LGBTQ+ People and Discrimination: What We Have and Continue to Face in the Fight for Our Lives

Anneliese Singh, Rebekah Ingram Estevez, and Natalia Truszczynski

Writing about the experiences of LGBTQ+ people and discrimination is both a solemn and daunting task, as there is much to cover. LGBTQ+ communities have faced pervasive and persistent generational trauma and discrimination due to colonization and indigenous erasure of LGBTQ+ identities over many centuries that has extended into our current sociopolitical times (Singh et al., 2020). This trauma and discrimination has become embedded in societal institutions, such as education, healthcare, law, and more—which then plays out across interpersonal relationships in multiple settings (e.g., family, dating, friendship, work) to create inequities on a grand scale for LGBTQ+ people (Fig. 1).

We note this solemn and daunting task at the outset of this chapter, as it will be impossible to cover LGTBQ+ discrimination exhaustively. We also note the overwhelming nature of this task, as we want to also push against this discrimination even as we write. Yes, LGBTQ+ people and communities have faced, and continue to face, extensive societal bias and prejudice. Yet, a key understanding of LGBTQ+ discrimination has also been that LGBTQ+ people have also fought for their lives in a multitude of ways through coping and resilience to discrimination that we must acknowledge in psychology and the helping professions. We must also note that because of intersecting advantages and disadvantages, some in the LGBTQ+ community have been able to buffer the effects of discrimination through their privileged identities (e.g., white, able-bodied, middle and upper class, educational access, U.S. citizen, Christianity, etc.). So, as we write this chapter, we issue at the outset a debt of gratitude to the generations of Black feminist women, such as

A. Singh (✉)
Office of Chief Diversity Officer, Tulane University, New Orleans, LA, USA
e-mail: anneliese@tulane.edu

R. I.Estevez · N. Truszczynski
Department of Counseling Psychology, University of Georgia, Athens, GA, USA
e-mail: rebeste@uga.edu; nattrus@uga.edu

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Fig. 1 Dr. Alexis Gumbs, author and poet, presents at the LGBTQ Scholars of Color Network Conference. Photo Courtesy of Riya Ortiz/Red Papillon Photography

Sojourner Truth (1863), Kimberlé Crenshaw (1991), Brittany Cooper (2018), and many, many more who have gifted us the scholarship of intersectionality that demands we examine how interlocking oppressions influence well-being and access to the resources people need to survive and fight against societal inequity.

In this chapter, we cover essential constructs to know in order to understand LGBTQ+ discrimination, and the types of discrimination experiences LGBTQ+ communities face. We also review the LGBTQ+ resilience and coping literature, share a case study that highlights the impact of discrimination for LGBTQ+ people from an intersectionality theory perspective. We end with implications for practice, policy, and advocacy, so mental health professionals can seek to dismantle cis-het supremacy and other interlocking oppressions through reducing the harm our professions have and continue to inflict on LGBTQ+ communities.

1 Understanding LGBTQ+ Experiences of Discrimination: Essential Concepts

The LGBTQ+ community is heterogenous in nature, made of several microgroups encompassing varying sexual orientations (e.g. lesbian, queer) and gender identities (e.g. non-binary, trans man; Mink et al., 2014). Sexual orientation is a separate, though related, construct from gender identity. A person's sexual orientation reflects

their sexual, emotional, and/or physical attraction to another person, while gender identity reflects a person's internally experienced sense of where they fall on the gender spectrum of identities such as woman, man, third gender, non-binary, and/or agender (American Psychological Association, 2015; Knutson et al., 2019).

In order to acknowledge the pervasive impact of LGBTQ+ discrimination, we must know terms related to the mechanisms of LGBTQ+ oppression. Society as a whole is steeped in heteronormativity—the social norm and policy-enforced belief that there are two genders (cisgender man and woman), two sexes (male and female), and that romantic and/or sexual relationships should consist of cisgender man/woman pairs and families should be headed by such gendered and sexually normative individuals (Oswald et al., 2005, as cited in Allen & Mendez, 2018). Heteronormativity is a powerful systemic force within the social, institutional, and political domains and confers privilege and power to groups whose identities align with these norms and values (Allen & Mendez, 2018; Mink et al., 2014). Thus, people whose sexual orientation and/or gender identity differ are subject to prejudice, discrimination, and rejection, the effects of which detrimentally impact health and wellbeing (Meyer, 2003; Meyer, 2015; Hendricks & Testa, 2012).

