2), 149–185.

Goffman, E. (1963). *Stigma: notes on the management of spoiled identity*. New York, NY: Simon & Schuster.

Grollman, E. A. (2012). Multiple forms of perceived discrimination and health among adolescents and young adults. *Journal of Health and Social Behavior, 53*(2), 199–214.

Grossman, A. H., & D'Augelli, A. R. (2007). Transgender youth and life-threatening behaviors. *Suicide and Life-Threatening Behavior, 37*, 527–537.

Grundy, J., & Smith, M. (2005). The politics of multiscalar citizenship: the case of lesbian and gay organizing in Canada. *Citizenship Studies, 9*(4), 389–404.

Gutzmore, C. (2004). Casting the first stone!: policing of homo/sexuality in Jamaican popular culture. *Interventions, 6*(1), 118–134.

Hatzenbuehler, M. L., McLaughlin, K. A., Keyes, K. M., & Hasin, D. S. (2010). The impact of institutional discrimination on psychiatric disorders in lesbian, gay, and bisexual populations: A prospective study. *American Journal of Public Health, 100*(3), 452–459.

Herek, G. M., Gillis, J. R., & Cogan, J. C. (1999). Psychological sequelae of hate-crime victimization among lesbian, gay, and bisexual adults. *Journal of Consulting and Clinical Psychology, 67*, 945–951.

Jaspal, R., & Cinnirella, M. (2010). Coping with potentially incompatible identities: accounts of religious, ethnic, and sexual identities from British Pakistani men who identify as Muslim and gay. *The British Journal of Social Psychology / the British Psychological Society, 49*, 849–870.

Jaspal, R., & Cinnirella, M. (2014). Hyper-affiliation to the religious in-group among British Pakistani Muslim gay men. *Journal of Community & Applied Social Psychology, 24*, 265–277.

Jaspal, R., & Siraj, A. (2011). Perceptions of 'coming out' among British Muslim gay men. *Psychology and Sexuality, 2*(3), 183–197.

Jefferson, K. B., Neilands, T., & Sevelius, J. (2013). Transgender women of color: discrimination and depression symptoms. *Ethnicity and Inequalities in Health and Social Care, 6*(4), 121–136.

Jordan, K. M., & Deluty, R. H. (1998). Coming out for lesbian women: its relation to anxiety, positive affectivity, self-esteem, and social support. *Journal of Homosexuality, 35*(2), 41–63.

Kertzner, R. M., Meyer, I. H., Frost, D. M., & Stirratt, M. J. (2009). Social and psychological well-being in lesbians, gay men, and bisexuals: the effects of race, gender, age, and sexual identity. *The American Journal of Orthopsychiatry, 79*(4), 500–10.

Krieger, N., Chen, J. T., Waterman, P. D., Hartman, C., Stoddard, A. M., Quinn, M., & Barbeau, E. M. (2008). The inverse hazard law: blood pressure, sexual harassment, racial discrimination, workplace abuse and occupational exposures in US low-income Black, White and Latino workers. *Social Science and Medicine, 67*(12), 1970–1981.

Kudler, B. A. (2007). *Confronting race and racism: social identity in African American gay men (Master's thesis). Smith College School for Social Work*. MA: Northampton.

Liao, K. Y., Weng, C., & West, L. M. (2016). Social connectedness and intolerance of uncertainty as moderators between racial microaggressions and anxiety among Black individuals. *Journal of Counseling Psychology, 63*(2), 240–246.

Littleton, H. L., Grills-Taquechel, A. E., Buck, K. S., Rosman, L., & Dodd, J. (2013). Health risk behavior and sexual assault among ethnically diverse women. *Psychology of Women Quarterly, 37*(1), 7–21.

Logie, C. H., James, L. L., Tharao, W., & Loutfy, M. R. (2012). "We don't exist": a qualitative study of marginalization experienced by HIV-positive lesbian, bisexual, queer and transgender women in Toronto, Canada. *Journal of the International AIDS Society, 15*(2), 1–11.

