



**Adult Advocacy
Centers**

White Paper

LGBTQ+ Identity, Disability and Victimization

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Introduction

The purpose of this paper is threefold:

1. To identify how lesbian, gay, bisexual, transgender, queer and other noncisgender (LGBTQ+) identities intersect with disabilities;
2. To explore the differences between the experiences of queer individuals with and without disabilities; and
3. To compare the experiences of disabled LGBTQ+ individuals with the experiences of disabled non-LGBTQ+ people in terms of victimization.

As an LGBTQ+-led and disability-led organization, the Adult Advocacy Centers (AACs) recognize the importance of addressing intersectional identities and the needs and barriers to care that accompany them. Enhancing our understanding of the unique and shared experiences within the specific historical frameworks of each of these communities will help us better identify the services and resources we should provide when people from these communities are victims of crime.

We acknowledge that the words individuals choose to describe their identities are personal. For the purposes of this paper, we use “LGBTQ+” and “queer” interchangeably, though we know that not everyone will identify with both terms. For the disability community, we also use identity-first language (disabled person) and person-first language (person with a disability) interchangeably. All of these choices are an attempt to be sensitive and inclusive to the broadest number of people.



A Brief History of Disability and LGBTQ+ Identities in the U.S.

Individuals with disabilities, members of the LGBTQ+ community, and those with intersecting identities have always existed. The societal response to those individuals has varied throughout history. There was no unified Native American response to disability, as cultures and beliefs varied. However, many tribes modeled full inclusivity of disabled individuals, accepting various physical disabilities and seizure disorders, and even developing sign language to assist tribesmen when hunting, which was used by all individuals, regardless of deafness or speech impairments (Patterson, 2014). Similarly, before colonization, gender identities and sexual orientations in Native communities were diverse and widely accepted. Two-Spirit individuals were often expected within their tribes to take on roles as medicine people, mentors, teachers and healers (Mas et al., 2021). Colonization and forced assimilation severely altered the acceptance of disabilities and LGBTQ+ identities within Native cultures.

From the 17th to mid-19th centuries, the country's economy grew to be primarily farm-based. Individuals with disabilities, depending on the nature and severity of their disability, were often able to contribute to their family's income (Patterson, 2014). As farming was replaced with industrial work, individuals with disabilities were deemed unable to perform specific skill-based tasks. Therefore, they were classified as "disabled." There is little information about the acceptance of LGBTQ+ individuals during this time. Many queer individuals hid their identities, as acts of sodomy committed by men or women were punishable by death (GLESN, 2016).

The introduction of mental asylums and psychiatric institutions during the 19th and 20th centuries was one of the darkest times for individuals within both the disability and LGBTQ+ communities. It was hypothesized by many psychologists within these institutions that homosexuality was a psychological disorder that could be "cured" through conversion techniques. This included electroconvulsive therapy, lobotomies and shock treatment that was administered directly into the brain (Blakemore, 2018). In the 1800s institutions opened for people with disabilities, and these individuals were placed there when their families were no longer willing or able to provide for them. These facilities focused more on "restraining and controlling patients, not treatment or therapy" (Action for Access, 2016). Institutions often housed disabled people throughout their entire lives and provided them with extremely poor care, including reports of sedative overdosing. The New York Times reported about cases of "cruel and inhumane treatment of inmates" within many facilities in 1875 (Action for Access, 2016). Even after this media attention, laws were passed that led to the forced institutionalization and even sterilization of people with disabilities until the 1970s.

Institutionalization and Pathologization of LGBTQ+ People/Identity

Throughout the 19th and 20th centuries, homosexuality was not just illegal—it was seen as a malady that many people thought could be cured. In 1952, the Diagnostic and Statistical Manual of Mental Disorders (DSM) was first published, with homosexuality listed as a sociopathic personality disorder. This categorization, along with anti-sodomy laws that had been in place since 1920, made possible the formation of laws and regulations that denied homosexual people employment or licensure in various professions. In many states, people who were identified as homosexual were categorized as sex criminals alongside pedophiles and rapists, further encouraging their institutionalization and attempts to cure them of their perceived sexual deviance (Institute of Medicine [US] Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, 2011). It would not be until 1987 that homosexuality would be removed from the DSM and until 2003 that the Supreme Court would rule anti-sodomy laws unconstitutional.

