APPENDIX A:
The Texas LGBTQ+ Community Members

Table A1 Income by Relationship Status

	Single	Dating, not cohabitating	Dating, cohabitating	Legally married	Total
Less than $10,000	17.94	21.05	10.73	2.72	12.25
$10,001 - $20,000	13.62	19.30	12.43	3.11	10.95
$20,001 - $30,000	13.95	11.40	8.47	5.45	9.89
$30,001 - $50,000	23.59	21.93	12.99	22.57	20.85
$50,001 - $70,000	13.29	13.16	19.77	13.23	14.61
$70,001 - $100,000	7.64	6.14	14.69	15.56	11.31
$100,001 - $150,000	7.31	3.51	11.86	19.84	11.54
$150,001 or more	2.66	3.51	9.04	17.51	8.60
Total	100.00	100.00	100.00	100.00	100.00
N	849				

Table A2 Income by Race/Ethnicity

	Asian / Pac. Is.	African American	Native American	Spanish / Latino	Caucasian	Total
Less than $10,000	25.00	7.14	34.48	17.33	9.29	12.29
$10,001 - $20,000	15.91	21.43	13.79	15.33	8.43	10.87
$20,001 - $30,000	13.64	4.76	6.90	12.67	9.12	9.69
$30,001 - $50,000	6.82	11.90	17.24	27.33	21.17	20.92
$50,001 - $70,000	13.64	21.43	6.90	10.00	15.83	14.66
$70,001 - $100,000	9.09	19.05	6.90	10.67	11.36	11.35
$100,001 - $150,000	9.09	9.52	10.34	4.67	13.77	11.58
$150,001 or more	6.82	4.76	3.45	2.00	11.02	8.63
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	846					

Column Percentages Shown

Table A3 Relationship Status by Gender

	Single	Dating, not cohabitating	Dating, cohabitating	Legally married	*N*
Male	44.06%	9.90%	20.79%	25.25%	404
Female	25.84%	13.76%	21.63%	38.76%	356
Transgender Male	33.33%	25.00%	19.44%	22.22%	36
Transgender Female	39.66%	27.59%	15.52%	17.24%	58
Total	35.71%	13.35%	20.73%	30.21%	854
N	305	114	177	258	854

Row Percentages Shown

Table A4 Size of Household by Gender

	Male	Female	Transgender Male	Transgender Female	Total	*N*
Single-person	33.16%	22.19%	17.14%	30.36%	27.71%	220
Two-person	45.45%	39.51%	28.57%	25.00%	40.81%	324
Three-person	12.03%	19.45%	14.29%	23.21%	15.99%	127
Four-person	5.88%	11.55%	31.43%	8.93%	9.57%	76
Five-person	2.14%	4.56%	5.71%	8.93%	3.78%	30
Six-person	0.80%	1.82%	2.86%	1.79%	1.39%	11
Seven-person	0.00%	0.30%	0.00%	1.79%	0.25%	2
Eight--person	0.27%	0.61%	0.00%	0.00%	0.38%	3
Nine-person	0.27%	0.00%	0.00%	0.00%	0.13%	1
Total	100.00%	100.00%	100.00%	100.00%	100.00%	794
N	374	329	35	56		794

Column Percentages Shown

Table A5 Percentage of Respondents Open About Their Sexuality/Gender Identity, by Race

	Asian/Pac. Is.	African American	Native American	Spanish / Latino	Caucasian
Out to friends	93.33%	97.62%	100.00%	94.59%	96.89%
Out to family	73.33%	73.17%	79.31%	80.00%	85.54%
Out to coworkers	57.78%	76.19%	67.86%	70.27%	77.26%
Out to healthcare provider	60.00%	65.85%	68.97%	62.16%	75.17%
Observations	45	42	29	152	586

Column Percentages Shown

Table A6 Percentage of Respondents Open About Their Sexuality/Gender Identity, by Community Size

	Large Urban	Midsize City	Suburban	Small City	Rural
Out to friends	97.53%	96.55%	91.03%	95.59%	95.12%
Out to family	86.42%	78.95%	67.53%	83.82%	87.80%
Out to coworkers	81.28%	66.08%	59.74%	66.18%	73.17%
Out to healthcare provider	78.40%	60.00%	53.85%	63.24%	85.37%
Observations	486	174	89	68	41

Column Percentages Shown

Table A7 Percentage of Respondents Open About Their Sexuality/Gender Identity, by Gender

	Male	Female	Transgender Male	Transgender Female
Out to friends	97.99%	94.05%	100.00%	98.28%
Out to family	84.21%	84.20%	83.33%	68.42%
Out to coworkers	81.82%	74.00%	52.78%	46.55%
Out to healthcare provider	78.03%	68.86%	66.67%	48.28%
Observations	404	357	36	58

Column Percentages Shown

Table A8 Percentage of Respondents Open About Their Sexuality/Gender Identity, by Age

	<20 years	20-29 y.o.	30-39 y.o.	40-49 y.o.	50-59 y.o.	60-69 y.o.	70+ y.o.
Out to friends	95.45%	94.44%	97.67%	98.46%	96.99%	94.34%	100.00%
Out to family	67.44%	69.19%	83.04%	93.80%	88.55%	90.48%	93.55%
Out to coworkers	33.33%	60.51%	83.04%	85.71%	84.34%	76.47%	70.97%
Out to healthcare provider	31.11%	53.30%	72.35%	83.08%	83.64%	83.81%	87.10%
Observations	45	202	172	134	168	106	31

Column Percentages Shown

Table A9 Number of Children by Gender

	Male	Female	Transgender Male	Transgender Female	Total	*N*
0	88.22%	65.24%	88.89%	85.96%	78.53%	664
1	4.01%	15.10%	2.78%	5.26%	8.66%	73
2	5.51%	13.11%	2.78%	5.26%	8.54%	72
3	1.25%	3.13%	0.00%	3.51%	2.14%	18
4 or more	1.00%	3.42%	5.56%	0.00%	2.14%	19
Total	100.00%	100.00%	100.00%	100.00%	100.00%	846
N	399	351	36	57		846

Column Percentages Shown

Table A10 Self-reported Disability Status by Gender

	No response	No disability	Disability	Total
Male	2.48	68.81	28.71	100.00
Female	2.25	74.72	23.03	100.00
Transgender Male	16.67	33.33	50.00	100.00
Transgender Female	6.90	41.38	51.72	100.00
Total	3.28	67.92	28.81	100.00
N	28	580	246	854

Row Percentages Shown

Table A11 Self-reported HIV/AIDS Status by Gender

	Male	Female	Transgender Male	Transgender Female	*N*
HIV/AIDS negative	44.41%	43.72%	3.79%	8.09%	581
HIV+, asymptomatic	100.00%	0.00%	0.00%	0.00%	47
HIV+, symptomatic	100.00%	0.00%	0.00%	0.00%	3
Advanced HIV Disease or AIDS	100.00%	0.00%	0.00%	0.00%	4
No response	36.36%	50.00%	13.64%	0.00%	22
Total	48.71%	40.33%	3.81%	7.15%	657
N	320	265	25	47	657

Row Percentages Shown

Table A12 Years Since Diagnosis by HIV/AIDS Status

	mean	sd	25th pctl	med	75th pctl	IQR	min	max
HIV+, asymptomatic	18.00	10.26	9	18	28	19	1	35
HIV+, symptomatic	16.33	14.19	1	19	29	28	1	29
Advanced HIV Disease or AIDS	17.50	9.574	10	18	25	15	6	28
Total	16.70	10.62	7	18	28	21	1	35

Table A13 Feeling of Safeness by Community Size

	Very unsafe	Unsafe	Safe	Moderately safe	Very safe	Total
Large urban	1.83	7.31	40.47	38.38	12.01	100.00
Midsize city	3.39	14.41	24.58	49.15	8.47	100.00
Suburban	1.54	10.77	33.85	41.54	12.31	100.00
Small city/town	3.64	7.27	38.18	40.00	10.91	100.00
Rural	11.11	8.33	41.67	25.00	13.89	100.00
Total	2.74	8.98	36.83	40.03	11.42	100.00
N	657					

Row Percentages Shown

Table A14 Feeling of Safeness by Race

	Very unsafe	Unsafe	Safe	Moderately safe	Very safe
Asian / Pac Is.	3.33	10.00	30.00	40.00	16.67
African American	9.38	9.38	34.38	31.25	15.63
Native American	0.00	25.00	37.50	29.17	8.33
Spanish / Hispanic	7.63	10.17	28.81	46.61	6.78
White	1.11	7.74	39.38	39.60	12.17
Total	2.74	8.99	36.74	40.09	11.43
N	656				

Row Percentages Shown

Table A15 Feeling of Safeness by Gender

	Very unsafe	Unsafe	Safe	Moderately safe	Very safe	Total
Male	4.69	8.44	40.31	34.06	12.50	100.00
Female	0.38	5.36	38.31	44.44	11.49	100.00
Transgender Male	3.85	23.08	19.23	42.31	11.54	100.00
Transgender Female	2.13	23.40	17.02	53.19	4.26	100.00
Total	2.75	8.87	37.00	39.91	11.47	100.00
N	654					

Row Percentages Shown

Table A16 Percent Reporting Access to LGBTQ Organizations by Education

	Some H.S.	H.S. diploma	Some College	2-year degree	4-year degree	Master's degree	JD/ MD/ PhD
1 Community Center	31.25%	41.86%	52.29%	64.71%	60.00%	67.22%	71.67%
2 Business/Professional	57.14%	50.00%	63.89%	82.35%	75.83%	78.03%	85.00%
3 Sports/Recreation	20.00%	30.77%	41.04%	58.33%	60.80%	71.34%	75.90%
4 Bars/Clubs	69.23%	65.12%	74.84%	88.14%	85.06%	86.67%	89.07%
5 Online Groups	81.82%	72.22%	85.43%	90.57%	87.62%	88.24%	90.90%
6 Mental Health	35.71%	28.57%	53.24%	64.29%	59.09%	74.00%	77.78%
7 Men's Health	16.67%	32.35%	41.94%	53.49%	56.00%	66.92%	66.67%
8 Women's Health	16.67%	29.73%	35.65%	47.06%	48.45%	59.35%	55.81%
9 Social Groups	66.67%	46.15%	74.32%	81.82%	80.09%	85.71%	85.25%
10 Arts/Cultural	30.77%	42.11%	54.35%	65.22%	61.41%	71.15%	80.70$
N	17	44	169	61	245	195	64

Issue Priority Levels to the LGBTQ+ Community, by Community Size:

Table A17 Affordable childcare

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	6.07	25.15	35.96	6.06	7.50	13.15
Slightly Important	5.65	5.85	8.99	13.64	15.00	7.11
Important	22.80	21.64	19.10	31.82	12.50	22.39
Moderately Important	15.27	16.37	13.48	21.21	15.00	15.76
Very Important	50.21	30.99	22.47	27.27	50.00	41.59
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	844					

Column Percentages Shown

Table A18 LGBTQ senior and aging issues

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	3.34	1.16	31.82	0.00	2.50	5.56
Slightly Important	5.01	8.14	15.91	8.96	35.00	8.51
Important	23.80	25.58	21.59	25.37	10.00	23.40
Moderately Important	10.86	13.95	17.05	17.91	15.00	12.88
Very Important	56.99	51.16	13.64	47.76	37.50	49.65
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	846					

Column Percentages Shown

Table A19 Alcohol use

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	3.60	20.71	26.14	4.62	5.00	9.59
Slightly Important	5.51	6.51	10.23	16.92	15.00	7.55
Important	23.31	20.71	19.32	30.77	27.50	23.14
Moderately Important	16.74	13.61	13.64	21.54	22.50	16.43
Very Important	50.85	38.46	30.68	26.15	30.00	43.29
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	834					

Column Percentages Shown

Table A20 Access to behavioral health care

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	20.33	0.00	18.18	2.99	7.32	14.03
Slightly Important	11.00	5.29	5.68	8.96	12.20	9.20
Important	23.65	24.71	20.45	23.88	21.95	23.47
Moderately Important	8.09	11.76	12.50	14.93	14.63	10.14
Very Important	36.93	58.24	43.18	49.25	43.90	43.16
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	848					

Column Percentages Shown

Table A21 Access to routine health care

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	21.92	4.65	14.61	4.41	0.00	15.19
Slightly Important	11.27	8.14	26.97	13.24	9.76	12.37
Important	17.95	20.93	14.61	19.12	21.95	18.49
Moderately Important	7.10	6.98	6.74	13.24	12.20	7.77
Very Important	41.75	59.30	37.08	50.00	56.10	46.17
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	849					