Importantly, expressions of heteronormativity intersect with other systems of power and oppression within which it is embedded—namely classism, ethnocentricity, racism, nationalism, and able-bodied bias, among others (Allen & Mendez, 2018; Crenshaw, 1989; Mink et al., 2014). Additionally, the classic model of heteronormativity has been expanded to include some previously "variant" genders (binary trans men and women), sexualities (lesbian, gay, and bisexual), and family groupings (monogamous gay and lesbian couples and their children; Allen & Mendez, 2018). However, people whose identities fall under the LGBTQ+ "umbrella" still face identity-based stigma and discrimination and subsequent negative impact on mental and physical health.

In addition to heteronormativity, essential concepts towards understanding the types of discrimination experienced by the LGBTQ+ community include intersectionality theory and the minority stress model (Meyer, 2003; Meyer, 2015). Introduced to the scholarly community by Black feminist author Kimberlé Crenshaw, intersectionality is a framework that allows an understanding of how intersecting systems of oppression (e.g. heteronormativity, cisgenderism, racism) create a unique experience of oppression in persons whose identities are tied to these systems. As herself stated:

> Intersectionality is a lens through which you can see where power comes and collides … it's not simply that there's a race problem here, a gender problem here, and a class or [LGBTQ+] problem there …

Thus, taking an intersectional approach to the study of LGBTQ+ communities is essential in order to fully understand risks and opportunities for healing (Mink et al., 2014; Tan et al., 2020).

After Crenshaw noted the importance of intersectionality in understanding legal inequities, Meyer (1995) developed the minority stress model to note the observed mental and physical health inequities experienced by the LGB community.

According to this model, distal or external (e.g. experiencing discrimination) and proximal or internal (e.g. expecting future discrimination experiences) stressors that are unique, identity-based, and emanate from the social/cultural level and have direct impacts on LGB health (Meyer, 2003). This initial model has since been expanded to be inclusive of trans and non-binary (TNB) identities, with unique distal (e.g. non-affirmation of identity) and proximal (e.g. concealment of trans identity) stressors identified in this population (Hendricks & Testa, 2012; Testa et al., 2015; McLemore, 2018). Importantly, the minority stress model and other models, such as the Intersectional Ecology Model (IEM) of LGBTQ+ health, show that the source of stress and subsequent negative impact on health does not lie *within* LGBTQ+ individuals, nor is due to one's LGBTQ+ identity (Mink et al., 2014; Meyer, 2015). Instead, observed health inequities that LGBTQ+ people face are due to social level determinants of health, such as stigma, discrimination, and rejection due to one's identity that does not align with heteronormativity.

2 General Impact of Discrimination on LGBTQ+ Health and Wellbeing

Researchers in public health and psychology have documented a number of detrimental impacts of minority stress and experiences of discrimination in the LGBTQ+ community. Broadly, LGBTQ+ identified peoples' reported rates of mental health disorders such as anxiety and depression (Irish et al., 2019; Plöderl & Tremblay, 2015), disordered eating behaviors (Austin et al., 2009), psychological distress (Kelleher, 2009; Becker et al., 2014), and substance abuse (Bränström & Pachankis, 2018) are elevated in relation to heterosexual persons. Further, some studies have found that LGB-identified individuals are significantly more likely to have comorbid mental health conditions than their same-gender heterosexual peers (e.g. Cochran et al., 2003; Bränström & Pachankis, 2018).

Additionally, suicidal ideation and attempts are a major concern for persons who fall under the LGBTQ+ umbrella, especially for LGBTQ+ youth (Haas et al., 2010; Hottes et al., 2016; Rhoades et al., 2018). Particular types of identity-related stressors faced by the LGB community include law enforcement harassment, threats of bodily harm, barred access to social resources and support, workplace discrimination, housing insecurity, concealment of identity, social isolation, familial rejection, identity disclosure-related stress, subsequent negative emotional experiences such as shame and guilt, and the use of maladaptive coping mechanisms (Mink et al., 2014; DeSouza et al., 2017; Riggle et al., 2017; Kaniuka et al., 2019; Bruce et al., 2015; Pachankis et al., 2015; Mereish et al., 2014; Mallory et al., 2014). Of particular importance, familial rejection (Needham & Austin, 2010) and experiencing conflict between one's religious and sexual minority identity (e.g. Gibbs & Goldbach, 2015) have been identified as predictors of psychiatric distress and negative socioeconomic outcomes such as housing insecurity.

