JHP

Article

Healthcare experiences of a Black lesbian in the United States

Journal of Health Psychology
1–13

DOI: 10.1177/1359105317690036
journals.sagepub.com/home/hpq
SAGE

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Abstract

Little is known about the healthcare experiences of Black lesbian and bisexual women. This exploratory study examined the healthcare experiences of a 24-year-old Black lesbian and the interconnection between race, ethnicity, gender, and sexual identity in her lived experiences. Data were gathered through an in-depth audio-recorded interview. Findings revealed the risks of and barriers to self-disclosure in healthcare settings, factors that influence the quality of the patient–provider relationship, and the positive and negative healthcare experiences of this Black American lesbian. This study is an important first step in exploring the healthcare experiences of Black lesbian and bisexual women. The findings of this case study highlight themes and avenues for future research. Clinical implications and suggestions for future research are discussed.

Keywords

Black woman, healthcare experiences, intersectionality, lesbian

Introduction

Studies investigating healthcare experiences of lesbian and bisexual women of color are scarce. Writings by Black feminists (Collins, 2002, 2006; Crenshaw, 1989, 1991; hooks, 2000, 2014) and empirical evidence examining the health disparities of lesbian and bisexual women of color (Murphy et al., 2013) suggest that healthcare access and health outcomes of these women are affected by multiple systems of oppression that differ from those experienced by White gay women and heterosexual women of color. Although Black sexual minority women share some of the same health risks as White heterosexual women and White sexual minority women, their social identities expose them to unique additional sets of health issues. Black women are subjected to racism, as well as sexism, by healthcare professionals and often receive a lower quality care (Jacobs et al., 2006). Similarly, lesbians and bisexuals experience sexual orientation-based prejudice and discrimination in the healthcare system (Solarz, 1999). Black lesbians and bisexuals have lower self-disclosure rates to their physicians and are more likely to experience opposite-sex relationships than their White counterparts (Cochran and Mays, 1988; Ramsey et al., 2010). Black lesbian and bisexual women's underutilization of preventive care may be due to limited access to care, limited awareness of the benefits of screening

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and early detection, and health beliefs (Ashing-Giwa et al., 2004; Mays et al., 2002).

Multiple marginalized identities and minority stress

Stress associated with experiences of prejudice is negatively associated with the well-being of Black lesbian and bisexual women. Minority stress theory posits that those with one or more marginalized social identities experience prejudice and discrimination that can cause stress, which negatively impacts mental and physical health (Frost et al., 2013; Meyer, 2013). The intersection of race- and gender-based stereotypes, which paint black women as being criminal, sexually promiscuous, and susceptible to aggressive behavior, makes it especially difficult for law and society to identify their particular sense of victimization and discrimination (Buchanan, 2007). Collins (2002) described this as controlling images—the "ideological dimension" of the marginalization of Black women in the United States—used to stereotype Black women in undesirable ways, to justify oppression (p. 5). In *Sister Citizen*, Melissa V. Harris-Perry presented the dominant stereotypes of Black women and their adverse effects: Jezebel, the hypersexual, licentious Black woman; Sapphire, the emasculating angry Black woman; and the Mammy, the Black woman who nurtures and protects White women and children (not her own). These stereotypes fail to capture the lived experiences of Black women, but instead, serve to place Black women in a perpetual state of marginalization to be exploited for the interest of others (Harris-Perry, 2011). In addition, these stereotypical images of Black women support and justify the discriminatory social practices against Black women (Collins, 2002; Harris-Perry, 2011).

Furthermore, Harris-Perry (2011) identified several myths of Black women that inhibit their ability for self-advocacy. Harris-Perry (2011) used the crooked room as an analogy of Black women's attempts to engage in political discourse. She depicted the myth of the strong Black woman as analogous to endeavoring to stand up in a crooked room, constructed to keep them off balance. Harris-Perry (2011) recognized that the myth of a strong Black woman can be empowering as it portrays a powerful image of Black women as driven, hardworking, emotionally self-sacrificing to support others. She noted that it is also limiting in that Black women are still seen as intimidating and aggressive and they have to mold themselves to fit these contradictory expectations that ultimately distorts them into "ugly caricatures of their true selves" (p. 183). Similarly, the myth of the angry Black woman is another incline in the crooked room as vocalization of their lived experiences is seen as angry and dismisses the validity of their statements. Black women's efforts to avoid invoking these negative stereotypes and myths prevalent in media force them to the margins of political discourse and reduce the credibility of their own accounts of their marginalization (Crenshaw, 1997; Harris-Perry, 2011).

For Black women who are lesbian and bisexual, the combination of gender, racial, and sexual minority statuses has been termed as "triple jeopardy" (Greene, 1996) and can be a salient risk factor for several health issues among Black lesbian and bisexual women. Sexual orientation-based discrimination is associated with increased emotional distress (Almeida et al., 2009) and exacerbates the severity of physical health symptoms (Lick et al., 2013). Sexual minorities are exposed to environmental stressors and sexual orientation-based societal prejudice and discrimination but Black lesbians face additional challenges and barriers to their health as a result of their gender, race, and sexual orientation (Balsam et al., 2015). Despite Black lesbians' higher health risk, they typically avoid or delay seeking healthcare (Ard and Makadon, 2012; Sabin et al., 2015).