Column Percentages Shown

Table A22 Access to specialized health care

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	18.96	1.18	6.90	1.52	2.50	11.98
Slightly Important	10.00	7.06	13.79	9.09	12.50	9.85
Important	20.83	27.06	21.84	34.85	30.00	23.72
Moderately Important	9.58	4.71	6.90	10.61	15.00	8.66
Very Important	40.63	60.00	50.57	43.94	40.00	45.79
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	843					

Column Percentages Shown

Table A23 Harassment/bullying

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	3.83	5.88	4.60	7.35	7.32	4.78
Slightly Important	8.51	7.65	10.34	13.24	12.20	9.09
Important	25.53	25.88	27.59	23.53	34.15	26.08
Moderately Important	13.19	14.12	14.94	11.76	19.51	13.76
Very Important	48.94	46.47	42.53	44.12	26.83	46.29
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	836					

Column Percentages Shown

Table A24 Chronic disease healthcare

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	2.30	1.15	42.05	0.00	2.44	6.00
Slightly Important	7.93	6.32	11.36	13.24	26.83	9.29
Important	27.77	28.74	14.77	30.88	12.20	26.12
Moderately Important	12.53	12.64	12.50	17.65	14.63	13.06
Very Important	49.48	51.15	19.32	38.24	43.90	45.53
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	850					

Column Percentages Shown

Table A25 Neighborhood crime and disintegration

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	3.19	21.97	27.59	26.47	36.59	13.11
Slightly Important	6.38	18.50	11.49	14.71	19.51	10.73
Important	29.57	21.39	19.54	16.18	21.95	25.39
Moderately Important	18.09	13.29	17.24	11.76	17.07	16.45
Very Important	42.77	24.86	24.14	30.88	4.88	34.33
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	839					

Column Percentages Shown

Table A26 Dental care

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	5.07	25.00	36.78	6.06	2.44	12.40
Slightly Important	8.88	12.21	11.49	9.09	9.76	9.89
Important	26.43	27.33	19.54	34.85	19.51	26.22
Moderately Important	16.70	12.21	14.94	18.18	9.76	15.38
Very Important	42.92	23.26	17.24	31.82	58.54	36.11
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	839					

Column Percentages Shown

Table A27 Intimate partner abuse

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	9.64	20.81	21.35	20.59	17.07	14.39
Slightly Important	13.84	22.54	31.46	23.53	34.15	19.22
Important	24.32	25.43	23.60	27.94	26.83	24.88
Moderately Important	15.09	10.40	10.11	11.76	14.63	13.33
Very Important	37.11	20.81	13.48	16.18	7.32	28.18
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	848					

Column Percentages Shown

Table A28 Drug use

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	3.59	23.67	37.50	6.06	7.32	11.58
Slightly Important	5.06	8.28	15.91	18.18	21.95	8.71
Important	19.83	23.67	17.05	21.21	21.95	20.53
Moderately Important	13.50	14.20	13.64	21.21	24.39	14.80
Very Important	58.02	30.18	15.91	33.33	24.39	44.39
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	838					

Column Percentages Shown

Table A29 Education quality

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	4.90	30.23	18.60	13.24	17.07	12.80
Slightly Important	4.48	15.12	12.79	7.35	24.39	8.73
Important	24.09	17.44	18.60	19.12	17.07	21.41
Moderately Important	15.35	12.21	17.44	11.76	29.27	15.31
Very Important	51.17	25.00	32.56	48.53	12.20	41.75
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	836					

Column Percentages Shown

Table A30 Employment discrimination

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	5.47	12.79	7.95	3.03	9.76	7.24
Slightly Important	10.74	19.77	13.64	12.12	14.63	13.18
Important	26.95	23.26	15.91	31.82	26.83	25.42
Moderately Important	13.89	11.63	15.91	13.64	19.51	13.90
Very Important	42.95	32.56	46.59	39.39	29.27	40.26
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	842					

Column Percentages Shown

Table A31 Fertility/adoption services

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	8.67	8.88	7.87	12.12	19.51	9.43
Slightly Important	13.32	11.24	17.98	18.18	24.39	14.32
Important	19.45	26.63	20.22	25.76	21.95	21.60
Moderately Important	24.10	23.67	23.60	16.67	19.51	23.15
Very Important	34.46	29.59	30.34	27.27	14.63	31.50
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	838					

Column Percentages Shown

Table A32 Gender discrimination

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	7.91	2.35	6.98	14.93	19.51	7.81
Slightly Important	13.03	7.65	18.60	17.91	24.39	13.46
Important	21.58	28.82	23.26	22.39	26.83	23.56
Moderately Important	16.45	15.88	18.60	11.94	17.07	16.23
Very Important	41.03	45.29	32.56	32.84	12.20	38.94
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	832					

Column Percentages Shown

Table A33 Gender transition

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	7.34	4.09	5.75	1.52	7.32	6.06
Slightly Important	7.13	7.60	11.49	15.15	17.07	8.79
Important	28.51	27.49	21.84	25.76	24.39	27.20
Moderately Important	16.35	19.30	22.99	24.24	29.27	18.88
Very Important	40.67	41.52	37.93	33.33	21.95	39.07
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	842					

Column Percentages Shown

Table A34 Healthy lifestyle (exercise/nutrition)

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	8.18	0.59	1.15	1.52	2.50	5.13
Slightly Important	6.50	8.28	6.90	10.61	10.00	7.39
Important	28.30	38.46	29.89	42.42	35.00	31.94
Moderately Important	13.63	18.34	22.99	28.79	30.00	17.52
Very Important	43.40	34.32	39.08	16.67	22.50	38.02
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	839					

Column Percentages Shown

Table A35 HIV education and care

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	39.96	45.40	7.87	38.24	29.27	37.08
Slightly Important	18.63	20.69	8.99	13.24	17.07	17.54
Important	12.42	9.20	21.35	16.18	21.95	13.45
Moderately Important	8.49	9.77	16.85	8.82	9.76	9.71
Very Important	20.50	14.94	44.94	23.53	21.95	22.22
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	855					

Column Percentages Shown

Table A36 Homelessness

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	28.42	31.61	7.87	36.76	26.83	27.52
Slightly Important	14.94	22.41	13.48	16.18	24.39	16.86
Important	20.54	16.67	14.61	11.76	17.07	18.27
Moderately Important	11.20	15.52	20.22	17.65	17.07	13.82
Very Important	24.90	13.79	43.82	17.65	14.63	23.54
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	854					

Column Percentages Shown

Table A37 Immigration

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	4.60	2.92	32.95	3.08	10.00	7.36
Slightly Important	7.74	12.28	10.23	13.85	15.00	9.74
Important	21.34	26.32	18.18	30.77	22.50	22.80
Moderately Important	15.27	16.37	15.91	13.85	20.00	15.68
Very Important	51.05	42.11	22.73	38.46	32.50	44.42
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	842					

Column Percentages Shown

Table A38 Job training/job skills

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	3.99	1.16	42.05	3.03	7.32	7.47
Slightly Important	7.14	8.72	6.82	7.58	12.20	7.71
Important	30.04	27.33	15.91	34.85	26.83	28.23
Moderately Important	16.18	13.37	15.91	25.76	19.51	16.49
Very Important	42.65	49.42	19.32	28.79	34.15	40.09
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	843					

Column Percentages Shown

Table A39 Legal issues

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	1.48	1.76	28.74	3.03	9.76	4.89
Slightly Important	6.12	7.65	10.34	9.09	14.63	7.52
Important	28.06	25.29	25.29	31.82	31.71	27.68
Moderately Important	14.98	18.24	12.64	12.12	17.07	15.27
Very Important	49.37	47.06	22.99	43.94	26.83	44.63
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	838					

Column Percentages Shown

Table A40 LGBTQ parenting

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	5.51	16.37	15.91	22.39	4.88	10.13
Slightly Important	7.20	4.68	14.77	10.45	7.32	7.75
Important	24.58	29.24	25.00	22.39	14.63	24.91
Moderately Important	16.95	14.04	21.59	11.94	24.39	16.81
Very Important	45.76	35.67	22.73	32.84	48.78	40.41
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	839					

Column Percentages Shown

Table A41 Long-term care services

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	2.29	0.58	25.84	0.00	7.32	4.48
Slightly Important	8.54	10.47	14.61	13.64	41.46	11.56
Important	23.54	25.58	22.47	27.27	7.32	23.35
Moderately Important	11.88	16.86	15.73	18.18	12.20	13.80
Very Important	53.75	46.51	21.35	40.91	31.71	46.82
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	848					

Column Percentages Shown

Table A42 Healthcare provider LGBTQ competency

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	32.78	8.72	1.12	0.00	2.44	20.56
Slightly Important	14.32	2.91	4.49	5.97	12.20	10.22
Important	18.67	21.51	16.85	22.39	21.95	19.51
Moderately Important	7.68	8.14	13.48	5.97	12.20	8.46
Very Important	26.56	58.72	64.04	65.67	51.22	41.25
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	851					

Column Percentages Shown

Table A43 Poverty/Income insecurity

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	2.74	5.78	10.11	2.94	5.00	4.26
Slightly Important	10.11	13.87	23.60	11.76	17.50	12.78
Important	23.37	22.54	24.72	36.76	22.50	24.38
Moderately Important	12.42	13.87	14.61	14.71	25.00	13.73
Very Important	51.37	43.93	26.97	33.82	30.00	44.85
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	845					

Column Percentages Shown

Table A44 LGBTQ individuals with disabilities

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	4.47	4.68	7.95	8.96	12.20	5.62
Slightly Important	10.64	10.53	12.50	16.42	19.51	11.71
Important	27.87	27.49	17.05	25.37	21.95	26.16
Moderately Important	13.62	17.54	21.59	22.39	19.51	16.25
Very Important	43.40	39.77	40.91	26.87	26.83	40.26
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	837					

Column Percentages Shown

Table A45 Prenatal care

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	10.19	25.00	50.00	16.67	10.26	17.94
Slightly Important	8.49	13.37	3.41	15.15	20.51	10.05
Important	24.84	22.09	14.77	27.27	12.82	22.85
Moderately Important	19.11	15.12	13.64	19.70	17.95	17.70
Very Important	37.37	24.42	18.18	21.21	38.46	31.46
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	836					

Column Percentages Shown

Table A46 Racial/ethnic discrimination

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	4.50	21.97	28.09	3.03	21.95	11.36
Slightly Important	8.99	29.48	38.20	9.09	29.27	17.34
Important	23.77	19.65	15.73	33.33	29.27	23.09
Moderately Important	14.35	10.98	7.87	16.67	14.63	13.16
Very Important	48.39	17.92	10.11	37.88	4.88	35.05
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	836					

Column Percentages Shown

Table A47 Self-harm

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	28.96	37.57	5.62	22.06	7.89	26.75
Slightly Important	15.01	19.65	13.48	10.29	18.42	15.58
Important	18.60	17.34	20.22	17.65	15.79	18.31
Moderately Important	19.03	18.50	17.98	14.71	23.68	18.67
Very Important	18.39	6.94	42.70	35.29	34.21	20.69
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	841					

Column Percentages Shown

Table A48 Sexual assault/sexual violence

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	6.44	20.23	28.41	14.93	19.51	12.82
Slightly Important	10.40	23.70	32.95	26.87	34.15	17.88
Important	20.17	20.81	10.23	23.88	24.39	19.76
Moderately Important	13.31	9.83	7.95	8.96	17.07	11.88
Very Important	49.69	25.43	20.45	25.37	4.88	37.65
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	850					

Column Percentages Shown

Table A49 LGBTQ social organizations

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	11.95	10.40	3.41	33.82	5.00	12.17
Slightly Important	10.27	15.03	10.23	10.29	17.50	11.58
Important	24.11	26.01	17.05	20.59	30.00	23.76
Moderately Important	17.61	11.56	25.00	11.76	20.00	16.78
Very Important	36.06	36.99	44.32	23.53	27.50	35.70
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	846					

Column Percentages Shown

Table A50 LGBTQ cultural arts centers

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	22.43	19.08	4.55	26.47	41.46	21.13
Slightly Important	18.24	17.34	13.64	10.29	14.63	16.77
Important	23.27	26.01	18.18	26.47	21.95	23.49
Moderately Important	14.88	16.18	22.73	13.24	17.07	15.94
Very Important	21.17	21.39	40.91	23.53	4.88	22.67
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	847					

Column Percentages Shown

Table A51 LGBTQ religious communities

Large urban	Midsize city	Suburban		Small city/town	Rural	Total
Not Important	11.58	11.70	5.75	19.40	22.50	12.14
Slightly Important	17.26	16.37	9.20	13.43	17.50	15.95
Important	26.11	26.32	14.94	23.88	30.00	25.00
Moderately Important	16.00	15.20	19.54	10.45	20.00	15.95
Very Important	29.05	30.41	50.57	32.84	10.00	30.95
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	840					