3 Impact of Discrimination on the Health and Wellbeing of LGBTQ+ BIPOC Communities

The scholarship using intersectionality theory to examine the impact of heteronormativity and racism, classism, ageism, adultism, xenophobia, and other interlocking oppressions on LGBTQ+ health is still emerging. Much of the research emerging initially has suggested that being LGBTQ+ and BIPOC (Black, Indigenous, People of Color) increases the likelihood of experiencing racialized forms of heteronormativity, such as unequal access to socioeconomic resources like employment and health insurance, and vicarious or secondary trauma through witnessing violence and rejection (Balsam et al., 2015; Ramirez & Paz Galupo, 2019). For instance, LGBTQ+ BIPOC experience both discrimination and anticipation of rejection from their own racial/ethnic communities *and* from the broader, majority white LGBTQ+ community (Hailey et al., 2020; McConnell et al., 2018; Balsam et al., 2011). These unique distal and proximal stressors create barriers in the access to social capital, such as experiencing a sense of belongingness, connection to community, and the conferral of other community level resources that can buffer the impact of racism and heterosexism.

Rejection and discrimination from within one's own racial/ethnic community can also be experienced as particularly distressing due to the absence of community support in the face of structural and interpersonal racism, and has been postulated as the reason for lower rates of sexual identity disclosure among LGBTQ+ BIPOC (Balsam et al., 2015). However, some studies have shown that despite being exposed to more discrimination and victimization, LGBTQ+ BIPOC show little to no differences in the domains of physical and mental health (e.g. Balsam et al., 2015; Hatzenbuehler, 2009). Scholars have suggested that this pattern of results may in part be due to LGBTQ+ BIPOC resilience and coping processes, perhaps informed by prior exposure to race-based stress in development and the need to cope with and be resilient to racism that then strengthens resistance to racialized heteronormative bias (Bowleg et al., 2003; McConnell et al., 2018).

4 Impact of Discrimination on the Health and Wellbeing of TNB Communities

As previously stated, the specific identity-related minority stressors due to heteronormativity and cisnormativity in society are similar yet distinct processes for members of the TNB community (Hendricks & Testa, 2012; Testa et al. 2015). The scholarship regarding TNB individuals' experiences of discrimination and subsequent impact on mental health has grown over the last few decades, but still lags in important areas such as epidemiology and psychology (Reisner et al., 2016; Valentine & Shipherd, 2018). We do know that TNB people experience highly disparate rates of negative health and wellbeing, as well as high rates of identity-related

stigma and victimization, when compared to their cisgender counterparts (Millet et al., 2017; Tan et al., 2020; James et al., 2016). This holds true even when compared to cisgender people who identify as a sexual minority (Sue et al., 2016).

Specific types of minority stressors for TNB individuals include non-affirmation of identity through misgendering or the incorrect use of name and pronouns, discrimination in medical settings, victimization and harassment in public settings like bathrooms, home and family violence, and loss of control over identity disclosure choice due to factors such as stage of medical transition and access to medical care (McLemore, 2018; Testa et al., 2015; Hendricks & Testa, 2012; Cogan et al., 2020; Goldberg et al., 2019). These distal or external stressors also contribute to specific proximal or internal identity based stressors, such as fear of future rejection or victimization, internalized negative beliefs about oneself due to TNB identity, identity concealment, and using subsequent maladaptive coping mechanisms such as isolation, substance abuse and non-suicidal self-harm behaviors to mitigate feelings of shame, fear, and hypervigilance (Dickey et al., 2015; Testa et al., 2017; Sue et al., 2016; Testa et al., 2015; Hendricks & Testa, 2012; Cogan et al., 2020; Rood et al., 2016).

Also of note, the TNB community is itself a community made of up of multiple micro-communities of individuals with varying gender identities such as binary trans people (e.g. trans man), non-binary people (e.g. genderqueer), and people who do not identify with having a gender identity (e.g. gendervoid; Matsuno, 2019). Recent scholarship has shown that non-binary people experience more frequent and pervasive minority stressors and subsequent increased rates of mental health disparities (e.g. Goldberg et al., 2019; Lefevor et al., 2019). More research is desperately needed regarding the unique experiences and needs of non-binary and genderqueer individuals as this literature base is nascent.