Even though many physical methods to cure homosexuality were proven ineffective as early as 1913 (Graham, 2019), attempted treatments through psychotherapy, hormone treatments, lobotomy, electroshock, castration and aversive conditioning with nausea-inducing drugs continued through the 1960s in both inpatient and outpatient settings. Some of these methods persist today. Over the years, a variety of long- and short-term studies have continued to prove the ineffectiveness of these attempts to cure homosexuality (Institute of Medicine [US] Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, 2011). While conversion therapy is not supported by any major professional healthcare associations today, most states do not have conversion therapy prohibitions, especially within religious settings (Graham, 2019).

Victimization of Disabled People and the LGBTQ+ Community

According to the Centers for Disease Control (CDC), 26% of adults in the United States have a disability (Okoro et al., 2018), and individuals with disabilities are almost four times more likely to be victims of abuse than non-disabled people (Harrell, 2021). These individuals are often victimized at a higher rate than their able-bodied peers due to their physical and mental limitations (Allen, 2015). Individuals with disabilities have a need for knowledgeable and affirming victim services, yet professionals within victim services often do not receive specialized training aimed at addressing the needs of people with disabilities. This lack of training often results in inaccessible supports and services for individuals with disabilities.

Most first responders do not include intake questions about sexual orientation or gender identity when working with victims of a crime unless they believe that the crime is related to the victim's sexual orientation or gender identity (LaSala & Fedor, 2020). Therefore, there are very few statistics available about the victimization rate for LGBTQ+ people. There is even less information available about crime and victimization at the intersection

of disability and queerness. When looking at the statistics for LGBTQ+ victimization and victimization of disabled people separately, it appears likely that disabled LGBTQ+ people experience victimization at a much higher rate than non-disabled people who are cisgender and heterosexual. LGBTQ+ individuals with disabilities also experience a moderately higher rate of victimization than people with disabilities who are cisgender and heterosexual (Rodríguez-Roldán, 2020).

One area of victimization that has received some attention is domestic violence among LGBTQ+ people. The disproportionate number of LGBTQ+ people being victimized by domestic violence in comparison to heterosexual/cisgender people can be seen through statistics published by the National Coalition Against Domestic Violence indicating that 43.8% of lesbians and 61.1% of bisexual women experience rape, stalking or physical violence in their lifetime. The same is true for 35% of heterosexual women. The statistics for gay and bisexual men compared to heterosexual men are less staggering, but still display similar disparities: about 26% of gay men and 37.3% of bisexual men experience rape, stalking or violence in their life. The same is true for 22% of heterosexual men (Woods, 2017).

Intersections of Queerness and Disability

Research about the intersection between queerness and disability is sparse, exclusive of the work examining the impact of the AIDS epidemic on the LGBTQ+ community. What little data we do have suggests that LGBTQ+ people are significantly more likely to be disabled than their cisgender, heterosexual counterparts.

A study published by the American Public Health Association reported that about 36% of lesbian and bisexual women have disabilities, as opposed to 25% of their heterosexual counterparts. About 26% of gay men and 40% of bisexual men are disabled. In contrast, about 22% of straight men have disabilities (Fredriksen-Goldsen, Kim & Barkan, 2012). Additionally, results from the U.S. Trans Survey of 2015 indicated that approximately 39% of transgender people have a disability—a staggeringly high proportion in comparison to the general population. This statistic from the U.S. Trans Survey is based on self-reported data. Therefore, 39% is likely an under-representation.

When examining the experiences of LGBTQ+ people with disabilities in healthcare and community services, O’Shea et al. found two overarching themes (2020). First, individuals with intersecting identities felt an impact in their services and supports. LGBTQ+ individuals with disabilities discussed having to repeatedly come out in “layered and complex ways,” which made it challenging for their full range of needs to be met. An example of this would be an individual being uncomfortable coming out to a service provider who lacked training or affirming care and therefore not informing the provider that their partner was a support at home or omitting their sexual health history. Second, people who had a strong sense of community with other LGBTQ+ disabled individuals were able to

find better services and care. They were able to promote a sense of belonging and resilience and therefore be their authentic selves while accessing care. This increased their capacity to manage health services and advocacy (O’Shea et al., 2020).

