Emily M. Lund
Claire Burgess
Andy J. Johnson *Editors*

Violence Against LGBTQ+ Persons

Research, Practice, and Advocacy

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To my friends, family, collaborators, and mentors—thank you for your love, time, and support.

Emily M. Lund

To those who hope for a brighter day... we are with you, and we will stay with you.

Claire Burgess

TO ALL GOD'S CHILDREN.

Andy J. Johnson

Preface

Violence against LGBTQ+ persons is a pervasive and serious problem. As the violence unfolds within cultural contexts, it is infused with misunderstandings, stereotypes, and biases that serve to convince perpetrators of interpersonal and systemic violence that their prejudice, discrimination, and abuse are justified and acceptable. Some institutions have adopted discriminatory policies which limit the human rights of LGBTQ+ persons and contribute to the problem of violence against LGBTQ+ persons. Even in cases where treatment facilities have adopted policies that prohibit discrimination, misinformed persons may act in accordance with personal biases and prejudices as opposed to policy mandated inclusion and affirmation and in doing so, increase, rather than ameliorate, the suffering of LGBTQ+ survivors.

Traditional, evidence-based clinical practices remain essential but may not be sufficient due to the need to provide advocacy and tailored, culturally responsive intervention for an LGBTQ+ client. In addition, some LGBTQ+ survivors of violence may become involved in protests, campaigns, and nonviolent means of seeking sociocultural change to obtain human rights. Clinicians serving these clients or providing consultation to LGBTQ+ organizations may also need to be familiar with the dynamics of cultural and systematic change and social justice to provide effective consultation.

Violence Against LGBTQ+ Persons: Research, Practice, and Advocacy emphasizes the complex dynamics of violence against diverse LGBTQ+ persons. Rather than lumping all LGBTQ+ survivors into one falsely monolithic group, the present text analyzes unique aspects of violence against specific subpopulations of LGBTQ+ persons. A scientist-practitioner-advocacy model that draws from the transformative justice movement is used to educate mental health providers concerning the unique needs of LGBTQ+ survivors of interpersonal and structural violence in order to promote the use of truly effective, tailored, and culturally responsive treatment strategies. This approach recognizes that presentations of trauma following the experiences of bullying, interpersonal violence, sexual assault, and trafficking are deeply rooted in sociocultural systems of oppression and injustice. Furthermore, the dynamics of intimate partner violence and sexual assault that LGBTQ+ survivors experience have a foundational base of homophobia and transphobia differs from those seen in heterosexual cisgender survivors. Thus, this book seeks to better equip mental health professionals to address social contexts that contribute to the violence and the internalized forms of prejudice and oppression which exacerbate the trauma of the survivor in addition to learning

how to facilitate healing, empowerment, healthy relationships, and resilience at the intersection of sexual orientation, gender identity, gender expression, and diverse social locations.

A backbone to much of the present text is Meyer's (1995, 2003) *Minority Stress Theory*. The seminal theory provides a framework for understanding how experiences of discrimination and stigma can put an individual at risk for problematic health outcomes. Life stressors along with minority-specific stressors expose sexual and gender minority individuals to health concerns such as obesity, poor behavioral health, suicidality, and other physical and mental health effects. Additionally, coping strategies for minority individuals may be impaired due to poor access to care, limited availability of quality, tailored treatments, and reduced availability of competent service providers. Minority stress has given researchers increasing understanding of exactly how victimization exists on a spectrum and may occur at different levels. No theory has come further in helping epidemiologists, interventions, and the lay public fully understand the connection between minority stress and functioning than minority stress.

Minority stress provides a basis for understanding the structural dimensions of interpersonal violence, such as isolation from sources of support, taking money or other resources, depriving of necessities (right to housing, employment, medical care, food), suppressing conflict and resistance, closing off escape or transportation, and creating and enforcing rules for everyday conduct. Many of the chapters in the present volume detail how LGBTQ+ persons' victimization impact not only sexual and gender minority populations but also the overall sense of safety and well-being in the surrounding context.

Let this comprehensive volume serve as a "guide from the experts" to further: (1) best practices in working with LGBTQ+ persons who have experienced (or may later experience) trauma; (2) understanding of minority stress and coercive control concepts as applied to this population; and (3) critical thinking about ethics, stakeholders, and your position in an ever-changing landscape of power relations. Many of the chapters include an examination of the pervasive and traumatic impact of structures in place at different levels that may contribute to traumatic experiences.

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I also owe a considerable debt of thanks to my friends, family, and colleagues for their support, kindness, and love throughout this process—thank you for understanding when this book had to take priority in my schedule and graciously accommodating and supporting me when it did. Thank you to my mentors, especially Erin Andrews, Rosemary Hughes, Michael Nadorff, Christina Nicolidias, and Timothy Slocum, for encouraging and supporting my research in the areas of social justice, diversity, intersectionality, and trauma and for always encouraging me to do work that addresses the "big questions," no matter how difficult they are. This book would not exist without your mentorship and support, and I am incredibly thankful for all you have done and continue to do for me.