Column Percentages Shown

Table A52 Transgender health

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	7.56	1.78	4.65	1.47	7.69	5.61
Slightly Important	4.83	5.33	6.98	10.29	7.69	5.73
Important	20.80	24.85	18.60	25.00	25.64	21.96
Moderately Important	12.82	12.43	15.12	19.12	12.82	13.48
Very Important	53.99	55.62	54.65	44.12	46.15	53.22
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	838					

Column Percentages Shown

Table A53 Adequate transportation

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	1.65	23.21	25.58	10.94	2.50	9.14
Slightly Important	6.20	8.93	10.47	6.25	7.50	7.24
Important	21.69	26.19	22.09	21.88	35.00	23.28
Moderately Important	11.16	11.31	16.28	12.50	10.00	11.76
Very Important	59.30	30.36	25.58	48.44	45.00	48.57
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	842					

Column Percentages Shown

Table A54 Unemployment/underemployment

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	2.93	2.35	23.86	3.03	2.44	4.98
Slightly Important	7.74	9.41	9.09	7.58	7.32	8.19
Important	23.64	32.35	26.14	25.76	21.95	25.74
Moderately Important	11.72	15.88	7.95	19.70	21.95	13.29
Very Important	53.97	40.00	32.95	43.94	46.34	47.81
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	843					

Column Percentages Shown

Table A55 Violence

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	5.77	16.57	16.09	17.65	21.95	10.80
Slightly Important	13.25	11.83	13.79	10.29	14.63	12.85
Important	24.36	22.49	22.99	22.06	26.83	23.77
Moderately Important	14.32	12.43	13.79	10.29	17.07	13.69
Very Important	42.31	36.69	33.33	39.71	19.51	38.90
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	833					

Column Percentages Shown

Table A56 Women's health

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	16.49	2.92	8.99	8.82	10.00	12.04
Slightly Important	9.19	6.43	16.85	14.71	12.50	10.04
Important	21.71	29.24	28.09	29.41	20.00	24.44
Moderately Important	11.06	12.87	29.21	20.59	17.50	14.40
Very Important	41.54	48.54	16.85	26.47	40.00	39.08
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	847					

Column Percentages Shown

Table A57 Youth delinquency

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	4.86	24.56	18.39	13.43	14.63	11.44
Slightly Important	8.03	9.94	12.64	5.97	4.88	8.58
Important	26.43	23.98	27.59	28.36	17.07	25.74
Moderately Important	19.87	18.71	17.24	16.42	21.95	19.19
Very Important	40.80	22.81	24.14	35.82	41.46	35.04
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	839					

Column Percentages Shown

Table A58 LGBTQ youth services

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Not Important	3.81	4.71	6.90	42.65	7.32	7.64
Slightly Important	8.90	10.00	11.49	10.29	17.07	9.90
Important	25.00	22.94	21.84	14.71	26.83	23.51
Moderately Important	17.80	15.29	9.20	8.82	19.51	15.75
Very Important	44.49	47.06	50.57	23.53	29.27	43.20
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	838					

Column Percentages Shown

Quality of Community Life Measures, by Community Size

Table A59 I am satisfied with the quality of life in this community.

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Strongly Agree	24.87	13.93	16.67	14.75	17.95	20.69
Somewhat Agree	50.00	45.90	59.09	34.43	35.90	47.89
Neither Agree nor Disagree	11.76	20.49	16.67	16.39	23.08	14.95
Somewhat Disagree	9.89	13.93	3.03	21.31	7.69	10.88
Strongly Disagree	3.48	5.74	4.55	13.11	15.38	5.59
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	662					

Column Percentages Shown

Table A60 The community is strengthened by its diversity

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Strongly Agree	55.53	42.86	33.85	40.00	36.84	48.74
Somewhat Agree	26.99	24.60	24.62	27.27	31.58	26.60
Neither Agree nor Disagree	11.31	19.84	20.00	14.55	10.53	13.97
Somewhat Disagree	4.11	9.52	16.92	5.45	13.16	6.98
Strongly Disagree	2.06	3.17	4.62	12.73	7.89	3.71
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	673					

Column Percentages Shown

Table A61 There are plenty recreational activities for my family

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Strongly Agree	39.47	22.13	21.21	25.00	28.95	32.48
Somewhat Agree	37.07	31.15	36.36	17.19	39.47	34.14
Neither Agree nor Disagree	14.13	21.31	19.70	17.19	13.16	16.24
Somewhat Disagree	7.73	16.39	12.12	7.81	13.16	10.08
Strongly Disagree	1.60	9.02	10.61	32.81	5.26	7.07
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	665					

Column Percentages Shown

Table A62 I am satisfied with the local school system

	Large urban	Midsize city	Suburban	Small city/town	Rural	Total
Strongly Agree	5.35	29.30	40.45	16.13	7.69	15.95
Somewhat Agree	17.65	23.57	16.85	19.35	17.95	19.00
Neither Agree nor Disagree	37.17	24.20	23.60	32.26	41.03	32.45
Somewhat Disagree	24.06	14.65	13.48	19.35	17.95	19.97
Strongly Disagree	15.78	8.28	5.62	12.90	15.38	12.62
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	721					

Column Percentages Shown

Effectiveness of LGBTQ+ Movement Actions, by Race:

Table A63 Additional LGBTQ community centers

	Asian / Pac Is.	African American	Native American	Spanish / Hispanic	Caucasian	Total
Highly effective	25.58	20.51	31.03	34.72	17.42	21.80
Moderately effective	23.26	23.08	24.14	31.94	26.61	27.15
Effective	18.60	23.08	17.24	18.06	25.05	22.98
Slightly ineffective	20.93	17.95	20.69	10.42	21.33	19.06
Ineffective	11.63	15.38	6.90	4.86	9.59	9.01
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	766					

Column Percentages Shown

Table A64 Expanding LGBTQ services

	Asian / Pac Is.	African American	Native American	Spanish / Hispanic	Caucasian	Total
Highly effective	55.56	12.50	48.28	50.00	20.71	28.70
Moderately effective	22.22	20.00	27.59	31.08	26.49	26.82
Effective	13.33	17.50	17.24	10.81	21.64	18.80
Slightly ineffective	4.44	35.00	3.45	4.73	22.57	18.17
Ineffective	4.44	15.00	3.45	3.38	8.58	7.52
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	798					

Column Percentages Shown

Table A65 Training and awareness

	Asian / Pac Is.	African American	Native American	Spanish / Hispanic	Caucasian	Total
Highly effective	47.73	7.32	24.14	37.41	21.83	25.50
Moderately effective	20.45	26.83	24.14	33.09	28.17	28.40
Effective	11.36	24.39	17.24	15.83	22.42	20.48
Slightly ineffective	9.09	26.83	20.69	10.07	19.64	17.70
Ineffective	11.36	14.63	13.79	3.60	7.94	7.93
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	757					

Column Percentages Shown

Table A66 Education about LGBTQ issues

	Asian / Pac Is.	African American	Native American	Spanish / Hispanic	Caucasian	Total
Highly effective	20.00	16.67	34.48	54.81	29.80	32.99
Moderately effective	28.89	21.43	31.03	24.44	25.33	25.38
Effective	17.78	19.05	13.79	12.59	18.06	17.01
Slightly ineffective	24.44	23.81	20.69	5.19	19.18	17.39
Ineffective	8.89	19.05	0.00	2.96	7.64	7.23
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	788					

Column Percentages Shown

Table A67 Information and visibility

	Asian / Pac Is.	African American	Native American	Spanish / Hispanic	Caucasian	Total
Highly effective	9.52	44.74	31.03	42.86	24.09	27.84
Moderately effective	23.81	23.68	27.59	33.08	28.49	28.76
Effective	21.43	13.16	20.69	15.79	20.08	19.08
Slightly ineffective	30.95	10.53	17.24	5.26	19.69	17.25
Ineffective	14.29	7.89	3.45	3.01	7.65	7.06
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	765					

Column Percentages Shown

Table A68 Community development

	Asian / Pac Is.	African American	Native American	Spanish / Hispanic	Caucasian	Total
Highly effective	15.38	41.03	34.62	39.34	20.68	24.93
Moderately effective	28.21	20.51	19.23	34.43	28.20	28.50
Effective	17.95	20.51	11.54	12.30	21.99	19.79
Slightly ineffective	28.21	12.82	23.08	9.02	19.92	18.34
Ineffective	10.26	5.13	11.54	4.92	9.21	8.44
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	758					

Column Percentages Shown

Table A69 Political activism

	Asian / Pac Is.	African American	Native American	Spanish / Hispanic	Caucasian	Total
Highly effective	35.56	30.95	25.93	49.63	41.48	41.44
Moderately effective	17.78	23.81	18.52	21.48	29.16	26.36
Effective	15.56	19.05	22.22	14.81	13.35	14.40
Slightly ineffective	22.22	19.05	25.93	10.37	11.70	13.04
Ineffective	8.89	7.14	7.41	3.70	4.31	4.76
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	736					

Column Percentages Shown

Table A70 Media responsibility

	Asian / Pac Is.	African American	Native American	Spanish / Hispanic	Caucasian	Total
Highly effective	16.28	28.95	25.00	24.31	36.23	31.99
Moderately effective	23.26	21.05	25.00	27.78	29.15	27.98
Effective	20.93	21.05	14.29	15.97	15.99	16.47
Slightly ineffective	25.58	23.68	28.57	22.92	12.96	16.73
Ineffective	13.95	5.26	7.14	9.03	5.67	6.83
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	747					

Column Percentages Shown

Table A71 Change of social attitude

	Asian / Pac Is.	African American	Native American	Spanish / Hispanic	Caucasian	Total
Highly effective	16.22	41.67	34.48	38.35	54.98	48.40
Moderately effective	29.73	27.78	27.59	24.81	21.78	23.29
Effective	16.22	8.33	10.34	15.04	10.37	11.44
Slightly ineffective	27.03	13.89	20.69	13.53	8.71	11.30
Ineffective	10.81	8.33	6.90	8.27	4.15	5.58
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	717					

Column Percentages Shown

Table A72 Funding

	Asian / Pac Is.	African American	Native American	Spanish / Hispanic	Caucasian	Total
Highly effective	36.36	40.54	41.38	53.60	40.68	42.72
Moderately effective	20.45	18.92	20.69	23.20	26.06	24.61
Effective	15.91	16.22	13.79	8.80	17.16	15.42
Slightly ineffective	20.45	13.51	17.24	9.60	11.02	11.74
Ineffective	6.82	10.81	6.90	4.80	5.08	5.52
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	707					

Column Percentages Shown

Table A73 Positive images/role models

	Asian / Pac Is.	African American	Native American	Spanish / Hispanic	Caucasian	Total
Highly effective	46.67	48.72	37.93	66.92	35.59	42.49
Moderately effective	26.67	25.64	24.14	21.54	23.86	23.73
Effective	11.11	7.69	13.79	7.69	18.29	15.28
Slightly ineffective	11.11	12.82	17.24	2.31	15.71	13.00
Ineffective	4.44	5.13	6.90	1.54	6.56	5.50
Total	100.00	100.00	100.00	100.00	100.00	100.00
N	746					

Column Percentages Shown

Participation in LGBTQ+ Community Supporting Activities:

Table A74 Percent Reporting LGBTQ Activity Participation by Age

	< 20 y.o.	20-29 y.o.	30-39 y.o.	40-49 y.o.	50-59 y.o.	60-69 y.o.	70+ years
Been a member of an LGBTQ organization	35.56%	49.01%	53.49%	70.90%	69.64%	76.42%	80.65%
Donated to politicians/organizations because of support for LGBTQ rights	22.22%	32.67%	48.84%	58.96%	57.14%	69.81%	83.87%
Donated to community groups because of support for LGBTQ rights	13.33%	25.25%	52.91%	63.43%	54.17%	67.92%	77.42%
Attended an LGBTQ pride event, rally, or march	33.33%	46.04%	71.51%	76.12%	74.40%	75.47%	80.65%
Boycotted products/services due to a lack of support for LGBTQ rights	28.89%	44.06%	57.56%	69.40%	63.10%	73.58%	74.19%
N	45	202	172	134	168	106	31

Column Percentages Shown

Table A75 Percent Reporting LGBTQ Activity Participation by Race

	Asian / Pac. Is.	African American	Native American	Spanish/Latino	Caucasian
Been a member of an LGBTQ organization	46.67%	59.52%	79.31%	62.50%	61.26%
Donated to politicians/organizations because of support for LGBTQ rights	33.33%	35.71%	44.83%	40.13%	56.48%
Donated to community groups because of support for LGBTQ rights	40.00%	38.10%	48.28%	40.13%	52.90%
Attended an LGBTQ pride event, rally, or march	48.89%	66.67%	72.41%	61.84%	67.75%
Boycotted products/services due to a lack of support for LGBTQ rights	48.89%	57.14%	68.97%	50.66%	60.92%
N	45	42	29	152	586