While research with the TNB community is growing, there is a dearth in research centering the unique experiences of racialized trans-prejudice in the lives of TNB BIPOC. Additionally, research centering the intersectional impact of other systems of oppression (e.g. classism, religious affiliation) are nascent. However, existing studies have shown that the detrimental impact of living at the intersection of racism and trans-prejudice produces particularly insidious and consistent patterns of exposure to violence, discrimination, and prejudice, with subsequent detrimental impacts on health (James et al., 2016). The deadly impact of racism intersecting with trans-prejudice, and the protective privilege of whiteness, was highlighted in a recent report showing that while overall, TNB individuals were less likely to be murdered than their cisgender counterparts, young Black and Latina transfeminine persons were significantly more likely to be murdered than their cisgender counterparts (Dinno, 2017). Similarly, in 2019, of the 25 reported killings of TNB people, 91% were Black trans women and 81% were younger than 30 (Human Rights Campaign Foundation, 2019). These reported statistics of violence against TNB people also highlight other variables that are salient in the lives of TNB BIPPOC—geographic location and age. For instance, the majority of TNB people murdered are under the age of 30 and live in the South (Human Rights Campaign Foundation, 2019).

In addition to homicide, documented distal stressors against TNB BIPOC include barred access to socioeconomic resources like employment discrimination and subsequent poverty and housing insecurity, emotional abuse, high rates of living with HIV, police harassment, dispirate incarceration rates, high levels of sexual assault and violence, and discrimination within healthcare settings (James et al., 2016; Poteat et al., 2016; James & Salcedo, 2017; Brown & Jones, 2014). Importantly, such experiences of discrimination have been linked to not just one's trans identity, but one's *racialized* trans identity (e.g. Howard et al., 2019). While there have been important methodological questions raised regarding the reported high rates of HIV/AIDS in the TNB community (e.g. Poteat et al., 2016), TNB BIPOC are often forced to engage in survival sex work, an employment strategy which carries with it a high risk for HIV/AIDS, due to factors such as employment discrimination and subsequent poverty, in order to provide for basic needs and access to trans-affirming medical procedures (Poteat et al., 2017; Bith-Melander et al., 2010; Sevelius, 2013). Further investigating unique intersectional structural impacts on experiences of discrimination, Latinx TNB individuals immigrating to the U.S. face unique stressors, such as trauma due to their TNB identity pre-immigration in their home country, and a severe lack of social and structural support post-immigration such as policy-level barriers to accessing resources such as housing, education, and employment (Morales, 2013; Rhodes et al., 2015).

Overall, it is clear that (a) sexual orientation and gender minority stress have real and detrimental impacts on the health and wellbeing of the LGBTQ+ community, (b) different types of minority stress exist within the micro-communities embedded under the LGBTQ+ umbrella, and (c) the impact of interlocking systems of oppression with heteronormativity and cisnormativity compound experiences of unique types of minority stress. Finally, more research is desperately needed that takes an intersectional approach to understanding the impact of discrimination, violence, rejection, and the internalization of these events in the lives of LGBTQ+ people (Fig. 2).

5 LGBTQ+ Coping and Resilience

When research studying the health outcomes of LGBTQ+ people first became prevalent, this scholarship initially focused heavily on what were considered unhealthy behaviors (e.g. substance use, sex work) and experienced violence (Benotsch et al., 2013; Clements-Nolle et al., 2006). However now, the research focus has shifted away from events that happen to LGBTQ+ people, and their "problem behaviors" to how these communities cope with anti-LGBTQ+ bias and build and express resilience (Kwon, 2013; Meyer, 2015; Singh et al., 2014). Research on coping and resilience has started with defining resilience and types of coping and has only recently started to examine how resilience and coping may help reduce the impact of anti-trans bias and improve health outcomes (Budge et al., 2017; Kwon 2013; Meyer, 2015; Singh et al., 2014; White Hughto et al., 2017).