While there is little data on the percentage of disabled LGBTQ+ people who are victimized by crime, the statistics on the victimization of disabled people and LGBTQ+ people individually display the need for further investigation and support. As we know, these identities and experiences intersect: a third of bisexual women are disabled (Fredriksen-Goldsen, Kim & Barkan, 2012), and disabled people are almost four times more likely than non-disabled people to be the victim of violent crimes (Harrell, 2021). Nearly two-thirds of bisexual women have reported being victims of rape, stalking or physical violence (Woods, 2017). With this data in mind, it is inferred that LGBTQ+ people are more likely to be disabled and more likely to be victims of crime. Despite these facts, the CDC has not identified disability as a priority health issue for LGBTQ+ people, leading to a lack of adequate resources for disabled LGBTQ+ adults in many different facets of their lives, especially when they become victims of crime.

Barriers to Reporting

When the Americans with Disabilities Act (ADA) was passed in 1990, homosexuality was determined to not qualify as a protected disability. Additionally, it was ruled that transgender people would not be protected under the ADA, despite “gender dysphoria” being an official diagnosis in the current volume of the DSM (the DSM-V). This ruling received split reactions from the LGBTQ+ community, as some believed that classifying gender dysphoria as a disability would validate arguments that transgender people are mentally ill. In contrast, others sought the protections of the ADA despite the cultural connotations the classification may have. There are very few systemic protections in place for disabled LGBTQ+ individuals, leading many LGBTQ+ people—and particularly transgender people—to avoid seeking justice and healthcare after being victimized. According to the 2015 U.S. Transgender Survey, “Thirty-three percent of transgender people reported experiencing verbal mistreatment by a healthcare provider. Twenty-three percent reported avoiding seeing a doctor when needed due to the fear of mistreatment because of their transgender status” (Rodríguez-Roldán, 2020). Additionally, in a survey of 6,540 transgender people, 11% of victims reported being denied the same care as cisgender people, 12% reported being harassed or disrespected and 2% reported being physically assaulted when seeking mental health services (Grant et al., 2011).

A study by the National Center for Victims of Crime and the National Coalition of Anti-Violence Programs (NCAVP) interviewed 648 victim assistance agents throughout the U.S. about the training they received regarding LGBTQ+ individuals. These agents worked for programs within the National Center for Victims of Crime’s network. Of these 648 respondents, 40.5% were from nonprofit domestic violence centers, 38.7% were from nonprofit sexual assault centers, 26.6% were from prosecutors’ offices, 16.5% were from law

enforcement agencies, and 16.5% were from nonprofit organizations serving child victims.

Results from this survey showed that 93.3% of service providers reported that they did not receive specific training addressing how to best serve transgender people. Seventy percent reported that they lacked training in how to serve lesbians and bisexual women, and 68.9% reported a lack of training in how to best serve gay and bisexual men. Since many victim services providers do not know how to adequately provide care for LGBTQ+ people, LGBTQ+ people often do not feel safe accessing community resources unless they are recommended by their peers (Turell & Herrmann, 2008).

The distrust that many LGBTQ+—and particularly transgender—people have towards medical professionals is especially dangerous due to the high rates of depression and suicide amongst LGBTQ+ people. According to the U.S. Transgender Survey, 82% of transgender people have contemplated suicide, and 40% have attempted suicide, with the highest rate of suicidality being reported among trans youth. Data from this survey has shown that as many as 40% of transgender individuals consider or attempt suicide during their youth or young adulthood (James et al., 2016). These statistics indicate a lifetime suicide attempt rate nine times greater than the general U.S. population (Nock & Kessler, 2006). While this report is primarily focusing on LGBTQ+ and disabled adults, distrust for medical care providers and the justice system is built through a lifetime of experiences, starting in childhood.

Affirming environments and access to medical care, such as gender-affirming hormone therapy (GAHT), has been shown to decrease suicidality among transgender people by as much as 40% (Green et al., 2021), yet anti-trans bills have been sweeping the nation. To date, 22 states in the U.S. have introduced bills to ban medical care for transgender youth, and Alabama has become the first state to pass a law formally criminalizing gender-affirming medical care for transgender youth.