Self-disclosure in the healthcare system

Self-disclosure, a significant part of the "coming out" or "being out" process for lesbian, bisexual, or gay individuals, is an influential factor in Black lesbian and bisexual women's healthcare

experience. Some lesbians find the healthcare setting a risky environment for self-disclosure (Hitchcock and Wilson, 1992). The apprehension surrounding self-disclosure is partially due to the perceived stigma of homosexuality in the healthcare setting. Medical institutions and the media generated a highly damaging image around lesbian identification and detecting lesbian patients (Anderson et al., 2001). Some of the stereotypical characteristics used to detect or diagnose "lesbianism" were based on physical attributes, such as muscular build, taller height, and gender-defying behaviors (Anderson et al., 2001; Stevens, 1996).

A recent study examining the intersectionality of sexual orientation, race, class, and gender suggests that the positive outcome of coming out does not extend to poor sexual minorities of color (McGarrity and Huebner, 2014). Although previous research has found that lesbians and bisexuals who self-disclose their sexual orientation report higher satisfaction with healthcare provider and are more likely to seek care (Hitchcock and Wilson, 1992), lower income lesbian and bisexual women who are "out" experience increased use of nonprescription medications, more physical symptoms, and higher levels of antigay discrimination. Hence, being out can be damaging to one's physical and mental health depending on socioeconomic status. To our knowledge, the role of self-disclosure in a healthcare setting for lesbian and bisexual Black women has yet to be examined. Studies on Black lesbians demonstrate that they experience racism, as well as heterosexism and sexism (Agénor et al., 2015; Wilson et al., 2011). This type of multiple minority stress may make self-disclosure especially difficult for Black lesbian and bisexual women.

Health disparities

Research has extensively demonstrated the association between minority identities and divergent health outcomes. Black women in the United States, in particular, are at higher risk for hypertension, diabetes, high cholesterol, obesity, and infant death rates than their White counterparts (Heron, 2016). Black women also have the highest rate of HIV infections among women (McCree et al., 2010), and HIV is the seventh leading cause of death for Black women aged 25–44 years (Murphy et al., 2013). According to 2014 census data, Black women accounted for up to 62 percent of all new HIV infections, despite constituting only 13 percent of the female population (Stein et al., 2016).

Several empirical studies have demonstrated some health disparities in relation to sexual orientation and race/ethnicity. Lesbian and bisexual women are less likely to receive mammograms or human papillomavirus tests than heterosexual women (Agénor et al., 2015; Miles-Richardson et al., 2012; Powers et al., 2001). A study of the health disparities of sexual minority women of color highlighted various health disparities among Black American, Hispanic, and Asian American women (Mays et al., 2002). Mays et al. (2002) found that Black American lesbians and bisexuals reported lower rates of receiving preventive care than the standardized estimates for Black American heterosexual women. It also reported that Hispanic and Black American lesbian and bisexual women experience reduced healthcare coverage, access to regular healthcare, and lower rates of receiving preventive care than Hispanic and Black American heterosexual women.

There are cultural and economic barriers that may account for the health disparities found among lesbians and bisexuals. Black lesbians are exposed to racism, sexism, and heterosexism, which may place them at higher risk of psychological distress than Black gay men (Cochran and Mays, 1994) and Black heterosexual women (Dibble et al., 2012). Lesbians are more likely to have lower socioeconomic status than heterosexual women and, hence, are less likely to have health coverage (Powers et al., 2001). Contextual factors such as lack of access to adequate care, greater poverty and incarceration rates, low education, and racism contribute to the cause of these health disparities (Buchmueller and Carpenter, 2010; Bulatao and Anderson, 2004; Ponce et al., 2010).

Research has also demonstrated that choosing to remain in the closet about one's sexual

orientation correlates with several negative health outcomes such as reduction in physical health and higher incidences of cancer and infectious diseases (Cole et al., 1996) and HIV progression (Ullrich et al., 2003). Closeted lesbian and bisexual women are at higher odds of reporting major depressive disorder than lesbians and bisexuals who have been recently out (Pachankis et al., 2015).

In light of this body of literature, the purpose of this study is to provide preliminary insight into the healthcare experiences of Black lesbian and bisexual women in the United States by presenting the story of one young Black American woman who identified as a lesbian. To protect her identity, this interviewee is given the pseudonym, "Z." In addition, she is a US-born daughter of immigrants from a country in Africa. Her parents' country of origin, and their African ethnicity, is coded as "X."

Method

The study protocol was approved by the Institutional Review Board. The first author conducted a 2-hour interview with a 24-year-old Black American lesbian, Z. Following the informed consent process, Z completed a demographic questionnaire. The interview consisted of open-ended questions pertaining to Z's healthcare experiences. At the end of the interview, Z received US$30 as compensation for participating.