Column Percentages Shown

Table A76 Percent Reporting LGBTQ Activity Participation by Gender

	Less than $10,000	$10,001 - $20,000	$20,001 - $30,000	$30,001 - $50,000	$50,001 - $70,000	$70,001 - $100,000	$100,001 - $150,000	$150,001 or more
Been a member of an LGBTQ organization	43.27%	47.31%	65.48%	66.67%	60.00%	67.71%	72.45%	65.75%
Donated to politicians/organizations because of support for LGBTQ rights	23.08%	25.81%	47.62%	48.59%	58.40%	68.75%	66.33%	75.34%
Donated to community groups because of support for LGBTQ rights	23.08%	27.96%	41.67%	48.59%	60.00%	64.58%	62.24%	68.49%
Attended an LGBTQ pride event, rally, or march	48.08%	46.24%	73.81%	72.88%	70.40%	66.67%	74.49%	71.23%
Boycotted products/services due to a lack of support for LGBTQ rights	40.38%	40.86%	66.67%	57.63%	67.20%	62.50%	64.29%	75.34%
N	104	93	84	177	125	96	98	73

Column Percentages Shown

APPENDIX B:
The Texas LGBTQ+ Organizations

Types of Services Delivered, by Region:

Table B1 Consumer advocacy

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	16.67	16.67	16.67	50.00	100.00
Gulf Coast	35.00	20.00	25.00	20.00	100.00
North East	30.30	27.27	6.06	36.36	100.00
Central	69.23	7.69	0.00	23.08	100.00
Total	35.90	20.51	11.54	32.05	100.00
N	78				

Row Percentages in Parentheses

Table B2 Couples therapy

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	25.00	25.00	41.67	8.33	100.00
Gulf Coast	35.00	55.00	0.00	10.00	100.00
North East	21.21	42.42	9.09	27.27	100.00
Central	69.23	30.77	0.00	0.00	100.00
Total	33.33	41.03	10.26	15.38	100.00
N	78				

Row Percentages in Parentheses

Table B3 Crisis response team/Crisis intervention

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	16.67	33.33	41.67	8.33	100.00
Gulf Coast	35.00	50.00	0.00	15.00	100.00
North East	24.24	33.33	9.09	33.33	100.00
Central	61.54	23.08	15.38	0.00	100.00
Total	32.05	35.90	12.82	19.23	100.00
N	78				

Row Percentages in Parentheses

Table B4 Domestic abuse/violence counseling

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	25.00	41.67	16.67	16.67	100.00
Gulf Coast	50.00	35.00	5.00	10.00	100.00
North East	27.27	21.21	21.21	30.30	100.00
Central	69.23	23.08	7.69	0.00	100.00
Total	39.74	28.21	14.10	17.95	100.00
N	78				

Row Percentages in Parentheses

Table B5 Family therapy

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	25.00	16.67	33.33	25.00	100.00
Gulf Coast	45.00	30.00	10.00	15.00	100.00
North East	24.24	30.30	3.03	42.42	100.00
Central	61.54	30.77	0.00	7.69	100.00
Total	35.90	28.21	8.97	26.92	100.00
N	78				

Row Percentages in Parentheses

Table B6 Financial assistance for mental health services

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	25.00	58.33	0.00	16.67	100.00
Gulf Coast	40.00	40.00	0.00	20.00	100.00
North East	30.30	36.36	18.18	15.15	100.00
Central	53.85	30.77	15.38	0.00	100.00
Total	35.90	39.74	10.26	14.10	100.00
N	78				

Row Percentages in Parentheses

Table B7 Gender identity/orientation counseling

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	25.00	8.33	33.33	33.33	100.00
Gulf Coast	40.00	10.00	35.00	15.00	100.00
North East	24.24	18.18	12.12	45.45	100.00
Central	61.54	30.77	0.00	7.69	100.00
Total	34.62	16.67	19.23	29.49	100.00
N	78				

Row Percentages in Parentheses

Table B8 Help lines

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	25.00	33.33	33.33	8.33	100.00
Gulf Coast	45.00	35.00	15.00	5.00	100.00
North East	36.36	27.27	27.27	9.09	100.00
Central	61.54	23.08	7.69	7.69	100.00
Total	41.03	29.49	21.79	7.69	100.00
N	78				

Row Percentages in Parentheses

Table B9 Individual therapy

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	25.00	33.33	33.33	8.33	100.00
Gulf Coast	30.00	30.00	5.00	35.00	100.00
North East	30.30	18.18	0.00	51.52	100.00
Central	69.23	23.08	0.00	7.69	100.00
Total	35.90	24.36	6.41	33.33	100.00
N	78				

Row Percentages in Parentheses

Table B10 Psychiatry/Medication management

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	33.33	50.00	0.00	16.67	100.00
Gulf Coast	45.00	40.00	10.00	5.00	100.00
North East	33.33	30.30	18.18	18.18	100.00
Central	61.54	23.08	7.69	7.69	100.00
Total	41.03	34.62	11.54	12.82	100.00
N	78				

Row Percentages in Parentheses

Table B11 Group therapy/Peer support

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	16.67	8.33	33.33	41.67	100.00
Gulf Coast	15.00	20.00	10.00	55.00	100.00
North East	21.21	18.18	6.06	54.55	100.00
Central	23.08	30.77	15.38	30.77	100.00
Total	19.23	19.23	12.82	48.72	100.00
N	78				

Row Percentages in Parentheses

Table B12 Drug/alcohol counseling

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	33.33	33.33	16.67	16.67	100.00
Gulf Coast	40.00	40.00	10.00	10.00	100.00
North East	24.24	48.48	6.06	21.21	100.00
Central	61.54	30.77	0.00	7.69	100.00
Total	35.90	41.03	7.69	15.38	100.00
N	78				

Row Percentages in Parentheses

Table B13 Mental health screenings

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	33.33	33.33	8.33	25.00	100.00
Gulf Coast	50.00	20.00	5.00	25.00	100.00
North East	24.24	21.21	15.15	39.39	100.00
Central	53.85	23.08	15.38	7.69	100.00
Total	37.18	23.08	11.54	28.21	100.00
N	78				

Row Percentages in Parentheses

Table B14 Discussion/support groups

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	8.33	0.00	25.00	66.67	100.00
Gulf Coast	30.00	0.00	15.00	55.00	100.00
North East	12.12	12.12	24.24	51.52	100.00
Central	7.69	7.69	38.46	46.15	100.00
Total	15.38	6.41	24.36	53.85	100.00
N	78				

Row Percentages in Parentheses

Table B15 Transgender mental health care

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	33.33	16.67	0.00	50.00	100.00
Gulf Coast	40.00	15.00	20.00	25.00	100.00
North East	33.33	12.12	12.12	42.42	100.00
Central	76.92	23.08	0.00	0.00	100.00
Total	42.31	15.38	10.26	32.05	100.00
N	78				

Row Percentages in Parentheses

Table B16 LGBTQ youth behavioral health

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	16.67	25.00	25.00	33.33	100.00
Gulf Coast	35.00	30.00	15.00	20.00	100.00
North East	15.15	27.27	18.18	39.39	100.00
Central	53.85	23.08	0.00	23.08	100.00
Total	26.92	26.92	15.38	30.77	100.00
N	78				

Row Percentages in Parentheses

Table B17 Cancer screenings

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	50.00	41.67	8.33	0.00	100.00
Gulf Coast	65.00	25.00	5.00	5.00	100.00
North East	51.52	39.39	6.06	3.03	100.00
Central	84.62	15.38	0.00	0.00	100.00
Total	60.26	32.05	5.13	2.56	100.00
N	78				

Row Percentages in Parentheses

Table B18 Chronic care management

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	33.33	33.33	25.00	8.33	100.00
Gulf Coast	50.00	30.00	5.00	15.00	100.00
North East	45.45	27.27	9.09	18.18	100.00
Central	53.85	15.38	7.69	23.08	100.00
Total	46.15	26.92	10.26	16.67	100.00
N	78				

Row Percentages in Parentheses

Table B19 Dental care

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	41.67	41.67	16.67	0.00	100.00
Gulf Coast	55.00	20.00	10.00	15.00	100.00
North East	48.48	21.21	18.18	12.12	100.00
Central	61.54	30.77	0.00	7.69	100.00
Total	51.28	25.64	12.82	10.26	100.00
N	78				

Row Percentages in Parentheses

Table B20 Diabetes screening and counseling

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	41.67	50.00	0.00	8.33	100.00
Gulf Coast	70.00	25.00	0.00	5.00	100.00
North East	57.58	30.30	3.03	9.09	100.00
Central	61.54	23.08	15.38	0.00	100.00
Total	58.97	30.77	3.85	6.41	100.00
N	78				

Row Percentages in Parentheses

Table B21 Healthcare education and prevention programs

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	16.67	25.00	8.33	50.00	100.00
Gulf Coast	50.00	15.00	5.00	30.00	100.00
North East	24.24	12.12	21.21	42.42	100.00
Central	30.77	23.08	0.00	46.15	100.00
Total	30.77	16.67	11.54	41.03	100.00
N	78				

Row Percentages in Parentheses

Table B22 Educational materials

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	16.67	16.67	33.33	33.33	100.00
Gulf Coast	35.00	20.00	20.00	25.00	100.00
North East	33.33	6.06	18.18	42.42	100.00
Central	30.77	15.38	15.38	38.46	100.00
Total	30.77	12.82	20.51	35.90	100.00
N	78				

Row Percentages in Parentheses

Table B23 Financial assistance for health care costs

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	41.67	50.00	0.00	8.33	100.00
Gulf Coast	50.00	30.00	0.00	20.00	100.00
North East	48.48	27.27	9.09	15.15	100.00
Central	53.85	23.08	0.00	23.08	100.00
Total	48.72	30.77	3.85	16.67	100.00
N	78				

Row Percentages in Parentheses

Table B24 Home and community based care for individuals with disabilities

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	33.33	33.33	25.00	8.33	100.00
Gulf Coast	65.00	25.00	5.00	5.00	100.00
North East	48.48	24.24	24.24	3.03	100.00
Central	76.92	15.38	7.69	0.00	100.00
Total	55.13	24.36	16.67	3.85	100.00
N	78				

Row Percentages in Parentheses

Table B25 Home and community based care for seniors

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	33.33	33.33	16.67	16.67	100.00
Gulf Coast	55.00	25.00	15.00	5.00	100.00
North East	48.48	30.30	9.09	12.12	100.00
Central	76.92	15.38	0.00	7.69	100.00
Total	52.56	26.92	10.26	10.26	100.00
N	78				

Row Percentages in Parentheses

Table B26 Laboratory services (CBC, urine testing, strep test, etc.)