Alabama's gender-affirming healthcare ban, the Alabama Vulnerable Child Compassion and Protection Act, has criminalized the administration of puberty blockers, hormone replacement therapy and gender-affirming surgery to anyone under 19 years old. This act also forces any "nurse, counselor, teacher, principal or other administrative officials at any public or private school" to tell parents if a child discloses that they are transgender or do not identify with their assigned sex/gender at birth (Alabama Vulnerable Child Compassion and Protection Act, Al. SB184). Studies have shown that transgender youth without supportive parents are up to three times more likely to have depressive symptoms, two times more likely to consider suicide, and up to 14 times more likely to attempt suicide than transgender youth with supportive parents (Travers et al., 2012). Transgender children being forcibly outed to potentially unsupportive parents threatens the health and safety of those children, especially within a system that denies them affirming care at large.

Disability Justice

The term “Disability Justice” was first coined in 2005 by a collective of disabled queer women of color—namely, Patty Berne, Mia Mingus and Stacey Milbern. While the previous Disability Rights Movement faced criticism for being white-centric, the Disability Justice Movement takes an intersectional approach to the framework established by the Disability Rights Movement by addressing how systems of oppression involving race, gender, class and sexuality inform the oppression of people with disabilities. The movement has 10 central principles, which have been developed by the team at Sins Invalid, a San Francisco-based performance group co-founded by Patty Berne that centers Disability Justice values, celebrating disabled artists and centering artists of color and LGBTQ+ artists:

1. Intersectionality
2. Leadership of Those Most Impacted
3. Anti-Capitalist Politic
4. Commitment to Cross-Movement Organizing
5. Recognizing Wholeness
6. Sustainability
7. Commitment to Cross-Disability Solidarity
8. Interdependence
9. Collective Access
10. Collective Liberation (Berne, 2015).

Long before Disability Justice was formally named, Black, disabled, lesbian feminist Audre Lorde wrote and published *The Cancer Journals* in 1980 to chronicle her experience with breast cancer. This book is one of the first written proponents for an intersectional approach to disability justice, as Lorde applies Black feminist ideals that she developed along with the Combahee River Collective in 1977 to her lived experiences as a woman with breast cancer. In their mission statement, the Combahee River Collective wrote, “the major systems of oppression are interlocking. The synthesis of these oppressions creates the conditions of our lives” (Combahee River Collective, 1977). This statement is the foundation for intersectional feminism as a whole and is essential for understanding the foundation and synthesis of the Disability Justice movement.

In an attempt to define Disability Justice and explain how it differs from the disability rights movement, movement co-founder Patty Berne wrote, “Disability Justice activists, organizers, [and] cultural workers understand that able-bodied supremacy has been formed in relation to intersecting systems of domination and exploitation...A Disability Justice framework understands that all bodies are unique and essential, that all bodies have strengths and needs that must be met” (Berne, 2015). These needs which must be

met vary from body to body, and depend not only upon disability, but also upon the other circumstances that make up each person's day-to-day life.

A Disability Justice framework helps us to understand better ways to provide care and support to LGBTQ+ people with disabilities who are victims of crime. By embracing and acknowledging all aspects of a person's identity, their needs can be met more holistically. It is through this framework that LGBTQ+/disabled people have created mutual aid webs they can rely on for the support and care that is often inaccessible through traditional routes.

Mutual Aid Webs and LGBTQ+/Disability-Led Organizations

Disabled and LGBTQ+ people often turn to each other to bridge the gaps in access and care often found in traditional services, and one way that they have done this is by creating community care webs for emotional support, medical care and help with everyday activities. These community efforts often look different from place to place, but they are always based on models of solidarity rather than charity—whether they involve only disabled people helping other disabled people or if they involve nondisabled people helping disabled people as well.