Results

Z's story

Z presented a complex story. She occupied multiple identities—she was the child of immigrants, lesbian, Black, Christian, had a history of sexual trauma, and had been diagnosed with depression and posttraumatic stress disorder. These identities at times were in conflict, and balancing them was a chronic stressor:

> [My family and I] went to X in 2011, and this was a couple of months after I had come out to my parents, which was a disaster. And when we were in X, there was an opinion piece in the newspaper on how X should refuse to take any funds from the U.S. if the U.S. is going to try to implement LGBT regulations. So, I read this article and I was just like, "Well, shit." So, if I am out, will I lose my connection to my culture? Will I be seen as someone who is discarding my culture?

hooks (2000) argued there was a competitive element rooted in these social identities that suggests an individual can only identify with one identity or the other, but not both. Z's narrative suggests that, as a child of immigrants, she experienced this challenge:

> I'm actually Black but I also do recognize that, technically, this isn't really my culture and therefore there are ways I have to interact with it and there are ways I can be respectful and there are ways I can engage with it as a Black person, but there are ways that I can't and shouldn't.

In addition, Z reported experiences of racism ("Even if you try to perform Blackness in the least offensive way possible, you're still Black") and how being lesbian added to the complexity of her experience ("American culture barely recognizes that Black people exist just straight up, and so then you add being gay to it and it's like, what?"). Z's sentiments echoed those of Black feminist writers who argue that gender, race, class, and all other social identities intersect with each other; however, multiple social and cultural identities a person may have is often overlooked (Collins, 2002; Crenshaw, 1989; hooks, 2000).

Z's attempts to deal with stress-inducing events involved avoidance or withholding aspects of who she is. Z expressed hesitation to communicate with her family and friends about certain life stressors:

> We did a prayer intervention and a couple of weeks later my dad referenced the fact that I was now free from the homosexual thing. I was like, "Oh, great." So now my parents think I'm straight and I don't know when I'm going to tell them.

Lewis et al. (2013) examined the coping strategies of Black women in college against gendered racial macroaggressions and found

that Black women use a combination of coping strategies to address macroaggressions based on the social context. Z was struggling to cope with stressors in her life and appeared to have adopted an avoidance coping style. Her coping strategy mirrors that the *Becoming Desensitized and Escaping* coping style (i.e. seeking escape from the harsh experience) described by Lewis et al. (2013). Z compartmentalized the conflict of managing cultural expectations and her parents' negative perception of sexual minorities; choosing instead to avoid engaging in discussions related to the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community. Although she would love to adopt the *Collective Coping Strategy: Leaning on One's Support* (i.e. reaching out to friends, families, and partners), she was unable to share her sexual identity with her close family and cannot seek support from them in this regard.

Like other individuals with multiple minority social identities, Z felt marginalized and alienated:

> I grew up in a city that was 90% White. There weren't other really other Black people so Black culture was something that I grew up completely disconnected to, and then even as I've moved, it's the type of thing where I see and I interact with but then at the same time I try not to act as if it's my own.

Z's experience of race reflects the politics of "Blackness," what it means to be Black and who gets to be Black. As E. Patrick Johnson (2003) expressed in *Appropriating Blackness*, the social construction of Blackness comes not only from "the theatrical fantasy of the White imaginary that is then projected onto Black bodies" but also the "ways in which the 'living of blackness' becomes a material way of knowing" (p. 8). Blackness involves the politics of social identifications, and it is arguably grounded in performance (Johnson, 2003). The dominant construction of blackness in political discourse can often omit women and sexual minorities (Collins, 2002; Crenshaw, 1989, 1991; Johnson, 2003). Black women are too female to represent racism and too Black to represent sexism in social and political movements (Collins, 2002; Crenshaw, 1989). The discrete categories that race and sex discrimination are allocated to suggest that Black women must pick which identity to fight for when engaged in social activism (Crenshaw, 1991; hooks, 2000).

A person is Black not because in essence they are Black, but because of how they experience the world in combination with their behavior (Jackson, 2010). The sentiments expressed by Jackson (2010) on who gets to be perceived as authentically Black was captured in Z's lived experiences. Z believed she had no claim to Black American culture. She felt that her behaviors did not fit the stereotypical understanding of Blackness and Black culture. However, because she grew up in a "super White town," she believed her limited access to Black culture influenced the degree to which she identified with it. As such, Z identified more with her African ethnicity but still recognized that she is Black. Z recalled that, in high school, White students said to her, "Oh yeah, I'm Blacker than you because I can XYZ"—"XYZ" referring to elements of Black American popular culture—but Z believed that "in reality no, you're not, you're White. You'll never be blacker than me. Because I exist, I'm blacker than you."

Healthcare experiences as a microcosm of American society

Z believed that "some people are afraid that facts such as like your sexual orientation, racial identity, gender, and age affect or influence their experiences." She believed this was because of the assumptions and prejudices that healthcare providers made. Nevertheless, Z reflected that in certain healthcare settings, such as at the optician's or dentist's office, the personal biases of the healthcare professional would not affect how the practitioner treated her. Employed as a technician in a pharmacy, Z was not necessarily worried about "safety" when it came to self-disclosure in the healthcare setting because "I don't think a doctor could say anything worse than like what a co-worker has said to me within the health medical field." Z was more worried about feeling "minimized" or

dismissed. She described the feeling of being "minimized" in the healthcare setting as "exhausting" and exacerbating her depression.