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Emily M. Lund

Let me begin by saying a thank you to my collaborators, who invited me to join them in the journey of writing this text, Andy Johnson and Emily Lund. I consider the recommendation from my mentors to write, edit, and facilitate the interchange of scholarly ideas through this avenue to be a privilege, and hold it close to my heart. My Boston mentors at Fenway and the VA have woven incredibly novel, impressive research trajectories. I am honored

to be included in their work, and also consider it an honor that some of their work is featured here in this book. To my colleagues at work with whom I bounce ideas off but have not yet written alongside: you are a daily inspiration. I hope to collaborate with you someday soon and bring the spotlight on the more creative, or rambunctious, things we do at work.

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Claire Burgess

Jackson Katz and Ron Clark each helped me begin to realize the necessity of addressing violence against LGBTQ+ persons. Lydia X.Z. Brown and Emily Lund highlighted this need further when we worked together on a previous project. I was honored when Emily agreed to work together with me on the next edited volume. We considered several different options. Jennifer Hadley from Springer encouraged us to place top priority on violence against LGBTQ+ persons. Emily has been a wonderful colleague, encouraging me as we developed the vision for the book and taking steps to ensure the work would be consistently affirming. Claire Burgess graciously agreed to join our editorial team in the spring of 2019 when my research ground to a halt as I was grieving the loss of my younger brother to pancreatic cancer. Claire revived the work and put us back on track. The insight, dedication, and wisdom of Emily and Claire account for the strengths of *Violence Against LGBTQ+ Persons*. Responsibility for any limitations falls squarely on my shoulders. Many thanks to our chapter authors for the generous giving of their time and efforts in writing for us. Jennifer Hadley, Janet Kim, and Sara Yanny-Tillar from Springer provided valuable input at critical points along the way. Shabib Shaikh from the copyediting department was exceptional, even contacting us to offer assistance before we submitted the manuscript.

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Andy J. Johnson

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Emily M. Lund, PhD, CRC (she/her/hers), is Assistant Professor of Counselor Education in the Department of Educational Studies in Psychology, Research Methodology, and Counseling at the University of Alabama in Tuscaloosa. She holds a PhD in rehabilitation counseling from Utah State University, a master's degree in educational psychology from Texas A&M University, and bachelor's degrees in psychology and social work from the University of Montana. She has worked with people with disabilities in their families in a variety of clinical and educational settings. Her primary research interests include interpersonal violence and trauma in people with disabilities; suicide and non-suicidal self-injury in people with disabilities; the experiences of counseling and psychology graduate students with disabilities; and LGBTQ+ issues, particularly as they intersect with disability. She has published and presented extensively on these topics and currently has over 80 peer-reviewed publications. In addition to this volume, she is an editor of the book, *Religion, Disability, and Interpersonal Violence* (2017), also published by Springer.

Claire Burgess, PhD (she/her/hers), is an Instructor at Harvard Medical School in Massachusetts and a clinical psychologist at the National Center for TeleMental Health at the Veterans Health Administration in Washington, DC. She serves as the LGBT Veteran Care Coordinator at VA Boston Healthcare System, where she connects veterans to care, and provides education locally to staff and trainees across disciplines. Dr. Burgess has expertise in assisting organizations with trauma-informed care considerations for transgender and gender diverse patients. Her passion lies in providing education to trainees, as she teaches nursing students and psychiatry residents topics such as cognitive behavioral therapy and LGBT health. Dr. Burgess has experience in research and intervention at the Fenway Institute and VA Boston Healthcare System, where she completed an LGBT Health Postdoctoral Fellowship. During her fellowship year, she led two national workgroups on transgender and intersex patient care within VA and is currently working on a third developing provider education on trauma-informed care of sexual minority veterans in healthcare settings. She received her MA and PhD in clinical psychology at the University of Southern California, where she was a graduate researcher in the Center for LGBT Health Equity.

Andy J. Johnson, PhD (he/him/his), teaches a variety of courses in the Department of Psychology at Bethel University in Saint Paul, Minnesota. His research interests center on the intersection of religion, ethnicity, national origin, immigration status, sexual orientation, gender identity, and ability/disability with interpersonal violence. A volume he edited, *Religion and Men's Violence Against Women*, and a volume he coedited with Ruth Nelson and Emily Lund, *Religion, Disability, and Interpersonal Violence*, are published by Springer.

Andy has served on the Board for the National Partnership to End Interpersonal Violence (NPEIV), where he was Co-Chair of Action Team 2: Training and Mentoring. A member of the Policy Committee for OutFront Minnesota, Andy has testified on the psychological research demonstrating the harmfulness and ineffectiveness of conversion therapy in support of efforts to ban conversion therapy in the state legislature.

He is current member of American Psychological Association (APA) Division 44: Society for the Psychology of Sexual Orientation and Gender Diversity, and a former Member-at-Large for APA Division 36: Society for the Psychology of Religion and Spirituality. Recently, Andy served as a member of the Olmstead Specialty Committee on Violence Against Persons with Disabilities for the State of Minnesota. He earned his MA and PhD in counseling psychology from the University of Notre Dame in Indiana.