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	25.00	58.33	8.33	8.33	100.00
Gulf Coast	45.00	25.00	15.00	15.00	100.00
North East	48.48	33.33	9.09	9.09	100.00
Central	53.85	23.08	23.08	0.00	100.00
Total	44.87	33.33	12.82	8.97	100.00
N	78				

Row Percentages in Parentheses

Table B27 Physical examinations/screenings

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	33.33	50.00	0.00	16.67	100.00
Gulf Coast	55.00	25.00	5.00	15.00	100.00
North East	54.55	21.21	12.12	12.12	100.00
Central	53.85	23.08	0.00	23.08	100.00
Total	51.28	26.92	6.41	15.38	100.00
N	78				

Row Percentages in Parentheses

Table B28 Pregnancy and prenatal care

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	41.67	50.00	8.33	0.00	100.00
Gulf Coast	70.00	20.00	0.00	10.00	100.00
North East	57.58	21.21	6.06	15.15	100.00
Central	76.92	23.08	0.00	0.00	100.00
Total	61.54	25.64	3.85	8.97	100.00
N	78				

Row Percentages in Parentheses

Table B29 Prescription assistance for low-income

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	41.67	50.00	8.33	0.00	100.00
Gulf Coast	35.00	40.00	5.00	20.00	100.00
North East	48.48	30.30	6.06	15.15	100.00
Central	53.85	23.08	0.00	23.08	100.00
Total	44.87	34.62	5.13	15.38	100.00
N	78				

Row Percentages in Parentheses

Table B30 Preventive health services

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	41.67	33.33	16.67	8.33	100.00
Gulf Coast	40.00	40.00	5.00	15.00	100.00
North East	45.45	18.18	15.15	21.21	100.00
Central	38.46	23.08	15.38	23.08	100.00
Total	42.31	26.92	12.82	17.95	100.00
N	78				

Row Percentages in Parentheses

Table B31 Referrals to LGTBQ-friendly health providers

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	16.67	0.00	8.33	75.00	100.00
Gulf Coast	20.00	10.00	25.00	45.00	100.00
North East	18.18	12.12	18.18	51.52	100.00
Central	23.08	0.00	15.38	61.54	100.00
Total	19.23	7.69	17.95	55.13	100.00
N	78				

Row Percentages in Parentheses

Table B32 Respite care

	Does Not Provide	Low Priority	Medium Priority	Total
West	41.67	50.00	8.33	100.00
Gulf Coast	60.00	35.00	5.00	100.00
North East	60.61	36.36	3.03	100.00
Central	76.92	23.08	0.00	100.00
Total	60.26	35.90	3.85	100.00
N	78			

Row Percentages in Parentheses

Table B33 Senior care and referrals

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	25.00	41.67	16.67	16.67	100.00
Gulf Coast	35.00	35.00	20.00	10.00	100.00
North East	42.42	30.30	9.09	18.18	100.00
Central	69.23	15.38	0.00	15.38	100.00
Total	42.31	30.77	11.54	15.38	100.00
N	78				

Row Percentages in Parentheses

Table B34 Smoking cessation

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	33.33	50.00	16.67	0.00	100.00
Gulf Coast	55.00	25.00	10.00	10.00	100.00
North East	42.42	33.33	9.09	15.15	100.00
Central	61.54	38.46	0.00	0.00	100.00
Total	47.44	34.62	8.97	8.97	100.00
N	78				

Row Percentages in Parentheses

Table B35 STD/HIV testing, treatment, and/or prevention

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	25.00	33.33	0.00	41.67	100.00
Gulf Coast	30.00	40.00	5.00	25.00	100.00
North East	18.18	15.15	24.24	42.42	100.00
Central	30.77	23.08	0.00	46.15	100.00
Total	24.36	25.64	11.54	38.46	100.00
N	78				

Row Percentages in Parentheses

Table B36 Vaccinations/immunizations

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	41.67	50.00	0.00	8.33	100.00
Gulf Coast	55.00	40.00	0.00	5.00	100.00
North East	54.55	33.33	3.03	9.09	100.00
Central	76.92	23.08	0.00	0.00	100.00
Total	56.41	35.90	1.28	6.41	100.00
N	78				

Row Percentages in Parentheses

Table B37 Vision care

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	41.67	41.67	16.67	0.00	100.00
Gulf Coast	60.00	35.00	0.00	5.00	100.00
North East	57.58	36.36	0.00	6.06	100.00
Central	76.92	23.08	0.00	0.00	100.00
Total	58.97	34.62	2.56	3.85	100.00
N	78				

Row Percentages in Parentheses

Table B38 Weight management/healthy lifestyle programs

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	25.00	50.00	25.00	0.00	100.00
Gulf Coast	50.00	25.00	25.00	0.00	100.00
North East	36.36	30.30	21.21	12.12	100.00
Central	61.54	23.08	15.38	0.00	100.00
Total	42.31	30.77	21.79	5.13	100.00
N	78				

Row Percentages in Parentheses

Table B39 Women's health

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	33.33	50.00	8.33	8.33	100.00
Gulf Coast	55.00	30.00	5.00	10.00	100.00
North East	48.48	18.18	9.09	24.24	100.00
Central	69.23	23.08	0.00	7.69	100.00
Total	51.28	26.92	6.41	15.38	100.00
N	78				

Row Percentages in Parentheses

Table B40 Children's/Teen health

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	41.67	33.33	8.33	16.67	100.00
Gulf Coast	60.00	25.00	10.00	5.00	100.00
North East	60.61	15.15	9.09	15.15	100.00
Central	76.92	23.08	0.00	0.00	100.00
Total	60.26	21.79	7.69	10.26	100.00
N	78				

Row Percentages in Parentheses

Table B41 Career training, employment referrals, vocational skills

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	25.00	41.67	25.00	8.33	100.00
Gulf Coast	50.00	35.00	5.00	10.00	100.00
North East	39.39	15.15	27.27	18.18	100.00
Central	46.15	23.08	7.69	23.08	100.00
Total	41.03	25.64	17.95	15.38	100.00
N	78				

Row Percentages in Parentheses

Table B42 Computer, internet, and email access

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	16.67	33.33	41.67	8.33	100.00
Gulf Coast	45.00	40.00	10.00	5.00	100.00
North East	45.45	15.15	15.15	24.24	100.00
Central	46.15	23.08	7.69	23.08	100.00
Total	41.03	25.64	16.67	16.67	100.00
N	78				

Row Percentages in Parentheses

Table B43 Financial literacy training

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	25.00	41.67	8.33	25.00	100.00
Gulf Coast	30.00	45.00	15.00	10.00	100.00
North East	36.36	12.12	21.21	30.30	100.00
Central	53.85	15.38	7.69	23.08	100.00
Total	35.90	25.64	15.38	23.08	100.00
N	78				

Row Percentages in Parentheses

Table B44 High school completion or GED programs

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	33.33	58.33	8.33	0.00	100.00
Gulf Coast	35.00	45.00	15.00	5.00	100.00
North East	51.52	30.30	0.00	18.18	100.00
Central	61.54	23.08	7.69	7.69	100.00
Total	46.15	37.18	6.41	10.26	100.00
N	78				

Row Percentages in Parentheses

Table B45 Classroom instruction or seminars

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	41.67	8.33	25.00	25.00	100.00
Gulf Coast	60.00	10.00	15.00	15.00	100.00
North East	45.45	9.09	21.21	24.24	100.00
Central	69.23	15.38	7.69	7.69	100.00
Total	52.56	10.26	17.95	19.23	100.00
N	78				

Row Percentages in Parentheses

Table B46 Tuition assistance/Scholarship opportunities

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	41.67	33.33	25.00	0.00	100.00
Gulf Coast	55.00	35.00	10.00	0.00	100.00
North East	54.55	15.15	18.18	12.12	100.00
Central	69.23	23.08	7.69	0.00	100.00
Total	55.13	24.36	15.38	5.13	100.00
N	78				

Row Percentages in Parentheses

Table B47 Tutoring and other student support services

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	41.67	50.00	0.00	8.33	100.00
Gulf Coast	45.00	40.00	5.00	10.00	100.00
North East	51.52	21.21	3.03	24.24	100.00
Central	53.85	15.38	0.00	30.77	100.00
Total	48.72	29.49	2.56	19.23	100.00
N	78				

Row Percentages in Parentheses

Table B48 Youth mentoring

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	16.67	33.33	8.33	41.67	100.00
Gulf Coast	45.00	30.00	5.00	20.00	100.00
North East	33.33	21.21	12.12	33.33	100.00
Central	38.46	30.77	7.69	23.08	100.00
Total	34.62	26.92	8.97	29.49	100.00
N	78				

Row Percentages in Parentheses

Table B49 Choral or instrumental groups

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	33.33	41.67	16.67	8.33	100.00
Gulf Coast	45.00	35.00	5.00	15.00	100.00
North East	51.52	45.45	3.03	0.00	100.00
Central	76.92	15.38	7.69	0.00	100.00
Total	51.28	37.18	6.41	5.13	100.00
N	78				

Row Percentages in Parentheses

Table B50 Creative arts programs

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	41.67	50.00	8.33	0.00	100.00
Gulf Coast	45.00	35.00	5.00	15.00	100.00
North East	36.36	42.42	6.06	15.15	100.00
Central	38.46	30.77	0.00	30.77	100.00
Total	39.74	39.74	5.13	15.38	100.00
N	78				

Row Percentages in Parentheses

Table B51 Film screenings, media rooms, art gallery or display space

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	33.33	50.00	16.67	0.00	100.00
Gulf Coast	45.00	35.00	15.00	5.00	100.00
North East	36.36	27.27	24.24	12.12	100.00
Central	69.23	23.08	0.00	7.69	100.00
Total	43.59	32.05	16.67	7.69	100.00
N	78				

Row Percentages in Parentheses

Table B52 Book clubs, lending library

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	41.67	50.00	8.33	0.00	100.00
Gulf Coast	60.00	25.00	10.00	5.00	100.00
North East	57.58	30.30	6.06	6.06	100.00
Central	69.23	23.08	7.69	0.00	100.00
Total	57.69	30.77	7.69	3.85	100.00
N	78				

Row Percentages in Parentheses

Table B53 Local pride celebrations

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	16.67	33.33	33.33	16.67	100.00
Gulf Coast	35.00	15.00	25.00	25.00	100.00
North East	39.39	15.15	27.27	18.18	100.00
Central	38.46	15.38	15.38	30.77	100.00
Total	34.62	17.95	25.64	21.79	100.00
N	78				

Row Percentages in Parentheses

Table B54 Religious programming

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	33.33	33.33	8.33	25.00	100.00
Gulf Coast	40.00	20.00	10.00	30.00	100.00
North East	51.52	36.36	3.03	9.09	100.00
Central	69.23	23.08	0.00	7.69	100.00
Total	48.72	29.49	5.13	16.67	100.00
N	78				

Row Percentages in Parentheses

Table B55 Senior citizen activities

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	25.00	41.67	16.67	16.67	100.00
Gulf Coast	25.00	50.00	10.00	15.00	100.00
North East	36.36	36.36	6.06	21.21	100.00
Central	38.46	30.77	7.69	23.08	100.00
Total	32.05	39.74	8.97	19.23	100.00
N	78				

Row Percentages in Parentheses

Table B56 Sports and leisure programs

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	33.33	41.67	25.00	0.00	100.00
Gulf Coast	60.00	20.00	15.00	5.00	100.00
North East	60.61	15.15	18.18	6.06	100.00
Central	84.62	15.38	0.00	0.00	100.00
Total	60.26	20.51	15.38	3.85	100.00
N	78				

Row Percentages in Parentheses

Table B57 Youth recreational organizations

	Does Not Provide	Low Priority	Medium Priority	High Priority	Total
West	41.67	33.33	16.67	8.33	100.00
Gulf Coast	65.00	20.00	10.00	5.00	100.00
North East	54.55	18.18	9.09	18.18	100.00
Central	76.92	23.08	0.00	0.00	100.00
Total	58.97	21.79	8.97	10.26	100.00
N	78				

Row Percentages in Parentheses

APPENDIX C:
LGBTQ Service Domains and Special Populations: A Literature Review

Introduction

This Appendix provides an overview of published research on needs of the LGBTQ community. It is organized into two sections. First is a review of studies focusing on LGBTQ domains, including demographics; economic security; housing; education; family; health and mental health; civic, legal, and economic participation; religion; and safety. We also provide a review of studies focusing on the needs of several special populations of interest within the broader LGBTQ community, including communities of color, youth, transgender, and senior citizens. While the research literature summarized here is not comprehensive, we are hopeful that it can serve as a useful resource in understanding what previous research tells us about LGBTQ community needs and the services offered.

CI Domains

CI.A Demographics

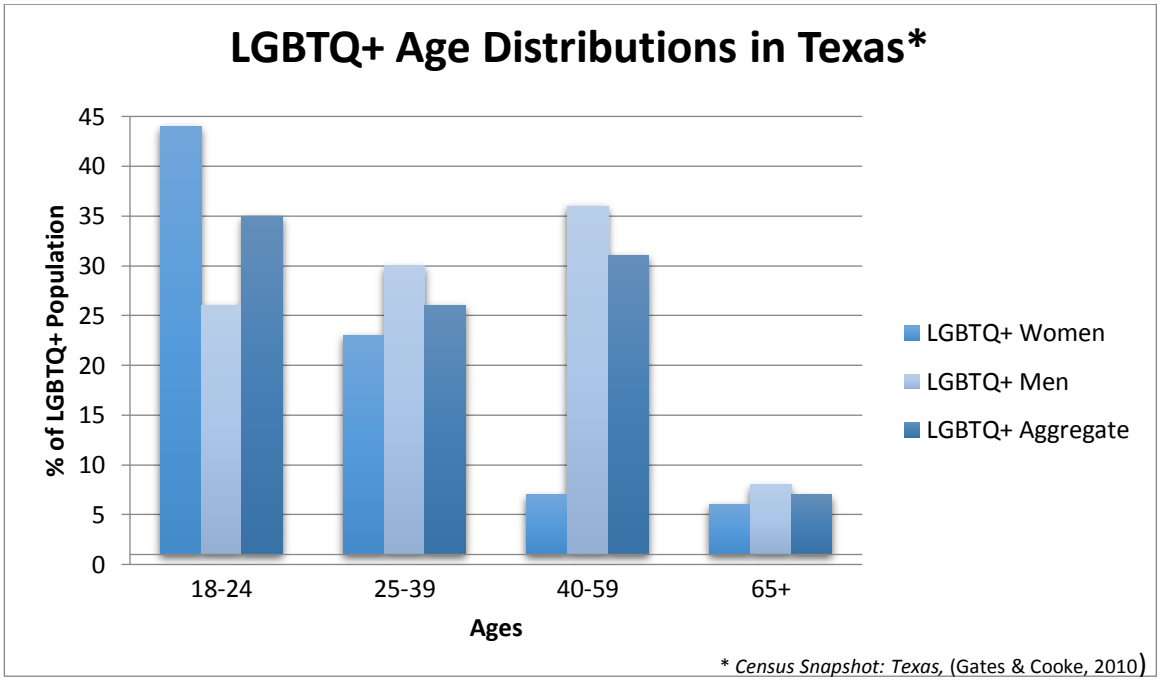
According to the most recent empirical research, Texas' LGBTQ community is a largely understudied population; thus, creating significant gaps and insufficient data to generate an all-encompassing analysis of the multi-variable demographics found in the large state (Gates, 2012; Gates & Cooke, 2010; Williams Institute, 2016). Although the data are not as robust as for some other studied populations, the Williams Institute (2016) has created an interactive United States LGBTQ data map. United States Census data describes the Texas LGBTQ population gender breakdown as equal parts self-identifying as female and male (Gates & Cooke, 2010).