Z believed that sexual orientation questions should only be asked when relevant to treatment, adding that there were instances when self-disclosure to a healthcare provider may be "relevant" or "necessary" but thought this pertained to "physical issues that relate to sexual activity." Z also believed that others may be willing to self-disclose when they "don't worry about the repercussions" or "do not care about them or have nothing to hide." Regarding her preference of being asked about her sexual orientation, Z would prefer if the healthcare provider provided the option to not say anything. She felt this was especially for those who are unsure or uncomfortable with their identity as self-disclosure "becomes an added pressure." Z would prefer to answer questions pertaining to sexual orientation in a written form because "it gives you more time to think" about whether or not to disclose. She also thought that being asked about her sexual orientation makes it easier to disclose, but believed this ease depends on "what you're being treated for also."

Z discussed the messages she had received regarding what makes a woman sexually healthy. For her, in terms of "societal perspectives" of sexually healthy women, a positive image was one of a woman being "able to and willing" to get pregnant and give birth, whereas a negative image was one of a woman with sexually transmitted diseases and infections. Z believed this image is a "fake, false definition of womanhood." Because she did not plan to have children and she reported not being sexually active at the time of the interview nor planned to be sexually active in the future, she believed she would be seen as unhealthy. Z also shared that having experienced sexual trauma made her "automatically" viewed as unhealthy.

Z described attitudes regarding sexual ideas, activities, and feelings that are classified as unhealthy. She stated, "If you have unhealthy sexual ideas or unhealthy sexual feelings, the goal is supposed to be to get back to a place where you are wanting to have sex with men." She added that the image of a sexually healthy woman from the perspective of her cultural background is that "culturally you're supposed to have children." This corresponded with her description of the image of a sexually healthy woman she was exposed to.

As a Black woman, Z reflected that the perceptions about Black women's sexuality were negative and that Black women were hyper-sexualized by society. She defined hyper-sexuality as "the way society views certain marginalized groups of people and puts them into either intense or negative sexual categories." Z felt hyper-sexualized "because of my Blackness but then hyper-sexuality [is viewed] as a component of a disorder." She described an event that occurred just before she went to college. She went to a doctor's visit with her mother and was informed that she would be getting a cervical cancer vaccination "because you can you know, you can get it from having sex with men." Being 17 years old at the time, it was up to her mother to decide whether she could get the vaccine and Z said, "My mom was just like, 'She's not getting it.'" Her mother thought it was unnecessary that she get the cervical cancer vaccine because the kind of sexual behavior that might cause this illness was culturally inappropriate. Z stated, "You're a Christian, you're a X, you are not going to have premarital sex." Yet, she stated that the doctor was "convinced" that she would need the vaccine and highly recommended that she should get it. Z wondered if the doctor's urging was based on "assumptions being made" about her due to the hyper-sexuality stereotype of Black women, or "if this doctor would have made this assumption with all of the college students."

Z recounted a time when went to see a new physician, at the encouragement of her former therapist, to see if getting on birth control would impact her mood fluctuations. She informed her therapist that she was hesitant because she "did not trust White men," and had a previous experience with a male physician she perceived to be "bad." She hoped this experience would not be like her last because she trusted her therapist (who is a woman), and believed she may have been

"overreacting" with her last experience. The physician asked Z how she came to be a patient of her therapist. Z replied that she was referred to her therapist through an organization that focused on support and advocacy for sexual abuse survivors. However, she did not want to share this information with this new physician because "one, strange man; two, none of his business" but he kept asking her and she said "it's hard for me to tell people no." Z ended up feeling pressured to disclose that she was sexually assaulted. She described this event as a "very triggering and negative experience" but she also said she believed she may have been "overreacting." Although she got the prescription she wanted from this physician and will not have to see him again, the thought of looking for another physician and having to "possibly navigate" a similar negative experience made her worried. When asked to elaborate on what she found "uncomfortable" about the questions asked by the male physician, she said she felt "attacked" because the questions were not relevant to her care and reason for visiting the doctor; she found them "invasive" and it "triggered my anxiety and then when I left I just, it kind of ruined like the rest of my day."

This anecdote is illustrative of Black lesbians' hesitation to seek care, so as to avoid dealing with questions pertaining to their sexual identity or other negative interactions with healthcare providers, such as being belittled, dismissed, or judged. The multiple "whammies" that Z embodied—due to race, gender, sexual orientation, and history of sexual assault—serve to heighten her distrust of a provider who is both male and White. For Black lesbians, the burden of being stereotyped as a hypersexual Jezebel and the fear of discrimination by providers due to sexual orientation jointly serve to heighten one's apprehension regarding healthcare utilization. For Z, the added dimension of her sexual assault history made it even more difficult for her, as she also experienced the physician's probing into her assault history as a form of revictimization and violation of her boundaries.

Indeed, inadequate patient–provider relationships can have a negative impact on health-seeking behavior. Empirical research has pointed to the impact of discrimination on the mental health of sexual minorities of color (Guyll et al., 2001). Similarly, this case study demonstrated that discriminatory or heteronormative patient–provider communications can cause psychological distress, feelings of being minimized and devalued, as well as decrease willingness to seek or follow-up with care.