Mayeda, D. T., & Pasko, L. (2012). Youth violence and hegemonic masculinity among Pacific Islander and Asian American adolescents. *Critical Criminology, 20*(2), 121–139.

McCabe, S. E., Bostwick, W. B., Hughes, T. L., West, B. T., & Boyd, C. J. (2010). The relationship between discrimination and substance use disorders among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health, 100*(10), 1946–1952.

McQueeney, K. (2009). "We are all God's children, ya'll:" race, gender, and sexuality in lesbian- and gay-affirming congregations. *Social Problems, 56*(1), 151–173.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697.

Meyer, I. H. (2010). Identity, stress, and resilience in lesbians, gay men, and bisexuals of color. *The Counseling Psychologist, 38*(3), 442–454.

Meyer, I. H., Frost, D. M., Narvaez, R., & Dietrich, J. H. (2006). Project Stride methodology and technical notes. Retrieved from Project STRIDE website: http://www.columbia.edu/~im15/method/stridemethod.pdf.

Meyer, I. H., Dietrich, J., & Schwartz, S. (2008a). Lifetime prevalence of mental disorders and suicide attempts in diverse lesbian, gay, and bisexual populations. *American Journal of Public Health, 98*(6), 1004–6.

Meyer, I. H., Schwartz, S., & Frost, D. M. (2008b). Social patterning of stress and coping: does disadvantaged social statuses confer more stress and fewer coping resources? *Social Science and Medicine, 67*(3), 368–79.

Meyer, I. H., Ouellette, S. C., Haile, R., & McFarlane, T. A. (2011). "We'd be free": narratives of life without homophobia, racism, or sexism. *Sexuality Research & Social Policy, 8*(3), 204–214.

Moradi, B., Wiseman, M. C., DeBlaere, C., Goodman, M. B., Sarkees, a., Brewster, M. E., & Huang, Y.-P. (2010). LGB of color and White individuals' perceptions of heterosexist stigma, internalized homophobia, and outness: comparisons of levels and links. *The Counseling Psychologist, 38*(3), 397–424.

Morris, J. F., Waldo, C. R., & Rothblum, E. D. (2001). A model of predictors and outcomes of outness among lesbian and bisexual women. *Journal of Orthopsychiatry, 71*, 61–71.

Munro, L., Travers, R., John, A. S., Klein, K., Hunter, H., Brennan, D., & Brett, C. (2013). A bed of roses?: exploring the experiences of LGBT newcomer youth who migrate to Toronto. *Ethnicity and Inequalities in Health and Social Care, 6*(4), 137–150.

Nadal, K. L. (2011). The Racial and Ethnic Microaggressions Scale (REMS): construction, reliability, and validity. *Journal of Counseling Psychology, 58*(4), 470–480.

Nadal, K. L., Issa, M. A., Leon, J., Meterko, V., Wideman, M., & Wong, Y. (2011). Sexual orientation microaggressions: "Death by a Thousand Cuts" for lesbian, gay, and bisexual youth. *Journal of LGBT Youth, 8*(3), 234–259.

Nakamura, N., & Zea, M. C. (2010). Experiences of homonegativity and sexual risk behavior in a sample of Latino MSM. *Culture, Health and Sexuality, 12*, 73–85.

Narváez, R. F., Meyer, I. H., Kertzner, R. M., Ouellette, S. C., & Gordon, A. R. (2009). A qualitative approach to the intersection of sexual, ethnic, and gender identities. *Identity, 9*(1), 63–86.

Noh, S., Kaspar, V., & Wickrama, K. A. S. (2007). Overt and subtle racial discrimination and mental health: preliminary findings for Korean immigrants. *American Journal of Public Health, 97*(7), 1269–1274.

Pachankis, J. E., Hatzenbuehler, M. L., Hickson, F., Weatherburn, P., Berg, R. C., Marcus, U., & Schmidt, A. J. (2015). Hidden from health: structural stigma, sexual orientation concealment, and HIV across 38 countries in the European MSM Internet Survey. *AIDS, 29*(10), 1239–1246.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage Publications, Inc.