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1 Queer Violence: Confronting Diverse Forms of Violence Against LGBTQ+ Persons and Communities

Emily M. Lund, Claire Burgess, and Andy J. Johnson

Abstract

This chapter introduces the topics of systemic and interpersonal violence against LGBTQ+ persons, a complex and multifaceted area that is marked by a variety of distinct but co-existing types of victimization. We describe this broad range of victimization, which spans from childhood to adulthood, covert to overt, and interpersonal to systematic, and discuss the cumulative effects of both acute and chronic victimization on the health and well-being of sexual and gender minority persons. We also highlight the importance of truly intersectional and culturally responsive care in working with LGBTQ+ clients who have experienced violence.

Violence is a complex and multifaceted concept, and members of the LGBTQ+ community (i.e., individuals who are non-heterosexual, non-cisgender, and/or intersex) have long been subject to increased rates of violence victimization in various forms (Katz-Wise & Hyde, 2012; Friedman et al., 2011). As detailed in the following chapters in this volume, violence against various communities under the LGBTQ+ umbrella is often both systematic—occurring at the level of social norms and political and public policy—and interpersonal, occurring at the level of the individual. This violence can be overt and explicit—up to and including homicide—and covert and subtle, such as microaggressions and invalidation (Nadal, Rivera, Corpus, & Sue, 2010). Although smaller-scale forms of aggression are often considered to be of relatively little concern by outsiders, researchers have found that they often have a considerable and damaging cumulative impact on recipients and lead to further feelings of isolation and decreased well-being (Galupo & Resnick, 2016).

Additionally, victimization of LGBTQ+ individuals often occurs across the lifespan and in a variety of forms and circumstances (Katz-Wise & Hyde, 2012; Friedman et al., 2011). Although the "It Gets Better" campaign sparked a popular anti-suicide and anti-bullying meme campaign aimed at LGBTQ+ youth (Gal, Shifman, & Kampf, 2016; Grzanka & Mann, 2014), the questions of if it gets better, how it gets better, and for whom it gets better remain open. Researchers have consistently found that LGBTQ+ individuals continue to experience violence victimization

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at high rates into adulthood (Katz-Wise & Hyde, 2012; Friedman et al., 2011), and bullying victimization, contrary to its popular depiction as a phenomenon of childhood and adolescence, continues into post-secondary education and the workplace (Lund & Ross, 2017; Nielsen & Einarsen, 2012).

Overt and interpersonal violence victimization may take a number of different forms, including physical, sexual, and emotional maltreatment (Brown & Herman, 2015; Corliss, Cochran, & Mays, 2002). Additionally, violence and aggression may be perpetrated by a number of different types of perpetrators, including parents, intimate partners, peers, co-workers, and strangers (Brown & Herman, 2015; Corliss, Cochran, & Mays, 2002; Freedner, Freed, Yang, & Austin, 2002; Friedman et al., 2011; Galupo & Resnick, 2016). It may also occur in a single instance or be episodic or even nearly continuous in nature, occurring repeatedly or cyclically over time. A single individual may often experience multiple types of violence victimization across the lifespan or even at a single point in time, and these acute experiences of victimization may occur alongside chronic, systematic violence, potentially heightening the cumulative negative effects of both the acute and chronic trauma and stress (Gabrielli, Gill, Koester, & Borntrager, 2014).

Understanding and asking about the experience of multiple forms of victimization and marginalization is key to understanding the lived experiences of LGBTQ+ individuals. The chronic experience of both overt and covert discrimination, marginalization, and violence has been linked to a continual high level of psychological stress and distress among LGBTQ+ individuals. This chronic stress, termed "minority stress," has been linked to the higher rates of health problems, including depression and suicide among LGBTQ+ individuals (Michaels, Parent, & Torrey, 2016; Meyer, 2003; Plöderl et al., 2013). The minority stress model includes both proximal stress, such as internalized homophobia and the stress of identity concealment, related to systematic violence and marginalization, and distal stress, such as that related to overt and direct violence and discrimination (Michaels et al., 2016; Meyer, 2003).

Experiences of victimization as well as social circumstances and patterns of marginalization and discrimination may differ for different subpopulations of the LGBTQ+ community (Corliss et al., 2002; Brown & Herman, 2015; Heck, Flentje, & Cochran, 2013). For example, although both may experience considerable victimization and marginalization, the particular patterns of violence and discrimination experienced by gay men and lesbian women may differ, and it is important to understand the unique social history and context of each subpopulation (Heck et al., 2013). Similarly, transgender and cisgender clients may face unique social stressors and patterns of prejudice and discrimination, and thus it is important to consider a client's individual identity and circumstances rather than assuming that all people under the broad LGBTQ+ umbrella face the exact same challenges. Considering a client's individual identity may be further complicated by the fact that many individuals within the LGBTQ+ community may hold multiple gender and sexual minority identities (e.g., a client who identifies as both non-binary and bisexual or a client who identifies as asexual, homoromantic [lesbian], and transgender), creating a complex web of intersecting identities and potential areas for marginalization and discrimination (Gupta, 2017; Pinto, 2014). It is critical that the clinician carefully listens to and understands the individual's identity in its entirety and how that identity has influenced the experience of discrimination, victimization, and resilience.