Discussion

Z's healthcare experiences are illustrative of constructs espoused by Black feminist scholars. For example, Collins (2002) explained that just as a Black person's social class determines the forms of racism they encounter, sexuality also influences Black women's varying responses to injustice, as Black lesbian contend with heterosexism, sexism, and racism. Collins (2002) identified Black women's responses to resist the derogatory images of Black women. In some literary works, Black women resort to substance use, excessive religion, or decline into madness. Some respond with denial against the prevailing images of Black women, by rejecting their connection to other Black women through assertions that they are different. Still others respond to the governing negative images of Black women through resistance—by rejecting the negative images and pursuing their own definition of themselves. Black women carve out self-definitions through family networks, Black communities that present more positive images of Black womanhood (Collins, 2002).

Therefore, occupying multiple marginalized social identities—race, ethnicity, gender, sexual identity, religion, and family immigration history—jointly affect the experiences of Black lesbian and bisexual women in their personal lives and in the healthcare system. The findings from this case study illustrate intersectionality theory's argument that multiple marginalized social identities are not mutually exclusive in how they inform on the lived experiences of Black women, but for some, specific identities may play a more central role to self-identification and may be arranged hierarchically in terms of importance to the self.

Limitations

The findings for this research came from an interview conducted with one participant. Case studies are accepted reliable methods of acquiring qualitative data and yield rich data that could form the basis of future research (McCracken, 1988). However, it increases the likelihood of experimenter bias and distortion of the obtained results (Pellisé et al., 2005). Furthermore, the interview involved retrospective data, which increases the chances of recollection errors, resulting in unreliable conclusions. In addition, interview questions may also result in responses from participants that are socially desirable or "best fit."

The second limitation pertains to the generalizability of findings. The subject of this case study is an educated woman of higher socioeconomic status. Level of education can influence the perceptions and appraisal of healthcare treatment (Spooner et al., 2016) and can influence access to healthcare (Powers et al., 2001). Caution should be taken in generalizing the implications of this study to the healthcare experiences of all Black lesbians.

Clinical implications and research recommendations

This case study highlighted several implications for healthcare professionals who counsel or treat Black lesbian and bisexual female patients. The clinical implications specified by this study pertain to cultural competency, traumatic stress and mental health, coping, patient–provider relationship, social isolation, and marginalization. The themes identified here also suggest several additional directions for research on the well-being of members of marginalized groups—particularly Black lesbians.

Clinical implications. First, it would be beneficial for healthcare professionals to receive cultural competence and anti-discrimination training. For example, increased awareness of a patient's cultural beliefs and health practices can influence health-seeking behaviors and treatment adherence (Kodjo, 2009). Cultural diversity training on racial and sexual minority patients should be introduced to the curriculum at medical schools to foster more tolerant and accepting attitudes toward Black lesbian patients, among many other kinds of patients. As discussed in the literature review, there are cultural barriers to Black lesbians' health-seeking behavior and compliance with treatment (Wesley, 2009). Healthcare practitioners' lack of cultural competency inhibits willingness to seek care among Black lesbians (Burgess et al., 2010; Melfi et al., 2000). Awareness of and training about how to best cater to patients of diverse cultural backgrounds, health beliefs, and health practices will increase health-seeking behavior and overall health satisfaction with healthcare treatment.

Additionally, there are several strategies that healthcare providers can utilize to promote a safe and welcoming environment. One strategy to promote willingness to self-disclose is to initially frame questions and statements using culturally sensitive or neutral language until the sexual orientation of the patient is ascertained. Another strategy is to increase competency among healthcare providers on how to recognize trauma history and communicate with patients. It may also be useful to inquire about the patient's significant relationships, and family structure, and convey a message of acceptance when discussing these relationships.

Second, it is imperative that healthcare practitioners are aware of their own personal biases, assumptions, and generalizations about their patients. The findings of this study suggest that heteronormative assumptions in the healthcare setting may inhibit self-disclosure of sexual identity and overall satisfaction with the quality of treatment. Being "out" has major social, mental, and physical health ramifications (Ramsey et al., 2010; Stevens and Hall, 1988). Hence, it is important that Black lesbians view the healthcare setting as a safe environment for self-disclosure to facilitate health-seeking behaviors and trust in healthcare providers. Other useful suggestions for clinicians include physician training—using standardized patients

to simulate interactions with racial minority, lesbian, gay, and bisexual patients.

The coping methods adopted by members of marginalized groups relate to how they perceive, process, and respond to prejudice and discrimination and are worthy of exploration. Previous research has noted that lesbians utilize mental health services at higher rates than heterosexual women (Bradford et al., 1994; Cochran et al., 2003). Exposure to prejudice and discrimination associated with multiple marginalized identities can be a source of internal conflict and stress. The complex manner in which multiple social identities are conjugated may expose a person to negative social experiences and relationships, as highlighted in this study and the literature review. Hence, it is important to examine how being out and having multiple minority statuses can affect mental health.