In 2012, Gates and Cooke further evaluated the 2010 U. S. Census data by rank-ordering United States cities by the number of same-sex couples per 1,000 households among cities of different sizes. Large cities, mid-sized cities, and small cities are determined by populations respectively to 250,000+, 100,000 to 250,000, and below 100,000. Two major Texas cities, Dallas and Austin, respectively ranked 13th and 15th out of 25. In Dallas, 12.25 out of every 1,000 households include same-sex couples, and in Austin the ratio is 11.76:1,000 (Gates & Cooke, 2012). No Texas cities ranked for mid-sized and small cities, suggesting that LGBTQ may be more closeted or less prevalent in less urban areas of the state. Comparatively, Texas ranks 23rd out of all 50 states and the District of Columbia in percentage of LGBTQ population at 3.8% (Williams Institute, 2016).

Race and ethnicity. Of the 3.8% LGBTQ individuals in Texas, 45% self-identify as White, 34% as Hispanic, 12% as African American, 7% as "Other Race," 1% as American Indian/Native Alaskan, and 1% as Asian/Pacific Islander. This data suggests that the racial composition of LGBTQ individuals significantly underrepresents self-identified Whites and Other Race individuals compared to their proportion within the state's general population (70.4% and 10.5% respectively), but is nearly on par with other racial groups (Gates & Cooke, 2010; U. S. Census Bureau, 2010b, Williams Institute, 2016). LGBTQ men in Texas self-report as 50% White, 34% Hispanic, 9% African Americans, 6% Other Race, and 1% Asian and Pacific Islander. LGBTQ women in Texas self-report as 40% White, 35% Hispanic, 15% African American, 8% Other Race,

and 1% American Indian/Native Alaskan (The Williams Institute, 2016). Just over 25% of households in Texas with same-sex partners include partners of mixed and diverse racial and ethnic origins (Gates & Cooke, 2010).

Age distribution. According to self-reported survey data, the LGBTQ age distribution in Texas is 35% ages 18-24, 26% ages 25-39, 31% ages 40-59, and 7% ages 65+ . The LQBTQ population is, on average, 36.5 years old, nearly 9 years younger than non-LGBTQ Texans at 45.2 years old. The discrepancy in distribution may be due to a multitude of health and socioeconomic factors; however, the large population of relatively young LGBTQ women in Texas could be responsible for skewing that aggregate average age. LGBTQ women in Texas have an average age of 33.8 years old: 44% ages 18-24, 23% ages 25-39, 27% ages 40-59, and 6% ages 65+ . Nearly half of the LGBTQ individuals who identify as female in Texas are young adults. The 35% of LGBTQ individuals who are young adults (18-24 years old) is more than double the state's percentage (15%) for the general population. LGBTQ men in Texas have an older average age of 39.3 years old:– 26% ages 18-24, 30% ages 25-39, 36% ages 40-59, 8% ages 65+ (Gates & Cooke, 2010; Williams Institute, 2016).



Households and children. The proportion of Texas' LGBTQ population who are raising children (31%) is above the national average of 21% (Williams Institute, 2016). According to the Williams Institute's 2010 Census Snapshot evaluation of Texas, there are 5.2 same-sex couples per 1,000 state households and over 81.9% of those couples are unmarried partners (Gates & Cooke, 2010). More female same-sex couples identify as unmarried partners at 52%, while 36% of LGBTQ women are raising children. Overall, 38% of same-sex couples who identify as spouses are raising their own children compared to 16% of same-sex couples who identify as unmarried partners (Williams Institute, 2016).

Socioeconomic indicators. Non-LGBTQ people in Texas have health insurance coverage at a rate of 78%, but only 62% of LGBTQ Texans have health insurance, and the number decreases further to 56% for LGBTQ women. (Williams Institute, 2016). Unfortunately, socioeconomic disparities do not stop at healthcare.

Although there are insufficient data to provide mean income statistics for LGBTQ Texans, the Williams Institute (2016) summarizes three additional socioeconomic indicators in addition to healthcare. LGBTQ individuals in Texas face higher levels of unemployment when compared to the non-LGBTQ state average. This seems counterintuitive when considering LGBTQ Texans obtain college degrees at the exact same rates

as non-LGBTQ individuals. When LGBTQ people secure work, they are 5% more likely (31% versus 26%) to earn less than $24,000 annually than non-LGBTQ Texans, and that probability increases to 36% for LGBTQ women in Texas (Williams Institute, 2016).

CI.B Economic Security

The state of Texas has no legal protections for most public or private employees who identify (or are perceived as) LGBTQ. Although federal employees cannot be fired on the basis of gender identity, gender expression, or sexual orientation, no other public or private employees are extended these protections under federal law. Several cities have put protections in place to prevent anti-LGBTQ discrimination, but these measures are only local and often exclusively apply to city employees and contractors, not private employees. According to the *Texas Tribune*, local ordinances that protect LGBTQ individuals from discrimination, including private employment, have been adopted in San Antonio, Dallas, Austin, Fort Worth, and Plano (Ura, Walters, McCullough, 2016). Houston is the only major city, with a population over 1 million, without legal protections for LGBTQ people. However, Houston, El Paso, Arlington, Corpus Christi, Brownsville, Mesquite, and Waco all offer protections for city employees (Ura et al., 2016). In 2015, it was reported that 86% of the Texas workforce was not protected from discrimination based on sexual orientation or gender identity (Mallory & Sears, 2015).

Income. Nationally **f**or both men and women, LGBTQ status was associated with a higher poverty rate, although it is important to note that the study did not find these differences in poverty rate to be statistically significant. Results do become statistically significant when looking at LGBTQ men living alone who have a higher poverty rate than heterosexual men living alone (Badgett et al., 2013a). Similar to different-sex households, higher education and employment are contributing factors to lower poverty rates among same-sex individuals (Badgett et al., 2013a). However, when comparing between different-sex and same-sex outcomes, it is important to note that a lesser amount of education is especially detrimental for individuals in the LGBTQ+ community at a statistically significant level. Women in same-sex relationships are especially hit hard by both educational attainment and employment status. Employed LGBTQ women face a significantly higher poverty rate than any other demographic group of employed persons (Badgett et al., 2013a).

LGBTQ individuals in Texas are disproportionately affected by poverty, especially transgender Texans. The Williams Institute indicates that even among employed LGBTQ individuals in Texas, men in same-gender relationships earned 9% less than couples with different genders (Mallory & Sears, 2015). Almost one-third of LGBTQ Texans (31%) have an annual income below $24,000, while 30% of the Texas general population have annual incomes below $30,000 (Gates & Cooke, 2010; Mallory & Sears, 2015; Williams Institute, 2016). One in four LGBTQ Texans reported not having enough money for food or healthcare, as opposed to one in five of the general population. LGBTQ Americans are also more likely to qualify for and receive government assistance due to low incomes than those who are not LGBTQ (Mallory & Sears, 2015). This suggests that LGBTQ individuals are more likely to be impacted by poverty and its symptoms such as food and housing insecurity.

Transgender individuals are far more likely to experience poverty and unemployment. According to the 2015 U. S. Transgender Survey (USTS), 17% of respondents in Texas were unemployed and 34% of respondents in Texas were living in poverty. Transgender Americans are heavily impacted during job searching – in almost all cases of legal employment, background checks will uncover previous names and civil records (including name/gender change court documents). Transgender individuals are often "outed" through this process. Only 9% of transgender Texans have all government-issued documents corrected with updated name and gender marker. In contrast, 77% of transgender Texans do not have identification that correlates to their name and

gender identity, and 42% of those individuals who do not have updated identification cite prohibitive cost as the reason ("2015 United States Transgender Survey," 2017; "Trans Road Map," 2015).

Youth. LGBTQ youth live in an economically challenging environment – often dependent on parents and have restricted agency over financial situations. Many LGBTQ youth are not affirmed by their parents and without this support, it can be very difficult to transition into adulthood and self-sufficiency. The Free Application for Federal Student Aid (FAFSA) is required for financial support at most institutions of higher learning, including universities, community colleges, and trade schools. However, the FAFSA considers the tax information of the parent for students, which can prevent students with bad parental relationships from applying for aid, let alone receiving it. Those who are considered "independent" are those in a graduate program, those who are married, legally emancipated, twenty-four or older, have a dependent, or are a veteran (Federal Student Aid, 2017). Students who do not receive financial support from their parents are not considered independent, and the parents' income is included in aid decisions. Outside of federal aid, there are no Texas-specific scholarships for LGBTQ students. Some Texas universities do offer institutional scholarships for LGBTQ students, but these often consider FAFSA information as well. Scholarships targeted to LGBTQ youth in general often have a requirement of not only being out in the community, but active in a context of LGBTQ activism, which can be challenging and dangerous (Drew & Strickler, 2015; Smallwood, Spencer, Ingram, Thrasher, & Thompson-Robinson, 2017).

Retirement and the Elderly. The U.S. Social Security retirement system is designed to have working citizens pay taxes into a trust fund that then pays benefits to retired individuals. Qualification for benefits depends on prior work history and aggregate paid social security taxes (USAGov, 2017). However, LGBTQ elders are more likely to have gaps in work history, less savings, fewer economic resources or capital, and less legal support. One-sixth of elders are poor or near poor and 42% said financial issues are a large issue. Forty-seven percent (47%) have less than $10,000 in assets and more than half fear outliving their assets. Married elder pairs have an average joint income of $38,304, while single elders have an average income of $16,000. Elders also have elevated health care costs compared to youth and non-elderly adults, meaning that the elderly are likely to have less of a safety net and require more income to maintain economic security. Financial security plays an important part in mental health; elderly individuals with incomes $20,000 annually or less are three times as likely than those with incomes of $50,000 or more to experience loneliness or depression, five times as likely to have issues paying bills, and twice as likely to experience memory loss or serious illness ("Improving the Lives of LGBT Older Adults: Full Report," 2010).