Likewise, LGBTQ+ clients who hold other marginalized identities outside of realm of gender and sexuality, such as those who are also racial or ethnic minorities or who are disabled, may also have complex experiences of identity construction, discrimination, victimization, and resilience (Lightfoot & Williams, 2009; Lund & Johnson, 2015; O'Toole & Brown, 2002). Because these other aspects of their identities also result in social marginalization, multiple marginalized individuals may face additional,

cumulative minority stress, violence, and discrimination due both to the individual components of their identity (e.g., disability status alone, LGBTQ+ status alone, race or ethnicity alone) and the complex intersections between the multiple aspects of their identities and the surrounding environment (Brown, 2017; Levine & Breshears, 2019). Individuals who are members of multiple marginalized groups may face implicit and explicit pressure to choose a single aspect of their identity, a task that is both offensive and impossible due to the intersectional nature of both identity and access needs (Lightfoot & Williams, 2009; Lund, Johnson, & Nelson, 2017). When fulfilling this request proves impossible, these clients often receive substandard care (Lightfoot & Williams, 2009; Lund, Johnson, & Nelson, 2017; O'Toole & Brown, 2002). Thus, it is vital that clinicians take a fully intersectional approach in understanding and affirming each client's identity, needs, and experiences.

By understanding the lived experiences of each client, including their experiences of various types of interpersonal and systematic victimization and discrimination and the effects of those experiences, clinicians can better provide an affirming and validating therapeutic environment (Heck et al., 2013) in which clients can address and heal from the effects of violence and discrimination and develop strategies that allow them to cope and even thrive in the face of victimization, oppression, and marginalization. A deep and thorough understanding of the scope, nature, and effects of victimization faced by LGBTQ+ individuals provides the foundation on which both LGBTQ+ individuals and allies can continue to dismantle the systems of macro-, mezzo-, and micro-level oppression that perpetuate such violence and harm. The other chapters in this volume explore the concepts introduced here—the various forms of violence and discrimination experienced by LGBTQ+ individuals, the minority stress model, the importance of affirmation and intersectionality—in depth and with specific application to particular groups within the broader LGBTQ+ community.

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Concepts of Sexual Orientation and Gender Identity

2

Geoffrey L. Ream

Abstract

Violence against lesbian, gay, bisexual, transgender, queer, and other sexual/gender minority (LGBTQ+) persons may be encouraged or discouraged by ideologies about sexual orientation and gender identity. Current concepts of sexual orientation and gender identity may be grouped into three broad categories. One is based on empirical, psychological, and biological science, which have found that sexual orientation and gender identity are partially heritable, have no necessary connection to mental illness, and cannot be intentionally influenced by anything that happens after birth. Another category is modern progressive views, mostly grounded in constructivism and critical theory. These support accepting LGBTQ+ and other oppressed groups' authority about their own experiences and calling people what they want to be called. The third is conservative ideologies, which generally hold that LGBTQ+ persons are disordered and dangerous, especially to children, unless they take steps to either change their nature or play a role prescribed for it.

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On August 14, 2018, a grand jury delivered a report of the largest investigation ever by a government agency of child sexual abuse in the Roman Catholic Church. It described the experiences of over 1000 survivors. The church had already paid out hundreds of millions of dollars in child sexual abuse settlements, and this report promised to make the issue more expensive than ever (Goodstein & Otterman, 2018). Four days later, Bishop Morlino of Madison, WI, issued a letter to the faithful. In that letter, posted on the Madison Catholic Herald's website (Morlino, 2018) and quoted at length in some other Roman Catholic sources, he said that it was inappropriate to ideologically separate homosexuality from pedophilia and blame the church's child abuse problems on pedophilia. He implicated a "homosexual subculture" within the church's leadership and called for "vengeance" – from heaven, of course – against those who act upon the "intrinsically disordered" desire that is homosexuality, especially when they direct their attentions to young people.

If narrowly read, Morlino's letter was not trying to raise the long-debunked (see Herek, 2018) idea that same-sex attracted people are generally more likely to abuse children. He was calling out a specific cadre of men within the church's hierarchy whose secrecy norms around sexual indiscretion have often had the side effect of protecting child abusers. This was a known issue that Pope

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Francis was trying to manage administratively (Martel, 2019). Roman Catholic faithful, however, took matters into their own hands. Openly gay pastoral associate Antonio Aaron Bianco, who had played a critical role in revitalizing a San Diego Roman Catholic parish, started receiving harassing phone calls from blocked numbers. A stranger threw a punch at him after Mass, and his church office was vandalized with homophobic graffiti (Goodstein, 2018). LifeSite, a conservative Catholic website (which would later be refused an Apple News channel for "intolerance towards a specific group," see LifeSiteNews, 2019), posted personally identifying information about ("doxed") him. Bianco resigned for his and his family's safety (Goodstein, 2018).