Furthermore, clinicians should work with patients to develop positive methods of coping with minority stress. This case study and the literature reviewed suggest that managing minority stress can result in the adoption of maladaptive coping styles and unhealthy behaviors. Black lesbians manage stress caused by multiple systems of oppression: racism, sexism, heterosexism, and possibly xenophobia within their racial and ethnic community and the dominant community. Mental health counselors may find how Black lesbians struggle to cope with minority stress an important area of focus when administering to the mental health of this population.

Research recommendations. The goal of qualitative research is often to isolate and define categories during the research process (McCracken, 1988). This study examined patterns in the interrelationship between various themes (such as social identity, the patient–provider relationship, stress, health) that may form the basis of future research. For the advancement of research in this area, future researchers may employ a more structured quantitative method to precisely isolate, define categories, and delineate relationships between these themes with a larger sample. The limitations of the case study methodology, previously discussed, highlight the need for research on larger sample sizes that are representative of this population, meaning Black lesbians of various ethnic, socioeconomic backgrounds, and age to ensure reliability and validity.

Furthermore, research on the healthcare experiences of Black lesbians may require a longitudinal research design. Longitudinal studies are needed to examine the long-term and causal relationships between multiple social identities and mental and physical well-being. The mediators and moderators of this relationship is also worth further examination, such as prejudice and discrimination, strength of affiliation to one's various cultural groups, role of family and cultural expectations, perceived support, and socioeconomic status. The implicit biases, communication styles, and assumptions of healthcare providers and how they affect healthcare delivery also warrant further exploration.

Researchers interested in designing and conducting intersectionality research may find the social identities, and social inequality based on an array of multiple identities (such as race, sexual orientation), methodologically challenging, but worthwhile. Health disparities and social inequalities are rooted in the interconnections between multiple social identities, such as race, ethnicity, socioeconomic status, religion, disability, gender, sexual orientation, religion, and in certain social context. Research on the experiences of Black lesbians and bisexuals may utilize an intersectionality framework that recognizes the heterogeneity of this population. Intersectionality approaches to research promotes examination of how multiple social identities are connected and how they influence the lived experiences of lesbians and bisexuals. Additionally, feminist and anti-racist participatory action research as described by Lykes and Scheib (2015) can contribute to a better understanding of Black sexual minority issues and experiences.

Characteristics of individuals (such as their coping style, mental health, the salience of

sexual and racial identity) are crucial factors that require further investigation. Attention should also be given to characteristics in the individual's social environments, such as social support networks, migration history, access to resources, sense of agency, and interpersonal relationships. The role of religion and spirituality on identity development among Black lesbians may be another area of focus. Previous researchers have demonstrated that religion is important to the Black community and a contributing factor in promoting homophobia in the Black community (Hurst, 2012). The findings of this case study indicate that religious affiliation may be a major element of identity conflict and worth further attention. Additionally, the case study highlighted some of the conflict a child of immigrant experiences that may direct future studies. Studies of the healthcare experiences of members of the sexual minority community focused primarily on White lesbians and gay men. Few have been designed specifically to include bisexual or transgender persons, and this may be an additional avenue for future researchers on this topic.

Conclusion

Previous research has highlighted the negative experiences of lesbians in the US healthcare system. This study provided a glimpse into the healthcare experiences of a Black American lesbian, who is the child of African immigrants. In considering the healthcare experiences of a Black lesbian, this study examined the factors that promote and inhibit assessing and receiving adequate healthcare. The subject of this case study revealed she experienced minority stress related to prejudice events. Managing the social inequalities associated with multiple marginalized identities is challenging and negatively impacted the well-being of this Black lesbian.

This study revealed that an individual's decision to self-disclose depends on a number of factors. Previous researchers have documented that heteronormative assumptions and heterosexism in the healthcare setting inhibit willingness to self-disclose in the healthcare setting (Neville and Henrickson, 2006). This case study also noted that healthcare providers' assumptions about the sexual orientation of their patient can not only negatively impact quality of care but also willingness to self-disclose. Z also recognized that personal comfort with sexual identity could influence a patient's decision to self-disclose in the healthcare setting.

Fish (2008) argued for the importance of incorporating intersectionality theory in research on the LGBTQ community. This study reinforces this perspective and indicates the importance of explicitly investigating the intersections between marginalized identities (such as sexual orientation, race, and ethnicity) and the social inequality related to marginalized identities explicitly. Intersectionality theory provides a framework to explore the lived experiences of those who occupy the margins of systems of oppression. Accordingly, it will provide a better understanding and capture the complexity of the social experiences of individuals and groups.

The exploration of the negative impact of perceived discrimination on mental and physical health in the healthcare setting is a viable area of research. The literature reviewed in this article provided multiple perspectives and reflect some common themes and experiences among marginalized individuals. However, it is important to note that each individual's perspective reflects a range of experiences and a unique cultural background. The history of invisibility and marginalization of Black women and other sexual minority women of color present the need for critical discourse and research to incorporate intersectionality theory as a methodological framework. There continues to be a need for culturally sensitive healthcare services. Thus, further research will help guide healthcare practitioners as they seek to appropriately address the needs of members of marginalized groups.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

References

Agénor M, Bailey Z, Krieger N, et al. (2015) Exploring the cervical cancer screening experiences of Black lesbian, bisexual, and queer women: The role of patient-provider communication. *Women & Health* 55(6): 717–736.