CI.C Workplace and Employment

According to a 2013 report conducted by the Center for American Progress, LGBTQ workers are more likely to experience bias in recruitment and hiring, discrimination within the workplace, and wage gaps and penalties compared to straight individuals. Employment discrimination and the fear of discrimination, against LGBTQ workers has led to increased levels of health complications, both physical and mental, as well as lower levels of job satisfaction and productivity (Sears & Mallory, 2014). In a review of data from the 2008 General Social Survey (GSS), Sears and Mallory note that 42% of lesbian, gay, and bisexual identified people reported experiencing at least one form of employment discrimination due to their orientation, with 27% reporting experiencing discrimination within the last 5 years (2014, pp.40-44). Harassment was the most reported form of discrimination (35%), followed by losing a job (16%). Of the respondents that were out, 56% reported at least one form of discrimination; in comparison, of the respondents that were not out, 10% reported at least one form of discrimination. Twenty-five percent (25%) of individuals that were employed by federal, local and state governments experienced discrimination within the last 5 years. Other surveys (conducted in 2013, 2007, and 2009) reported by Sears and Mallory found that 21% of LGBTQ respondents reported having been treated unfairly in hiring, pay or promotions, 10% of LGBTQ respondents said they had been fired or denied

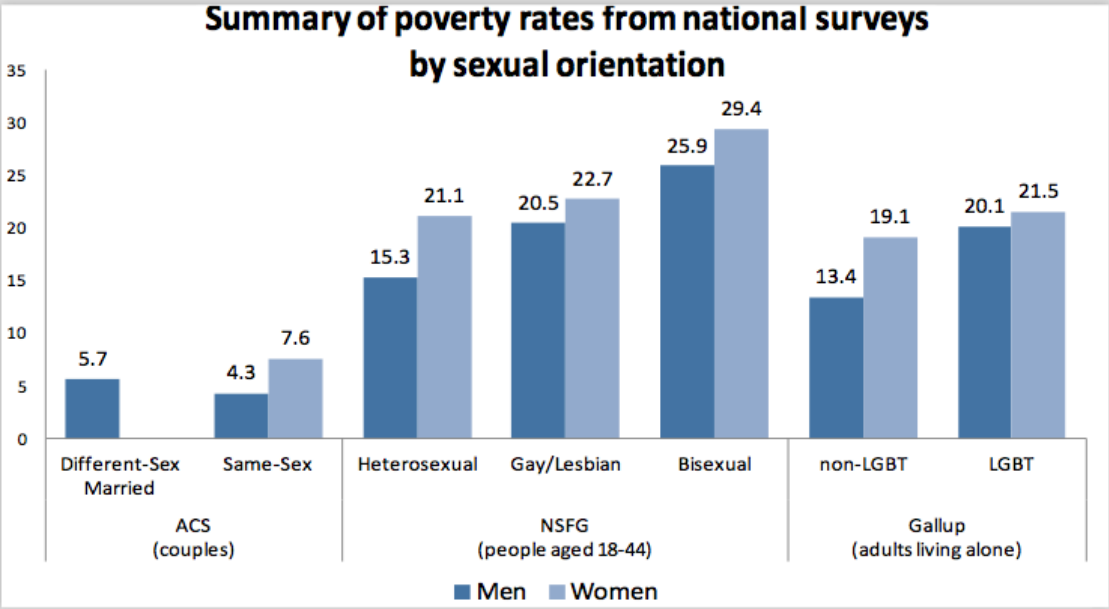
promotion, and 58% of LGBTQ respondents reported hearing derogatory comments about sexual orientation and gender identity (2014).

Wage gaps and penalties. According to Sears and Mallory (2014), twelve recent studies found evidence that gay men earn less than their straight co-workers and that men in same-sex couples earned less than men in opposite-sex marriages. Women in same-sex couples, however, earn the same or more than women in opposite-sex marriages. Mize (2016) found that when compared to heterosexual men and women counterparts, most sexual minorities face wage penalties. Mize argues that wage penalties experienced by gay men can be explained through differences in marriage rates and childrearing and an overall "preferential treatment of married men and fathers" (2016). Mize's findings show that lesbian women earn a similar amount to heterosexual women, and that wage penalties can be attributed to the motherhood wage gap. Bisexual men and women face large wage penalties compared to heterosexual men and women that cannot be explained by human capital differences or occupational characteristics (Mize, 2016).

LGBTQ experiences. Kaplan (2014) attempts to explain the career experiences of gay, lesbian, and bisexual workers and the decisions that they make. For these workers, stigmatization and visibility (in particular disclosing their sexual orientation to their co-workers) are huge factors in their career decisions. Gay, lesbian, and bisexual workers, due to the stigmatization of their sexual orientation in society are more likely to seek out organizations that are perceived to be "GLB- friendly" (Kaplan, 2014). Individual who are closeted are more likely to look for a position that allows them to work independently and possess a low degree of collaborative interdependence. This way, the likelihood of revealing one's sexual identity is reduced. Closeted individuals often choose to not to reveal their sexual orientation in fear of discrimination and choose invisibility as a form of protection and is often the driving force for closeted individuals (Kaplan 2014; Sears & Mallory, 2014). However, Kaplan (2014) argues that closeted individuals are at greater risk for discrimination because if they are "outed," they become vulnerable to their co-workers and superiors. Most non-discrimination codes work in favor of individuals with visible characteristics (i.e. race and sex). In order for a closeted individual to gain protections, information regarding their personal and professional lives must be disclosed, a situation that Kaplan explains many try to avoid. Furthermore, closeted individuals are less likely to engage in relationships with other workers, less likely to seek out internal mentors and networks, and "less likely to engage in organizationally-oriented careers" (Kaplan, 2014). Closeted individuals spend more time covering their identities than managing their careers making them more likely to develop high levels of stress (Kaplan, 2014; Sears & Mallory, 2014). Kaplan (2014) also points out that a closeted individual might choose a company that is not inclusive as it will "insulate" them from out individuals removing the possibility of stigmatization by association, while an individual who is out is more likely to look for an inclusive work environment where the likelihood of being denied certain privileges, such as time off to take care of loved ones or health care coverage, is lower. Once individuals are out, they are more likely to engage in relationships with other workers and "develop firm-specific human capital" as a form of psychological and economic protection (Kaplan, 2014). These individuals not only seek organizations that are inclusive, but also have visible representation as well as organizationally-oriented careers.

By sector and industry. Yoder and Mattheis surveyed individuals who are employed across sectors who identified as LGBTQ within the STEM field (2016). Collecting a total of 1,427 responses, the authors found that individuals within the STEM field are more likely to be out to their co-workers compared to participants in the broader workforce. Individuals who reported a higher degree of openness were also more likely to describe their workplace as "safe and welcoming" (Yoder & Mattheis, 2016). Mallory and Sears found evidence of discrimination against LGBTQ public sector employees on a national level (2014). Public sector workers in 123 jurisdictions filed a total of 589 complaints of sexual orientation and gender identity discrimination. Discrimination against LGBTQ workers within the public sector is pervasive and occurs at a frequency similar to the private sector (Mallory & Sears, 2014; Yoder & Mattheis, 2016).

Impact of discrimination. The impact of discrimination in Texas employment is significant. More than one in five (21%) LGBTQ individuals report being impacted by discrimination in hiring, pay, or promotions. There are many reports of people being passed up for promotions, paid less for comparable work compared to straight or "straight-passing" coworkers, or not hired due to real or perceived sexual orientation. Men in same-gender relationships are paid 9% less than those in heterosexual relationships, despite having higher levels of education (Mallory & Sears, 2015.) Gay men, or men who are perceived as gay, are passed up for more jobs in which employers seek "typically masculine" traits, such as assertiveness, aggressiveness, or decisiveness. Openly gay men in Texas are almost three times less likely to receive a call back after a job interview – a 3.7% callback rate for gay men compared to 12% for straight men (Tilcsek, 2011). Seventy-nine percent (79%) of transgender Texans surveyed report being discriminated against in the workplace, including being called the wrong name or pronoun, being forced to use the incorrect bathroom, and being incorrectly gendered or outed (2015 U. S. Transgender Survey, 2017).



Corporate Support for LGBTQ Identities and Politics. As corporations begin to take positions on social issues to improve customer relationships, many have come to stand behind the LGBTQ community. One of the most effective forms of LGBTQ support within corporations are Employee Resource Groups (ERGs). ERGs are groups of employees that advocate for common issues, for example, an LGBTQ ERG might advocate for increased insurance benefit coverage for transition care, PrEP/PEP coverage, or other needs like sensitivity training for management. ERGs offer employees agency over their workspace and environment as well as provide a venue for direct discussion between employees and management (Mallory & Sears, 2015). Additionally, having clearly defined policies regarding discrimination against LGBTQ employees and explicitly protecting employment rights and atmosphere is important to health and economic security for LGBTQ Texans. Around 80% of the 51 Fortune 500 companies based in Texas already include sexual orientation in anti-discrimination policies, and more than 40% include gender identity protections (Mallory & Sears, 2015).

CI.D Housing

Neither the State of Texas nor the federal government have explicit legislation to protect LGBTQ individuals against discrimination in housing. This means that LGBTQ individuals can be evicted or denied housing

because of their sexual orientation, gender identity, or gender expression. Municipalities in Texas that do include housing under their anti-discrimination laws are Plano, Fort Worth, Austin, San Antonio, and Dallas (Ura et al., 2016).

Youth. Youth are often only granted housing access through their parents and often possess little legal, social, or monetary capital; they are particularly vulnerable to housing insecurity, food insecurity, violence, and abuse. Shelters that are available and cater to youth are often faith-based and offer sex-segregated facilities that are unable to adequately accommodate people with non-traditional gender identities. Some shelters can be places of fear for many LGBTQ youth. Youth surveyed for the construction of the first LGBTQ youth shelter/center in the U.S. (Hillcrest Youth Center) consistently identified housing for 18-24 year-olds as one of the most needed services. According to the survey, a number of responding youth slept on porches or crashed on couches for fear of discrimination and harassment in traditional youth shelters. Many of these youth had psychiatric diagnoses, histories in the juvenile justice system, and/or had instances of being placed in group housing or foster homes. Thirty-nine percent (39%) reported that they had been forced out of their homes because of their sexual orientation or gender identity.

Youth interviewed in the process of developing the Hillcrest Youth Center also identified participation in underground economies as a necessary part of their economic survival. Ninety percent (90%) had engaged in dealing drugs, 75% had stolen, and 35% had engaged in survival sex whereby sex is traded for food, shelter, or money for basic necessities. The need for housing that offered LGBTQ culturally competent staff was reported as more important than competence with regard to racial/ethnic or other differences. Youth also cited safety as a primary concern, although the author of the study notes that only 20% of adults in the area who were involved in providing LGBTQ services identified safety as a concern. In the survey, safety was defined by responding youth as the prevention of social and physical harassment within the shelter space, while to adults it meant merely physical safety outside of the shelter. Adults in the study tended to assume that current social services were sufficient and catered to youth issues, which was not the perspective of LGBTQ youth in the area. All responding youth stated that they often did not disclose their identity to staff at youth service shelters for fear of harassment, mistreatment, denial of services, and/or abuse (Berberet, 2006).

Few shelters in Texas cater specifically to LGBTQ youth, although there are a number that are open to all youth. Proposed improvements included reducing maximum capacity, offering single stall shower and changing facilities, mandating training for staff in LGBTQ sensitivity and care, and creating more LGBTQ specific youth shelters (Hunter, 2008).

Elders. The LGBT Center for Ageing (2010) reports that 39% of LGBTQ elders identified housing and shelter needs as a significant concern. With limited financial resources and expensive needs, elders are particularly challenged when looking for appropriate and sufficient living accommodations. LGBTQ elders are less likely to be married or have blood family members who they reside with or have contact with. Although there is little data available about the impact of housing discrimination on LGBTQ elders, more than one-third of them felt that if they were to move into a retirement home, they would have to hide their sexual or gender identity. Elders in the LGBTQ community are also at higher risk of social isolation. Many have tentative or estranged relationships with blood family and may be closeted or only partially out, and there is significant homophobia and transphobia within the greater elder community. Communities that engage LGBTQ elders can combat this issue very effectively by creating spaces where elders can contribute to the community, bond with others, and advocate for shared rights and needs. Investment should be directed into promoting culturally competent assisted living, retirement homes, and end of life care facilities. Ensuring that LGBTQ elders have agency over their social life and access to services, and are protected from discrimination and the bias of caretakers, blood family, and medical providers is integral to providing facilities that are safe for LGBTQ elders (“Improving,” 2010).

Gentrification. LGBTQ individuals have historically been shunned from traditional homes and family structures and discriminated against in employment, housing, healthcare, and public accommodations. To combat these effects, the LGBTQ community has established "gay" neighborhoods ("Gayborhoods") as safe spaces to live and exist outside of the violence and mistreatment of the rest of the world. These neighborhoods frequently attain high cultural worth, as they are often highly diverse and low-rent at first. However, as these neighborhoods appreciate in cultural value, and buildings are restored and maintained, straight people and high-privilege LGBTQ persons move in, raise rents, displacing individuals who need the security of LGBTQ living spaces and communities, rather than simply the cultural experience of living there (Garrison, 2009).

Violence against LGBTQ individuals is unfortunately common in Texas, and low-income neighborhoods tend to have higher rates of crime (Jansen, 2011). While many perceive LGBTQ individuals to be wealthy and belonging to dual income partnerships, that is not the reality for many. Affordable housing in LGBTQ friendly neighborhoods is necessary to protect vulnerable members, as is a commitment to training public services personnel such as police to treat all members of the community with respect and humanity.