The above does not sound like the sort of thing that ought to happen in modern America, where public opinions toward lesbian, gay, bisexual, transgender, queer, questioning, and other sexual/gender minority (LGBTQ+) persons have steadily improved over many years (Charlesworth & Banaji, 2019; Twenge, Sherman, & Wells, 2016) and same-sex marriage is becoming the law of the land (Chappell, 2015). However, in a social struggle, the progressive side is rarely the only one trying to make progress (Kendi, 2016; MacLean, 2017; M. White, 2006). The Roman Catholic Church and other promulgators of ideologies that empower violence against LGBTQ+ persons also work hard, believing that they are doing what is best for the society.

This chapter reviews concepts of sexual orientation and gender identity that are currently relevant to violence against LGBTQ+ persons. It covers the seminal, empirical, biological, and psychological studies that provided some of the first authoritative alternatives to traditional conservative anti-LGBTQ+ views (Bailey et al., 2016; Savin-Williams & Ream, 2007). It goes on to review the constructivist and critical sociological perspectives which underlie the modern norms of calling LGBTQ+ what they want to be called, respecting their authority to define their own experiences, and scrutinizing all generalizable knowledge about LGBTQ+ people for pro-oppressor biases (Diamond & Rosky, 2016; Jackson & Scott, 2010). Finally, it discusses conservative anti-LGBTQ+ ideologies that encourage violence against LGBTQ+ persons.

Empirical Science

Throughout much of the history of the social sciences, it was rare to find work that seriously questioned dominant ideologies about human sexuality (Jackson & Scott, 2010). This changed with the famous "Kinsey Report" (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953). By "describing a range of [human] sexuality without judgment," the Kinsey Report revolutionized society. It inspired Hugh Hefner to create *Playboy* (Abumrad, 2018). It also precipitated a change in thinking about same-sex sexual activity and several other taboo behaviors which, according to Kinsey's results, were far too common to be reasonably thought of as pathological. Alfred Kinsey himself was well-known to be bisexual and polyamorous, but his work could not be dismissed as self-justificatory theorizing because he had scientific survey data from a large sample to support his statements. Another influential contribution was Evelyn Hooker's (1957) famous finding that there was no significant correlation between male sexual orientation and expert-rated mental health. Science does not often foreground non-findings, but this one is noteworthy because Hooker should not have been able to find *any* gay men who were neither mentally ill nor criminals if society's ideologies about LGBTQ+ persons at the time had been correct. Since Hooker and Kinsey's time, empirical research has often been a leading voice in challenging dominant conservative anti-LGBTQ+ ideologies and exposing policies and practices that are harmful to LGBTQ+ persons.

The Biological Basis of Sexual Orientation and Gender Expression

Empirical science has firmly debunked the conservative anti-LGBTQ+ belief that being LGBTQ+ is associated with psychopathology which the environment either causes or allows

to express itself (Kinney, 2014). If sexual orientation and gender have any "causes" at all, they lie in biological processes that occur before birth. Androgen levels that are present in the mother's womb before a person is born affect several sexually dimorphic characteristics, including finger length ratio, various aspects of brain lateralization, sexual orientation, and gender. Research supporting this theory includes findings that gender differences in self-expression emerge very early in childhood, before environmental influences like parenting behaviors could have had any effect, and that gendered attributes are correlated with sexual orientation, which is a prerequisite to suggesting that gender and sexual orientation have the same biological underpinnings. Also, animal model studies found that directly manipulating prenatal hormone levels affects adulthood sexual behavior (Bailey et al., 2016). There is no single "gay gene" (Ganna et al., 2019), but heritability of sexual orientation is found to be about one-third, within the range of other complex behavioral traits (Bailey et al., 2016; Diamond & Rosky, 2016; Luoto, Krams, & Rantala, 2018). The consensus of these and other biological findings is that sexual orientation and gender are natural variations in human development and not part of some disease process. This invalidates conservative anti-LGBTQ+ ideologies predicated on the assumption that homosexuality and transgenderism are diseases that can be prevented (Dobson, 2001) or treated (Jones & Yarhouse, 2011). Conservative anti-LGBTQ+ ideologues assert that being LGBTQ+ is a problem because it is just "common sense" (Cameron & Cameron, 1998) or because being LGBTQ+ is so often correlated with problems (Mayer & McHugh, 2016). These are not scientifically valid arguments, which suggests that these talking points, even when they appear in scholarly journals, are aimed more at general readers than at scientists.