Stories of successful care models—formal and informal—are plentiful. In a chapter titled “Care Webs” from her book *Care Work: Dreaming Disability Justice*, queer disabled activist Leah Lakshmi Piepzna-Samarasinha describes different versions of care webs that she has witnessed first-hand and the importance of disabled community in general. She explains her life-changing experience with these collectives; specifically, she highlights Creating Collective Access (CCA), a care web that she formed alongside Mia Mingus and Stacey Milbern. This web began to take shape in 2010 when the trio, along with some other disabled queer and transgender people of color, was having trouble figuring out how they would travel to disability rights conferences in Detroit while ensuring all of their needs were met. As they brainstormed possible solutions, it occurred to them that people with disabilities don't have to choose between handling their own access needs or relying on able-bodied people in order to get the services they need. They could instead create a community of disabled people who were ready and willing to help meet each other's accessibility needs. They formed the collective through a WordPress website, and everyone who took part was amazed by how supported they felt through a process that was typically extremely stressful. Piepzna-Samarasinha describes the aftermath of the collective:

CCA changed everyone who was present for it and a lot of people who just heard about it. It was just four days, but people went home to their communities transformed. We were no longer willing to accept isolation, or a tiny bit of access, or being surrounded by white disabled folks as the only kind of disability community we could access, or being forgotten...We came back less willing to accept ableism from conferences and community spaces, because we knew it could be different—and if CCA could happen in someplace with scarce physical resources like Detroit, it could happen anywhere. (Piepzna-Samarasinha, 2018).

The CCA is just one example of a collective utilizing a Disability Justice framework to provide reciprocal community care. There are other care webs like CCA, but not everyone has access to a community of other people with disabilities to help them. And while community care webs have been extremely beneficial for many LGBTQ+ people with disabilities, especially Black and brown people, there are issues with relying wholly on this support. For some, access to care is a matter of life and death, and having someone in your care web fail to show up for a “shift” could be life-threatening.

Strengthening Our System to Provide Resources for Disabled LGBTQ+ People

LGBTQ+ cultural competency training within law enforcement agencies, mental and physical health care organizations, social services and victim service agencies is crucial if we expect these professionals to identify the underlying biases that impact their ability to serve LGBTQ+ victims.

Research has found that victim services providers do not believe that someone’s sexual or gender identity is important to consider unless it is related to the crime (LaSala & Fedor, 2020). This, however, makes it impossible to determine how many LGBTQ+ people are being victimized or what crimes they are most vulnerable to. Some victim services providers don’t ask for information about a victim’s sexual or gender identity out of fear that the victim will face further harassment from law enforcement or legal officials (LaSala & Fedor, 2020). Therefore, it is particularly important to address homophobia and cultural competency. Omission of sexual and gender identity leads to the erasure of experiences specific to LGBTQ+ people and leads to LGBTQ+ people not feeling safe or supported in victim services spaces.

While every disabled LGBTQ+ person has different needs depending on their disability, sexuality and gender identity, it is crucial to approach people in this community with cultural awareness and an openness to adapt to their needs. Sexuality and gender identity impact the way people interact with the world around them and inform their responses to traumatic experiences.

The inclusion of intake questions regarding gender and sexuality would create the opportunity to better understand the crimes that disabled LGBTQ+ people face most frequently and enable better preventative and responsive measures in the future. Training on different facets of LGBTQ+ identity—such as gender identity, gender expression and sexuality—and how they interact with disability, victimization and trauma is essential for providing effective care for LGBTQ+ people with disabilities. Overall, the most impactful thing that professionals who work with disabled LGBTQ+ victims can do to provide effective care is to listen to the needs and suggestions of those people, and to be open to adapting care to match their needs.

Glossary

Bisexual: Sexual or romantic attraction to people of one's own gender identity and of other gender identities (Merriam-Webster, 2022). Often shortened as "bi."

Cisgender: A person whose gender identity corresponds with the sex the person had or was identified as having at birth (Merriam-Webster, 2022). Often shortened as "cis."

Gay: Typically referring to men. An individual who is sexually and/or romantically attracted to people of the same sex (Merriam-Webster, 2022)

Heterosexual: Typically referring to an individual who experiences sexual or romantic attraction to people of the opposite sex. (Merriam-Webster, 2022)

Lesbian: A woman who is sexually or romantically attracted to other women (Merriam-Webster, 2022). Recent definitions have shifted to include non-men who are sexually or romantically attracted to other non-men ("Gender and Sexuality Terms," 2022).

Transgender: A person whose gender identity differs from the sex the person had or was identified as having at birth (Merriam-Webster, 2022). Often shortened as "trans."

Two-Spirit: A third gender found in some Native American cultures, often involving birth-assigned men or women taking on the identities and roles of the opposite sex. A sacred and historical identity, two-spirit can include but is by no means limited to LGBTQ identities (Dictionary.com, 2022)

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