Almeida J, Johnson RM, Corliss HL, et al. (2009) Emotional distress among LGBT youth: The influence of perceived discrimination based on sexual orientation. *Journal of Youth and Adolescence* 38(7): 1001–1014.

Anderson L, Healy T, Herringer B, et al. (2001) *Out in the Cold: The Context of Lesbian Health in Northern British Columbia*. Vancouver, BC, Canada: British Columbia Centre of Excellence for Women's Health.

Ard KL and Makadon HJ (2012) *Improving the Health Care of Lesbian, Gay, Bisexual and Transgender (LGBT) People: Understanding and Eliminating Health Disparities*. Boston, MA: The Fenway Institute, Fenway Health.

Ashing-Giwa K, Padilla G, Tejero J, et al. (2004) Understanding the breast cancer experience of women: A qualitative study of African American, Asian American, Latina and Caucasian cancer survivors. *Psycho-Oncology* 13(6): 408–428.

Balsam KF, Molina Y, Blayney JA, et al. (2015) Racial/ethnic differences in identity and mental health outcomes among young sexual minority women. *Cultural Diversity & Ethnic Minority Psychology* 21(3): 380–390.

Bradford J, Ryan C and Rothblum ED (1994) National Lesbian Health Care Survey: Implications for mental health care. *Journal of Consulting and Clinical Psychology* 62(2): 228–242.

Buchanan KS (2007) Impunity: Sexual abuse in women's prisons. *Harvard Civil Rights-Civil Liberties Law Review* 42(1): 45–97.

Buchmueller T and Carpenter CS (2010) Disparities in health insurance coverage, access, and outcomes for individuals in same-sex versus different-sex relationships, 2000–2007. *American Journal of Public Health* 100(3): 489–495.

Bulatao RA and Anderson NB (eds) (2004) *Understanding Racial and Ethnic Differences in Health in Late Life: A Research Agenda*. Washington, DC: National Academies Press.

Burgess DJ, Warren J, Phelan S, et al. (2010) Stereotype threat and health disparities: What medical educators and future physicians need to know. *Journal of General Internal Medicine* 25(2): 169–177.

Cochran SD and Mays VM (1988) Disclosure of sexual preference to physicians by Black lesbian and bisexual women. *Western Journal of Medicine* 149(5): 616–619.

Cochran SD and Mays VM (1994) Depressive distress among homosexually active African American men and women. *American Journal of Psychiatry* 151(4): 524–529.

Cochran SD, Sullivan JG and Mays VM (2003) Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology* 71(1): 53–61.

Cole SW, Kemeny ME, Taylor SE, et al. (1996) Elevated physical health risk among gay men who conceal their homosexual identity. *Health Psychology* 15(4): 243–251.

Collins CF (ed.) (2006) *African American Women's Health and Social Issues*. Westport, CT: Greenwood Publishing Group.

Collins PH (2002) *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. New York: Taylor & Francis.

Crenshaw K (1989) Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *The University of Chicago Legal Forum* 140: 139–167.

Crenshaw K (1991) Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review* 43(6): 1241–1299.

Crenshaw KW (1997) Beyond racism and misogyny: Black feminism and 2 live crew. In: Meyers DT (ed.) *Feminist Social Thought: A Reader*. New York: Routledge, pp. 246–263.

Dibble SL, Eliason MJ and Crawford B (2012) Correlates of wellbeing among African American lesbians. *Journal of Homosexuality* 59(6): 820–838.

Fish J (2008) Navigating queer street: Researching the intersections of lesbian, gay, bisexual and trans (LGBT) identities in health research. *Sociological Research Online* 13(1): 12.

Frost DM, Lehavot K and Meyer IH (2013) Minority stress and physical health among sexual minority individuals. *Journal of Behavioral Medicine* 38(1): 1–8.

Greene B (1996) Lesbian women of color: Triple jeopardy. *Journal of Lesbian Studies* 1(1): 109–147.

Guyll M, Matthews KA and Bromberger JT (2001) Discrimination and unfair treatment: Relationship to cardiovascular reactivity among African American and European American women. *Health Psychology* 20(5): 315–325.

Harris-Perry MV (2011) *Sister Citizen: Shame, Stereotypes, and Black Women in America*. New Haven, CT: Yale University Press.

Heron M (2016) Deaths: Leading causes for 2013. *National Vital Statistics Reports* 65(2): 1–95.

Hitchcock J and Wilson H (1992) Personal risking: Lesbian self-disclosure of sexual orientation to professional health care providers. *Nursing Research* 41(3): 178–183.

hooks b (2000) *Feminist Theory: From Margin to Center*. Cambridge, MA: South End Press.

hooks b (2014) *Ain't I a Woman: Black Women and Feminism* (2nd edn). New York: Routledge.

Hurst C (2012) *Social Inequality: Forms, Causes, and Consequences* (8th edn). Boston, MA: Pearson Education.

Jackson JL (2010) *Harlemworld: Doing Race and Class in Contemporary Black America*. Chicago, IL: University of Chicago Press.