The Evolutionary Value of Traits Associated with Being LGBTQ+

Empirical science also debunks the conservative anti-LGBTQ+ assertion that there cannot possibly be a "gay gene" because it would have died out millennia ago (Dobson, 2001). That notion is based on the idea that same-sex oriented people are very unlikely to reproduce, which is simply not true. Many men who have sex with men are in stable relationships with women (M. R. Friedman et al., 2017) and identify as heterosexual (Savin-Williams & Ream, 2007). Also, women who are of reproductive age and not exclusively heterosexual are actually more sexually active with men than exclusively heterosexual women are, not less (Ela & Budnick, 2017). Far from describing how the gay gene should have died out, modern evolutionary science actually supports several theories for why biological traits associated with being LGBTQ+ persist and enhance the survival of the human species. A theory behind male homosexuality is that of the "gay uncle" who does not have children of his own and instead puts his time and resources into supporting family members' children (VanderLaan, Ren, & Vasey, 2013). A theory of women's bisexuality and sexual fluidity suggests that men are drawn to women being sexual with each other because this promoted bonding within the patriarchal and polygamous societies wherein most of the human race evolved (Luoto et al., 2018). It also enabled women to turn their attentions to each other rather than cuckolding the men to whom they belonged when those men were unavailable. The only sexual orientation category of women that would be unappealing to men would be those who have no interest in men at all, which may explain why exclusive attraction to women is currently less prevalent among women than bisexuality is (Apostolou, 2018). Evolutionary researchers generally agree that there is not one single evolutionary theory for all sexual orientation and gender diversity. Various sexual orientation and gender expressions, even

distinctions like "butch" vs. "femme," may have different evolutionary stories behind them and unique adaptive value for the species (Apostolou, 2018; Ela & Budnick, 2017; Luoto et al., 2018).

Multidimensionality of Sexual Orientation

Survey research confirms expectations based on biological, laboratory, and evolutionary science that there would be more gay men than bisexual men and more bisexual women than lesbians (Gates, 2011). It has also invalidated the conservative anti-LGBTQ+ epidemiological view that being LGBTQ+ is a condition that some people have and others do not. Modern surveys, improving on Kinsey's methods, ask separate questions about sexual attraction, dating, orientation identity, behavior, sex, and gender. They find that people who fit precisely into commonly understood sexuality and gender categories are the exception, not the norm (Laumann, Gagnon, & Michael, 2000; Savin-Williams, Joyner, & Rieger, 2012; Savin-Williams & Ream, 2007). Across surveys, 11% of American adults acknowledge some same-sex attraction, and 8.2% have engaged in same-sex behavior, but only 3.5% identify as lesbian, gay, or bisexual (Gates, 2011). This implies that the majority of people who experience same-sex attraction and/or engage in same-sex sexual behavior identify as straight, which sets the stage for investigating same-sex sexuality among straight-identified people (e.g., Ward, 2015).

Another key finding of surveys is that there are limits to survey research. Transgender, nonbinary, and other non-cisgender categories are too rare to reliably appear in surveys with sufficiently large subsamples for analysis (Gates, 2011). The many subcategories for sexual orientation specified in intricate multidimensional schemas like "The More Complicated Attraction Layer Cake," which addresses issues like how someone fits sex into the context of romance and whether attraction even depends on the object's gender (Rudd, 2017), are probably too small to emerge in even the largest population-representative surveys. Despite these limitations, it is still important to recognize the contributions of large-scale representative data, not least because these databases come from major government projects where politics have been an issue and including variables measuring sexual orientation and transgender identity was a hard-won accomplishment (Ream, 2019; Savin-Williams & Joyner, 2014; Twenge et al., 2016). If the census were to ask about sexual orientation and gender identity, this would create a treasure trove of freely available information for researchers and anyone else to analyze. However, the Census Bureau has declined to include these questions (Moreau, 2018).

Fluidity and Other Trajectories of Change in Sexual Orientation Identity

Empirical studies conducted either by conservative anti-LGBTQ+ ideologues or with their involvement find that, if one looks hard enough, one will be able to find at least a few people who say that sexual orientation change efforts (SOCE) and gender identity change efforts (GICE) worked for them (Jones & Yarhouse, 2011; Spitzer, 2003). Most LGBTQ+ persons do not have that experience, even though many have both engaged in therapy and wanted to change their sexual orientation or gender. Historically, researchers hesitated to look seriously into change in sexual orientation and gender identity because they knew that conservative anti-LGBTQ+ ideologues would take the findings and use them to support SOCE and GICE (Diamond & Rosky, 2016). Now, sexual orientation change efforts (SOCE) and gender identity change efforts (GICE) are rejected in theory and practice by probably all major scientific and human services organizations to which SOCE and GICE are relevant (Ashley, 2018). SOCE and GICE are also illegal in 18 US states plus a long list of localities (Taylor, 2019). The idea of intentional change in sexual orientation or gender is, at least at the present state of the art, so far beyond rehabilitation that researchers can investigate natural

change over time without worry that SOCE/GICE proponents could cause any real damage by trying to co-opt their findings (Diamond & Rosky, 2016). This is an important development, because it is becoming increasingly clear that there is more to the story of being LGBTQ+ than having been "born this way" (Ganna et al., 2019).