Fig. 2 Kalaya'an Mendoza and Robyn Ayers are members of Across Front Lines—a collective of social justice practitioners who work alongside communities to advocate for justice and equity. Photo Courtesy of Kalaya'an Mendoza

Literature defining the coping strategies among LGBTQ+ people is still scarce. The majority of studies that do exist examine avoidant coping strategies (e.g. substance use, self-harm, ignoring the problem) in response to discrimination and stigma. In line with other coping research, avoidant coping in LGBTQ+ people is associated with more negative mental health outcomes in response to stigma than those who did not endorse avoidant coping mechanisms. Avoidant coping has been associated with higher levels of depression and anxiety in multiple studies (Budge et al., 2013; Kwon, 2013; Mizock & Mueser, 2014; White Hughto et al., 2017). Only in one study was coping clearly defined as the mediator between discrimination and mental health, leaving room for future research (White Hughto et al., 2017).

One study with TNB people examined adaptive strategies mediating the impact of coming out on mental health (Budge et al., 2017). Nine themes of adaptive coping were identified that closely reflect resilience strategies as well. Some themes were: accepting support and seeking support, utilization of agency and increasing protection of self, self-efficacy, and self-acceptance. This study marks the beginning of researchers identifying identity-specific coping strategies and bridging the gap in research between TNB resilience and coping (Budge et al., 2017).

Where there is a dearth in research adaptive coping strategies among TNB people, multiple qualitative studies have examined the themes of resilience among TNB people. Qualitative research has identified seven themes of resilience among transgender and TNB people (Moody et al., 2015; Singh, 2013; Singh et al., 2011; Singh

& McKleroy, 2010; Singh et al., 2014). They are: (1) evolving definition of self, (2) embracing self-worth, (3) awareness of oppressions, (4) connection with a supportive community, (5) cultivating hope for the future, (6) social activism and (7) being a positive role model (Moody et al., 2015; Singh, 2013; Singh et al., 2011; Singh & McKleroy, 2010; Singh et al., 2014).

Another resilience factor that has recently emerged in research is asserting oneself or confrontation (Bry et al., 2017; Budge et al., 2016). Qualitative research with TNB young people has found this factor to be especially important in building confidence and dealing with microaggressions and other forms of discriminatory stress (Bry et al., 2017; Budge et al., 2016). The act of standing up for oneself and expressing one's opinion allowed the participants to feel heard, and feel like they took action, even if it did not result in the person changing their mind (Bry et al., 2017; Budge et al., 2016). This resilience factor combines other previously identified factors, such as self-defining identity and participation in activism/advocacy.

The themes of resilience represent individual processes that exist within the context of a TNB person's community and resources. Resilience, as conceptualized for TNB people in response to minority stress, exists on the community level, where it cannot exist without the presence of the community, and community-based, affirming resources (Meyer, 2015). While to be resilient, the person must take part in individual resilient processes, it is not solely dependent on the processes listed previously, making it different from coping strategies. Additionally, resilience has been described as successful coping (Meyer, 2015). Whereas coping can be adaptive or maladaptive, resilience is by definition adaptive.

The community context of resilience is a key element in TNB resilience and is what differentiates it from the original academic conceptualizations of resilience. Because TNB individuals experience chronic stress and discrimination based on their community identity, it would be unrealistic to claim that the response to the community stress is individualistic (Meyer, 2015). Thinking about resilience on the community level allows for resilience to rely on the presence of resources such as community centers, affirming clinics and other healthcare providers, support groups, networking, and organizations that provide opportunities to both provide advocacy and needed resources (Meyer, 2015; Singh et al., 2014). It is within the context of the community provided resources that individuals can participate in individual resilience processes (Meyer, 2015; Singh et al., 2011).

Current research in the field of resilience among TNB individuals has focused on describing the processes of resilience and providing conceptual and theoretical frameworks. Most studies that examine resilience do not directly tie it to any outcomes other than to hypothesize that it increases survival and decreases mental health issues (Moody et al., 2015; Singh & McKleroy, 2010). However, some researchers have examined how specific components of resilience are associated with health outcomes among TNB people, mainly mental health outcomes (Bockting et al., 2013; Breslow et al., 2015; Budge et al., 2013; Pflum et al., 2015).