Jacobs EA, Rolle I, Ferrans CE, et al. (2006) Understanding African Americans' views of the trustworthiness of physicians. *Journal of General Internal Medicine* 21(6): 642–647.

Johnson EP (2003) *Appropriating Blackness: Performance and the Politics of Authenticity*. Durham, NC: Duke University Press.

Kodjo C (2009) Cultural competence in clinician communication. *Pediatrics in Review/American Academy of Pediatrics* 30(2): 57–64.

Lewis JA, Mendenhall R, Harwood SA, et al. (2013) Coping with gendered racial microaggressions among Black women college students. *Journal of African American Studies* 17(1): 51–73.

Lick DJ, Durso LE and Johnson KL (2013) Minority stress and physical health among sexual minorities. *Perspectives on Psychological Science* 8(5): 521–548.

Lykes MB and Scheib H (2015) The artistry of emancipatory practice: Photovoice, creative techniques, and feminist anti-racist participatory action research. In: Bradbury-Huang H (ed.) *Handbook of Action Research III*. Thousand Oaks, CA: SAGE, pp. 131–142.

McCracken GD (1988) *The Long Interview*. Newbury Park, CA: SAGE.

McCree DH, Jones KT and O'Leary A (2010) *African Americans and HIV/AIDS: Understanding and Addressing the Epidemic*. New York: Springer.

McGarrity L and Huebner D (2014) Is being out about sexual orientation uniformly healthy? The moderating role of socioeconomic status in a prospective study of gay and bisexual men. *Annals of Behavioral Medicine* 47(1): 28–38.

Mays VM, Yancey AK, Cochran SD, et al. (2002) Heterogeneity of health disparities among African American, Hispanic, and Asian American women: Unrecognized influences of sexual orientation. *American Journal of Public Health* 92(4): 632–639.

Melfi CA, Croghan TW, Hanna MP, et al. (2000) Racial variation in antidepressant treatment in a Medicaid population. *Journal of Clinical Psychiatry* 61(1): 16–21.

Meyer IH (2013) Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychology of Sexual Orientation and Gender Diversity* 1(S): 3–26.

Miles-Richardson S, Blumenthal D and Alema-Mensah E (2012) A comparison of breast and cervical cancer legislation and screening in Georgia, North Carolina, and South Carolina. *Journal of Health Care for the Poor and Underserved* 23: 98–108.

Murphy SL, Xu J and Kochanek KD (2013) Deaths: Final data for 2010. *National Vital Statistics Reports* 61(4): 1–117.

Neville S and Henrickson M (2006) Perceptions of lesbian, gay and bisexual people of primary healthcare services. *Journal of Advanced Nursing* 55(4): 407–415.

Pachankis JE, Cochran SD and Mays VM (2015) The mental health of sexual minority adults in and out of the closet: A population-based study. *Journal of Consulting and Clinical Psychology* 83(5): 890–901.

Pellisé F, Vidal X, Hernández A, et al. (2005) Reliability of retrospective clinical data to evaluate the effectiveness of lumbar fusion in chronic low back pain. *Spine* 30(3): 365–368.

Ponce NA, Cochran SD, Pizer JC, et al. (2010) The effects of unequal access to health insurance for

same-sex couples in California. *Health Affairs* 29(8): 1539–1548.

Powers D, Bowen DJ and White J (2001) The influence of sexual orientation on health behaviors in women. *Journal of Prevention & Intervention in the Community* 22(2): 43–60.

Ramsey F, Hill MJ and Kellam C (2010) *Black Lesbians Matter*. Sacramento, CA: Zuna Institute.

Sabin JA, Riskind RG and Nosek BA (2015) Health care providers' implicit and explicit attitudes toward lesbian women and gay men. *American Journal of Public Health* 105(9): 1831–1841.

Solarz AL (ed.) (1999) *Lesbian Health: Current Assessment and Directions for the Future*. Washington, DC: National Academies Press.

Spooner KK, Salemi JL, Salihu HM, et al. (2016) Disparities in perceived patient–provider communication quality in the United States: Trends and correlates. *Patient Education and Counseling* 99(55): 844–854.

Stein R, Pierce T, Hollis N, et al. (2016) HIV testing and service delivery among Black females—61 health department jurisdictions, United States, 2012–2014. *MMWR: Morbidity and Mortality Weekly Report* 65(4): 83–84.

Stevens PE (1996) Lesbians and doctors: Experiences of solidarity and domination in health care settings. *Gender & Society* 10(1): 24–41.

Stevens PE and Hall JM (1988) Stigma, health beliefs and experiences with health care in lesbian women. *Image: Journal of Nursing Scholarship* 20(2): 69–73.

Ullrich PM, Lutgendorf SK and Stapleton JT (2003) Concealment of homosexual identity, social support and CD4 cell count among HIV-seropositive gay men. *Journal of Psychosomatic Research* 54(3): 205–212.

Wesley Y (2009) *Black Women's Health: Challenges and Opportunities*. New York: Nova Science Publishers.

Wilson BD, Okwu C and Mills SA (2011) Brief report: The relationship between multiple forms of oppression and subjective health among Black lesbian and bisexual women. *Journal of Lesbian Studies* 15(1): 15–24.