Latent class analysis of data from the National Longitudinal Study of Adolescent to Adult Health, the same longitudinal panel study that helped set the norm of dimensional operationalization of sexual orientation (see Savin-Williams & Ream, 2007), found three trajectories of sexual orientation identity development to be prevalent within the sample. One group, about half male and half female, were lesbian/gay/bisexual throughout adolescence and young adulthood. The other two groups, mostly female, were "heteroflexible" and "later bisexually identified." Latent class analysis of a different, females-only sample found that sexual fluidity itself is a stable sexual orientation category. It did not find support for the idea that fluidity is something that most women experience (Berona, Stepp, Hipwell, & Keenan, 2018). Other panel data studies found young men reporting sexual minority status in earlier waves but not in later waves. They might have been "mischievous responders" (Savin-Williams & Joyner, 2014), or they could have been involved in some experimentation or unwanted contact that caused them to question (Katz-Wise et al., 2017). Some of them might have felt genuine flushes of attraction toward same-age peers very early in adolescence, before those peers developed secondary sex characteristics. Fluidity is probably not the explanation for adolescents' inconsistent responses to sexual orientation questions across waves of panel data. Fluidity and other more complex identities may be more characteristic of adulthood, when people are past the adolescent need to achieve and maintain a fixed, stable identity (Better, 2014). The major sexual and gender identity change of adolescence is coming out as LGBTQ+ (Ott, Corliss, Wypij, Rosario, & Austin, 2011).

Bisexuality in Identity Politics and Public Health

In empirical science, the final authority on how a group of people are represented is the scientists. This has not always resulted in the most empowering conversation for bisexuals. Psychological and biological research have struggled with the question of whether bisexuality, in the sense of physiological arousal to both male and female erotic stimuli, even exists (Rieger et al., 2013). Conventional wisdom is that sexual orientation identity is healthiest when it is consistent with one's biological inclinations (e.g., Savin-Williams, 2001), so this inquiry raises issues with the validity of bisexual identity. Research from a public health paradigm often deals with the question of identity by not dealing with it, instead assigning categories like "men who have sex with men and women" (MSMW) that few people would probably choose for themselves (Wolff, Wells, Ventura-DiPersia, Renson, & Grov, 2017). Researchers do this because it allows them to study sexual risk behavior while being inclusive of people who would never identify as LGBTQ+ (Benoit, Pass, Randolph, Murray, & Downing Jr., 2012). Public health research is especially interested in MSMW in urban poor communities of color because they can be HIV "infection bridges" between high-risk "cores" of MSM (men who have sex with men) and women who would presumably not necessarily be at high risk except for their contact with MSMW (Friedman, Cooper, & Osborne, 2009). According to one count, the number of research articles describing bisexuality as an infection bridge outnumbered those addressing it as a legitimate identity category (Wolff et al., 2017). The mere existence of the "infection bridge" line of inquiry helps support the conservative anti-LGBTQ+ narrative within urban poor communities of color that HIV is an LGBTQ+ problem, one which may be addressed by – or provide a convenient reason for – fiercely oppressing people based on their sexual orientation and gender (Stanford, 2013).

Homophobia

One case in which scientific authority to define terms really served to empower LGBTQ+ people is the concept of homophobia. Homophobia is the idea that people with anti-LGBTQ+ prejudice, not LGBTQ+ people themselves, are the ones with a problem. The concept supposedly first emerged in George Weinberg's *Society and the Healthy Homosexual* (1972, p. 1), where Weinberg, who was heterosexual himself, said, "I would never consider a patient healthy unless he had overcome his prejudice against homosexuality." He went on to assert that "homosexuals" could be healthy and that the real mental health problem was society's prejudices. In later work, he called that prejudice "homophobia," defined as "The dread of being in close quarters with homosexuals – and in the case of homosexuals themselves, self-loathing" (quoted in Herek, 2017). One possible objection to the "-phobia" formulation is that, like homosexuality itself, homophobia cannot reasonably be called a mental illness if it is broadly prevalent among well-functioning members of the society (Colwell, 1999). Research finds that, while it might not be a mental illness, it is definitely a prejudice which, like other prejudices, causes people to make judgments that are automatic, intuitive, not necessarily based on conscious principled reasoning (Callender, 2015), and sometimes destructive. Terms other than homophobia have been tried over the years, e.g., homonegativity (Berg, Munthe-Kaas, & Ross, 2016), but "homophobia" has persisted.