Rasmussen, M. L. (2004). The problem of coming out. *Theory Into Practice, 43*(2), 144–150.

Remedios, J. D., Chasteen, A. L., Rule, N. O., & Plaks, J. E. (2011). Impressions at the intersection of ambiguous and obvious social categories: Does gay+Black=likable? *Journal of Experimental Social Psychology, 47*(6), 1312–1315.

Reygan, F., & Lynette, A. (2014). Heteronormativity, homophobia and "culture" arguments in KwaZulu-Natal, South Africa. *Sexualities, 17*(5-6), 707–723.

Rosario, M., Schrimshaw, E. W., & Hunter, J. (2004). Ethnic/racial differences in the coming-out process of lesbian, gay, and bisexual youths: a comparison of sexual identity development over time. *Cultural Diversity & Ethnic Minority Psychology, 10*(3), 215–28.

Sandfort, T. G., de Graaf, R., Bijl, R. V., & Schnabel, P. (2001). Same-sex sexual behavior and psychiatric disorders: findings from the Netherlands Mental Health Survey and Incidence Study (NEMESIS). *Archives of General Psychiatry, 58*, 85–91.

Serano, J. (2007). *Whipping girl: a transsexual woman on sexism and the scapegoating of femininity.* Emeryville, CA: Seal.

Simien, E. M. (2007). Doing intersectionality research: from conceptual issues to practical examples. *Politics & Gender, 3*(02), 264–272.

Singh, A. A. (2013). Transgender youth of color and resilience: negotiating oppression and finding support. *Sex Roles, 68*(11-12), 690–702.

Smith, J. (1996). Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11*(2), 261–271.

Steele, L. S., Ross, L. E., Dobinson, C., Veldhuizen, S., & Tinmouth, J. M. (2009). Women's sexual orientation and health: Results from a Canadian population-based survey. *Women & Health, 49*(5), 353–67.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: implications for clinical practice. *The American Psychologist, 62*(4), 271–86.

Teengs, D., & Travers, R. (2006). "River of life, rapids of change": understanding HIV vulnerability among Two-Spirit youth who migrate to Toronto. *Canadian Journal of Aboriginal Community-Based HIV/AIDS Research, 1*, 17–28.

Thoits, P. A. (1995). Stress, coping, and social support processes: where are we? What next? *Journal of Health and Social Behavior, 35*, 53–79.

Todorova, I. L. G., Falcón, L. M., Lincoln, A. K., & Price, L. L. (2010). Perceived discrimination, psychological distress and health. *Sociology of Health & Illness, 32*(6), 843–861.

Unger, R. K. (2000). The 1999 SPSSI Presidential Address: outsiders inside: positive marginality and social change. *Journal of Social Issues, 56*(1), 163–179.

Ward, E. G. (2005). Homophobia, hypermasculinity and the US black church. *Culture, Health and Sexuality, 7*(5), 493–504.

Ward, J. (2008). White normativity : the cultural dimensions of whiteness in a racially diverse LGBT organization. Sociological Perspectives, 51(3), 563–586

Whitman, C. N., & Nadal, K. L. (2015). Sexual minority identities: outness and well-being among lesbian, gay, and bisexual adults. *Journal of Gay & Lesbian Mental Health, 19*(4), 370–396.

Williams, L. (2000). Homophobia and gay rights activism in Jamaica. *Small Axe, 7*, 106–111.

Williams, D. R., Yu, Y., Jackson, J. S., & Anderson, N. B. (1997). Racial differences in physical and mental health socio-economic status, stress and discrimination. *Journal of Health Psychology, 2*(3), 335–351.

Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2003). Racial/ethnic discrimination and health: findings from community studies. *American Journal of Public Health, 93*(2), 200–208.

Yampolsky, M. A., Amiot, C. E., & de la Sablonnière, R. (2013). Multicultural identity integration and well-being: a qualitative exploration of variations in narrative coherence and multicultural identification. *Frontiers in Psychology, 4*(March), 1–15.