Multiple studies found that social (or peer) support moderates the impact of stigma on mental health (Bockting et al., 2013; Breslow et al., 2015; Budge et al., 2013; Pflum et al., 2015). Social support is the resilience theme that has been found

most consistently in research to improve the mental health outcomes of TNB people. One key factor about social support is that, while not necessary, social support from other TNB people was especially protective against negative mental health outcomes (Budge et al., 2013; Moody et al., 2015; Pflum et al., 2015). Other resilience themes such as identity pride and activism/advocacy have contradictory findings in terms of their impact on TNB mental health (Breslow et al., 2015). This may come from the lack of a community-specific measurement tool, or from small sample sizes. What is clear from these findings in that more research must be conducted on both adaptive coping strategies and resilience to discrimination so that future interventions and counseling methods can be constructed from clear research-based evidence.

Up to now in this chapter, we have explored the broad experiences of LGBTQ+ discrimination, resilience, and coping. In the next section, we integrate attention to how sexism, classism, immigration, and fatphobia can interlock with the oppressions of anti-LGBTQ+ discrimination and racism. We follow this intersectional case example with implications for practice, policy, and advocacy.

6 Case Example

Pritham is a 66-year old lesbian, cisgender woman who identifies as a Sikh, third-generation South Asian American and U.S. citizen who uses she/her/hers pronouns. She works as an engineer in the southern U.S., where she is Vice-President of her organization. Pritham has struggled the last 2 years with depression that emerged after the death of her partner of 30 years. She is estranged from her immediate siblings who rejected her because of her lesbian identity, although she does have strong relationships with some of her nephews and nieces. Pritham does not believe in counseling, however, she has been having difficulty getting out of bed in the mornings and is starting to miss work a few days a month. She sought counseling at the urging of her friend, who is extremely worried about her overall well-being.

As you work with Pritham, you explore her family history. She shares that her grandfather immigrated to the U.S. to work on the railroad in California. Her grandfather married a Chicana woman, and they had four children together. Her grandparents did not live long due to working in harsh conditions and exposure to toxins as they worked in agriculture in their 30s. Pritham never met her grandparents and does not identify with her Chicana heritage, as her father felt he had to hide this part of himself or be at risk of even more discrimination as a dark-skinned Indian, Sikh person wearing a turban. Pritham shares experiences of racism throughout her life in school and within her job currently, although when asked more about these experiences, she minimizes them.

Pritham shares that she never shared her lesbian identity with her family, as she was fearful that she would not be accepted. She always felt like she was hiding something from them and struggled with feelings of worthlessness. Pritham describes beginning to gain weight in her early 20s and experiencing fatphobia from

her South Asian family and friends. She also shares that she felt pressure to "do everything right" and become an "engineer or doctor" to please her family. During college, she was able to explore her sexuality and date cisgender women, and she met her partner in her doctoral studies as an engineer. Her parents were accepting of her relationship, however, her siblings were not accepting, which caused strife throughout the rest of her life, especially as her parents died. Three months after her parents died, her partner died as well. Pritham had been caring for her partner alone, while also interfacing with her siblings and grieving their deaths. She shares that she has nothing to live for anymore, and that she has no community or friends—although she describes that her nieces and nephews ask to spend time with her and were close with her partner. Pritham was recently diagnosed with Multiple Sclerosis, and she has not shared this diagnosis with anyone. She makes a high salary at her job; however, she spent her life savings and sold her house in order to pay for necessary medical care for her partner and parents, so she is struggling with debt as she is also thinking about retirement. Pritham shares she has many questions about her life—whether she should have had children and whether she failed her parents by being a lesbian. Pritham also shares that she has been thinking about her own death and what she might experience as she ages with no partner.

7 Implications for Practice, Policy, and Advocacy

Pritham's case is a complex one. The forces of LGBTQ+ bias and racism are certainly operating on her life and provide context for her depression. However, the interlocking oppressions related to racism, immigration, disability, gender, class, age, and more are also influencing how she is coping in the aftermath of multiple deaths of loved ones. There are multiple implications for practice, policy, and advocacy.

7.1 Practice

With regard to practice, the mental health professional who works with Pritham should have a strong understanding of the history of racism in the U.S., including how racism interlocks with anti-immigrant, anti-Latinx, anti-Sikh, and anti-South Asian discrimination. A first step is of course, validating the multiple grief processes that Pritham is experiencing with the loss of her parents and long-time partner. However, there are other losses as well—loss of complete understanding of her Chicana history, loss of her sibling support, and the losses that come with feeling she had to please her family through becoming an engineer and worrying about whether she would lose connection with her parents as a lesbian. In addition, there may be losses related to her gender and sexism, as there is much to explore about how she experienced patriarchy within her family and within her work as an

engineer. There is also the recent grief of knowing Pritham is living with a disability and that she had experienced fatphobia within her community and society that resulted in distrust and not valuing her body. There is also the lived experience of multiple classes statuses—having access to wealth, losing wealth, and still having access to wealth through her job, but not being able to build wealth because of her age and the disappearance of her savings.