Constructivism and Critical Theory

Alfred Kinsey (Kinsey et al., 1948; Kinsey et al., 1953) and Evelyn Hooker (Hooker, 1957) laid the foundation for a growing scientific consensus about LGBTQ+ persons, but scientific consensus is usually not enough to change policy, practice, and public opinion on politically charged issues. When the American Psychiatric Association (APA) finally removed homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1973 (Drescher, 2015), they did so because other intellectual and grassroots movements had forced the issue. These movements were part of a broader trend of social forces that drew attention to oppression and abuse that occurred under the auspices of psychiatry and which eventually dislodged psychiatry from its role as society's chief arbiter of psychological abnormality (Bayer, 1987). These forces established new norms for discourse about psychological issues, which included respecting people's authority about their own experiences, describing them in terms that their identity groups chose and which they find empowering, and scrutinizing research, theory, and all other generalizable knowledge for how it might even subtly serve the interests of oppression. These ideas are not fundamental to empirical science, but they are consistent with constructivist and critical intellectual traditions. It is constructivist and critical perspectives that frame modern progressive conceptualization of LGBTQ+ issues.

Depathologizing Homosexuality and Debunking Sexual Orientation Change Efforts (SOCE)

As of 1969, the year of the Stonewall riots, the authoritative psychiatric work on homosexuality was Irving Bieber's *Homosexuality: A Psychoanalytic Study of Male Homosexuals* (1962). He said "A homosexual is a person whose heterosexual function is crippled, like the legs of a polio victim" (quoted in Myers, 1981). According to his wife, he really thought he was helping people by suggesting that same-sex attracted men should receive treatment rather than punishment (National Public Radio, 2002), even though many of the available treatments involved apparent punishments like electric shocks. Psychologist Gerald Davison helped introduce orgasmic reconditioning (Abumrad, 2018). This was probably less unpleasant but still wholly ineffective (Conrad & Wincze, 1976). There was little hope during the Stonewall Era that the APA would change its ideas about homosexuality on its own. Even gay psychiatrists

thought they were hypocrites on some level for trying to support patients toward wellness when they were not well themselves (National Public Radio, 2002). The impetus to change came from LGBTQ+ activists who saw the stigma of mental illness as a major barrier to their rights and made depathologization of homosexuality a primary goal. They attended psychology and psychiatry conference presentations about conversion therapy, including one by Bieber in San Francisco in 1970. They were not there to debate politely with the speakers but to disrupt sessions and stop normal proceedings from going forward, just as the conversion therapists' ideologies stopped LGBTQ+ persons' normal lives from going forward. Activists also published notable conversion therapists' home addresses, putting conversion therapists in fear during their daily lives, just as conversion therapists' ideologies empowered law enforcement and other entities to put LGBTQ+ people in fear during their daily lives (Bayer, 1987; National Public Radio, 2002).

An exception to this demeanor was Charles Silverstein, then a Ph.D. student at Rutgers. Silverstein found Gerald Davison at a conference in New York and invited him to a workshop. At the workshop, Silverstein was one of three people presenting to a packed audience. Silverstein shared the following:

> To suggest that a person comes voluntarily to change his sexual orientation is to ignore the powerful environmental stress, oppression if you will, that has been telling him for years that he should change. To grow up in a family where the word homosexual was whispered, to play in the playground and hear the words faggot and queer, to go to church and hear of sin, and then to college and hear of illness, and finally to the counseling center that promises to cure, is hardly to create an environment of freedom and voluntary choice. What brings them into the counseling center is guilt, shame, and the loneliness that comes from their secret. If you really wish to help them freely choose, I suggest you first desensitize them to their guilt. After that let them choose. But not before. (Abumrad, 2018)

By listening to Silverstein's presentation, Davison accepted an LGBTQ+ person's authority to define his own experience. This helped guide Davison's own thinking around to the modern progressive idea that a clinician should not even entertain the idea of whether they could help someone change their sexual orientation, because that is the wrong question to ask. A clinician should consider it inappropriate to even try to help a client change their sexual orientation, because keeping that possibility alive contributes to the oppression of LGBTQ+ people (Abumrad, 2018). Silverstein went on to become the founding editor of the *Journal of Homosexuality* and win a lifetime achievement award from the American Psychological Foundation ("Gold medal award for life achievement in the practice of psychology: Charles Silverstein," 2011).

From Dysphoria to Diversity: Debunking Gender Identity Change Efforts (GICE)

David Reimer, born in 1965 as Bruce Reimer, one of a pair of twin brothers, was also assigned the name "Brenda" by his parents and "Joan" in case study reports. At 8 months of age, David lost his penis in a botched circumcision. Dr. John Money at the Johns Hopkins' Gender Identity Clinic persuaded David's parents to have him surgically reassigned as female and to raise him as a girl. Money's theory – consistent with social constructionist ideas that predominated at the time – was that gender comes from how someone is raised and taught and that it has no innate biological component. In David and his brother (called "John" in Money's writings), Money found the perfect twin study to illustrate his theory. Money wrote several research reports about the happy upbringing of "John/Joan" as a well-adjusted twin brother and sister pair. These writings gave the medical community all the evidence they needed to make it standard practice to surgically reassign babies as female if, like David's, their genitalia were damaged or if they did not fit the standard definitions for male or female (referred to as anatomical "intersex" conditions, see American Psychological Association, 2006). Physicians and families moved forward with these surgeries in full confidence that these children would be happy raised as girls (Colapinto, 2000).