As she begins to process these multiple losses, it is important to do a thorough trauma and suicide assessment, and it is also important to assess the resiliencies and coping strategies that Pritham developed over her life. Exploring these strategies will provide insight into Pritham's strengths that she can leverage to address the influence of interlocking areas of discrimination in her life. For instance, the support and desire to connect expressed from her nieces and nephews—and their closeness to her long-time partner—could be possible areas to explore related to not only connection, but the trust that she may need and want to build as she thinks about aging with a physical and mental health disability. There is also the potential resilience and coping related to her religious/spiritual beliefs, as well as the privileges associated with her advanced educational degree, job status as a leader, and her third generation U.S. citizen status.

As Pritham explores her grief in counseling, it is also important that she be validated in her grief. The systems of oppression that have operated on her life—and across generations of her life—have real impacts on her well-being now. Her mental health practitioner should have a strong understanding of what community support resources exist with regard to grief for LGBTQ+ people of color, as well as resources for people living with Multiple Sclerosis and financial stressors. There is also the opportunity to identify to what degree Pritham has internalized the mechanisms of oppression that have operated on her life. For instance, does she feel valuable as a lesbian, as a cisgender woman, as an engineer, and as a person recently learning about her physical disability and also mental health challenges. Assessing these degrees of internalized oppression will be helpful to support her on the journey of valuing herself and knowing she is deserving of support and help during the most stressful time in her life. If LGBTQ+ discrimination and interlocking oppressions are designed to suppress and oppress historically marginalized groups, creating a practice environment where Pritham is able to remember, explore, and value her own resilience, learn about her self-defined interests, and even experience joy and empowerment as a 66-year old, cisgender, lesbian, Sikh, South Asian with Chicana heritage, engineer, person of size, and living with disability is the antidote to these oppressions.

7.2 Advocacy and Policy

Pritham's case has many issues related to advocacy and policy embedded within it. Her mental health provider should have strong skills and knowledge of how to access the culturally-responsive and empowering resources for LGBTQ+ BIPOC

Fig. 3 A young Black person expressing themselves through art and fashion. Photo Courtesy of Allan Franca

people experiencing grief and be connected with support resources related to mental and physical disability. As this provider shares these resources with Pritham, it is important to vet them beforehand to ensure they are affirming of LGBTQ+ people in all of their diversities; and, to advocate for LGBTQ+ affirming policies and procedures when anti-LGBTQ+ ones are encountered in vetting these resources so that Pritham does not experience further harm.

Because societal anti-LGBTQ+ discrimination and other oppression is so widespread, it will be challenging to refer Pritham to the right ones even as a strong advocate. Therefore, an important aspect of advocacy bridges back to practice, and to ensure that Pritham has the opportunity to role-play and know her rights when she is interfacing with societal institutions and other family and work settings where she needs to advocate for herself. Other policy needs include advocating for universal healthcare and extensive and interdisciplinary support resources for LGBTQ+ BIPOC as they age, while also seeking to counter anti-immigrant and anti-disability policies. For instance, what are the policies that will help and/ or harm Pritham as she experiences more impact on her life as someone living with Multiple Sclerosis? Fatphobia was certainly operating on Pritham's life in many ways, so it is also important to ask how might fatphobic policies in society be challenged and revised? Strong advocacy and policy change can also include demanding that the entire

history, her-story, and trans-story of LGBTQ+ communities be more widely known, taught, and affirmed across all societal institutions.

8 Conclusion

As we noted in the opening to this chapter, writing about LGBTQ+ discrimination and interlocking oppressions is a task where we literally grieve as we write. Yet, we in the mental health professions with the power, privilege, and advantage we have can feel this grief and channel it into action every opportunity we can. When we take these actions, we are changing the future possibilities for LGBTQ+ people and communities to experience less harm and less discrimination, which in turns develops environments that are more affirming and more liberating (Fig. 3).

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