CI.E Education

Educational institutions play a critical role in shaping cultural perceptions and values, including prejudice and stereotypes. Despite improvements in how LGBTQ people are perceived in the general culture, many schools and colleges nationwide are still unwelcoming and hostile environments for LGBTQ students (Center for American Progress, 2014; Kosciw, Kull, & Palmer, 2016). Twenty percent (20%) of LGBTQ students reported not feeling safe on their college campuses according to the National Gay and Lesbian Task Force (Beck, Rausch, Lane, & Wood, 2016). Students identifying as LGBTQ reported school and bullying problems were persistent problems (Beck et al., 2016). According to a study by Birkett, Espelange, and Koeng (2009), lesbian, gay, bisexual, and sexually questioning youth were more likely than heterosexual youth to report bullying, homophobic victimization, and various negative outcomes in schools. Sexually questioning youth reported the most bullying, the most homophobic victimization, the most drug use, the most suicidal feelings, more depression, and poorer attendance than either heterosexual or LGBTQ students (Birkett et al., 2009).

"No-promo homo" policies. Seven states, including Texas, and a number of localities, have policies that officially prohibit teachers from discussing LGBTQ history and lives to students, encouraging biased language against LGBTQ students and preventing school districts from incorporating an inclusive curriculum. While the severity of these policies varies, these "no-promo homo" policies, or "don't say gay" policies, encourage a hostile, unwelcoming school climate for LGBTQ youth (McGovern, 2012; Movement Advancement Project, 2016; State Maps, 2016).

A recent ruling from Judge Reed O'Connor of the Federal District Court for the Northern District of Texas has stirred controversy. This ruling, according to GLSEN (2016), states that the U.S. Department of Education cannot use Title IX to protect transgender and gender nonconforming students by providing guidance to school districts on how to better accommodate transgender and gender nonconforming students. This decision is extremely problematic since transgender and gender nonconforming students are more likely to avoid gender-segregated rooms for fear of bullying and harassment. In Texas, the recent passage of the transgender "bathroom" bill will likely negatively affect transgender students by further stigmatizing them.

Gay-straight alliances. The presence of a gay-straight alliance (GSA) can promote positive attitudes towards LGBTQ persons, and may have long-lasting impact (Toomey, Ryan, Diaz, & Russell, 2011; Kosciw, Kull, & Palmer, 2015; Worthen, 2014). In a 2011 study, Toomey, Ryan, Diaz, and Russell reported an association between the presence of a gay-straight alliance in high schools and positive health, well-being, and improved academic outcomes. In some cases, the presence of a GSA helped to reduce the impact of low levels of bullying

and victimization (Toomey et. al., 2011; Kosciw et al., 2016). In Worthen's study (2014) the impact of the GSA on perceptions of LGBTQ persons varied by location, with smaller rural areas showing less support for members of the LGBTQ community. Areas in the South were shown to have a negative impact on attitudes towards LGBTQ persons, as the presence of a GSA in an environment hostile to LGBTQ persons may worsen perceptions toward these individuals (Toomey et al., 2011).

College Readiness. While research of LGBTQ students and college readiness is limited, LGBTQ students may be more likely to experience lower levels of college readiness and preparedness due to their status as a minority group (Windmeyer, Humphrey, & Barker, 2013; Center for American Progress, 2012; Kosciw et al., 2016). In addition, LGBTQ students are more likely to experience difficulty in paying for university (Windmeyer et al., 2013; Center for American Progress, 2012). College and universities are increasing efforts to increase the enrollment of LGBTQ persons; however, many of these institutions lack the necessary resources and an overall inclusive environment to promote retention efforts. Research shows that LGBTQ students are often faced with unfriendly campus environments. According to Windmeyer et al. (2013), efforts for inclusion and support for LGBTQ persons often fall on the backs of student organizations and clubs, such as the gay-straight alliances, with only 7% of campuses having institutional resources such as part-time or full-time staff dedicated to LGBTQ issues. Further, only a few colleges and universities track retention rates of LGBTQ students (Koswic et al., 2016; Windmeyer et al., 2013).

The American School Counselor Association (ASCA) identifies the following as the most important values pertaining to college and career exploration within the LGBTQ population: self-affirmation and overall positive well-being, safe and inclusive environments, the ability to adapt to situations, and self-advocacy (Beck, Rausch, Lane, & Wood, 2016). A 2012 study revealed that gay and bisexual male students who were visible or out viewed campus involvement and a sense of belonging as pivotal to overall college experiences. In particular, the classroom environment played a major factor in the students' perceived safety and overall success (Robison, 2012), and that navigating masculinity is difficult due to traditional gender roles (Robison, 2012). Singh, Meng, and Hansen's (2013) qualitative study notes that transgender college students often find themselves in institutions that do not provide the resources and support necessary to support transgender students, and that the presence of a trans-affirming community played a huge role in promoting resilience and self-advocacy.

A report by The Center for American Progress (2014) addresses the needs of LGBTQ college students who are survivors of sexual assault. Despite efforts to create a safer campus climate for LGBTQ students, many report harassment and violence based on sexual orientation or gender identity. According to a 2006 study conducted by the American Association of University Women, 73% of LGBTQ students faced both noncontact and contact forms of sexual harassment, and 44% reported facing contact forms of sexual harassment. In contrast, 61% of non-LGBTQ students reported not facing any form of sexual harassment, and 31% reported facing contact forms of sexual harassment (Center for American Progress, 2014). LGBTQ survivors of sexual assault are more likely to experience disruptions in education, lower levels of self-esteem and confidence, high levels of psychological distress, and are less likely to report negative experiences due to fear of stigmatization and backlash compared to non-LGBTQ survivors (Center for American Progress, 2014). While the Federal Bureau of Investigation has expanded the definition of rape and removed references to gender, individual cases are still determined by state and local laws. College campuses and universities must consider reports of sexual assault and the needs of victims regardless of sexual orientation or gender identity. According to the Center of American Progress (2014), Title IX only covers gender-based bullying or harassment of LGBTQ college students. In addition, many colleges and universities still lack the resources necessary to support LGBTQ survivors.

Support on college campuses. Linley & Nguyen (2015) point out that higher education institutions must create supportive "cocurricular spaces" by recruiting and educating "inclusion-minded trustees, administrators, faculty and staff members," who can provide support for LGBTQ students and create safe environments. Re-

engaging LGBTQ graduates and promoting collaborations between university units and community LGBTQ resource centers would help to improve university climates, improving their appeal to future students, who may judge institutions based on how they address LGBTQ needs (Linley, Nguyen, Brazelton, Becker, Renn, & Woodford, 2016).

Moreover, Linley and colleagues contend that faculty should have knowledge regarding sexual orientation, gender and identity expression, and LGBTQ people. These authors find that there are different levels of awareness among faculty members. While most respondents believe that faculty members are quite knowledgeable about sexual orientation and LGBTQ people, almost a third assessed faculty members as comparably low in knowledge about gender and identity expression and transgender people. (Linley & Nguyen, 2015; Linley et al., 2016).

Researchers believe that improved faculty knowledge will depend on campus initiatives. However, the findings indicate that less than a third of institutions conducted any types of LGBTQ-related faculty development during the previous two years. The study suggested areas for particular focus, including materials on LGBTQ youth, and "especially how content on LGBTQ youth can be infused in courses on child welfare and throughout the curriculum"; gender identity and expression and transgender people; and how to include "LGBT-related content in research courses" (Linley & Nguyen, 2015; Linley et al., 2016; Martin, Messinger, Kill, Holmes, Bermudez & Sommer, 2009).

Finally, the findings indicate that comparatively few academic programs have a gender identity nondiscrimination policy. The authors suggest that the lack of such a policy can cause an uncomfortable, less welcoming, and less positive environment for some students, with the result that LGBTQ students might be less likely to apply to these programs. Furthermore, in some cases, staff and faculty were not aware of existing LGBTQ-supportive policies and conditions (Linley & Nguyen, 2015; Linley et al., 2016).

Need for well-trained social workers. There have been several studies focused on the education and training of social work students to develop well-elaborated and effective services for the LGBTQ community. A Council on Social Work Education and Lambda Legal study was conducted among social work program directors and faculty members in 2009. The study revealed that most programs do not conduct any student assessment on competencies for serving the LGBTQ community. More than half of program directors stated that students who participated in their programs were "slightly" or "not at all" prepared to organize a service support for LGBTQ individuals. At the same time, a larger majority of all respondents believed that LGBTQ students probably feel comfortable in those programs (Martin et al., 2009). Few of the programs reviewed provide field placement opportunities in an LGBTQ context, and social work curricula contain inadequate material on gender identity/expression, transgender people, and bisexuals. The study's authors believe that more diverse LGBTQ-related content should be included across curriculum areas, with greater attention to transgender and gender identity and expression issues and that social work education should be more attentive to curriculum and assessment of student preparation with the regard to serving LGBTQ clients (Martin et al., 2009).

CI.F Family

An integral and unavoidable part of every LGBTQ individual's life revolves around family. Whether it is the one they were born into or the one they create as they progress through life, the concept of family plays a very impactful role in the way that members of the LGBTQ community develop and exist in society.

Parenthood. The idea of same-sex parenthood often invokes questions about the consequences for children, and arguments are often made that lack scientific backing. Many political and religious activists argue that children raised by gay fathers or lesbian mothers are more likely to grow up to be gay or lesbian, but two

decades of research suggest otherwise. A longitudinal study in the 1990s found that "no significant difference was found among young adults from lesbian and heterosexual single-mother households in the proportion who had experienced sexual attraction to someone of the same gender" (Tasker & Golombok, 1995). This finding has been replicated multiple times, and was instrumental in shifting the conversation about homosexuality in modern society.

In recent years, efforts have been made to identify the demography of LGBTQ parents in America. One analysis, which included a choropleth map that outlined the geospatial distribution of same-sex parenting aggregates, found that "parenting is more prevalent among racial and ethnic minorities" than among white individuals in same-sex families (Gates, 2010). The map provided is useful in analyzing the spatial distribution of parenting at the county-level across the United States.

When same-sex couples do raise children together, there can be negative repercussions from society. An analysis of the National Longitudinal Lesbian Family Survey (NLLFS) found that "forty-three percent of the NLLFS children indicated that they had experienced homophobia," in spite of the fact "that most of the NLLFS families resided in progressive, metropolitan areas of the United States" (Bos, Gartrell, Peyser, & Balen, 2008). Though the quality of parenting does not seem to differ between same-sex and different-sex parents, the societal reaction to having same-sex parents can take a toll on children. The note that most of the families studied were in metropolitan areas suggests that more research is required on the outcomes of lesbian, as well as gay male, couples raising children together.

In spite of many barriers to equality, a significant number of transgender individuals are parents to children. In one study of discrimination against transgender individuals in the United States, "thirty-eight percent (38%) of the sample were parents with 18% reporting that they currently [had] at least one dependent child." Furthermore, "seventy percent (70%) of respondents reported that their children continued to speak to them and spend time with them after coming out" (Grant, Motter, Tanis, Harrison, Herman, & Keisling, 2011). The needs of transgender parents include parenting rights and family acceptance.

It is important to consider the gaps in existing literature when looking to analyze the needs of LGBTQ Texans. Though there have been a wide variety of studies that are cross-sectional in nature, one literature review points out that "no studies have tracked a large sample of children raised by gay and lesbian parents well into adulthood to know what their sexual identifications become" (Biblarz & Savci, 2010). Longitudinal research is essential, as political and social opponents to same-sex parenting claim that the outcomes of children raised by same-sex couples experience adverse outcomes. While there is a great deal of research that supports the idea of same-sex parenting as essentially 'normal,' not all studies in recent years agree. Marks' 2012 research uses 59 studies to look at whether or not the American Psychological Association's assessment that children of LGBTQ parents are not disadvantaged is valid, and argues, "such a statement would not be grounded in science".

Family acceptance. It would be remiss to ignore how an LGBTQ individual fits into their family when considering the impact that family has on the LGBTQ community. A direct link between acceptance and health has been established through several works, with one articulating that "support and acceptance from both family and friends correlated significantly and positively with participants' well-being and negatively with participants' mental distress" (Shilo & Savaya, 2011). The importance of family in ensuring the social and emotional development of LGBTQ people goes well beyond comfort and happiness, affecting factors such as health that are perceived as purely biological by many. When it comes to addressing a variety of needs for members of the LGBTQ community, programs aimed at social support and the family has the potential to yield lasting results.

As with the literature on LGBTQ parenting, the unique life experiences of transgender individuals warrant an examination of their needs separately from gay, lesbian, and bisexual individuals. A qualitative study looking

at the experiences of transgender women of color found that they "frequently experience verbal and physical abuse at the hands of their family members upon disclosing their transgender identity" (Koken, Bimbi, & Parsons, 2009).

The decision made by LGBTQ youth or adults to 'come out' to their family members, friends, and the general public is also linked to family support. An analysis of LGBTQ adults found "direct effects of parental sexual orientation support – specifically, father support – on negative identity and public outness" (Mohr & Fassinger, 2003). The viewpoint of the father, therefore, might directly affect an LGBTQ child or adult self-perception, with implications for health and wellbeing. More recent studies have reinforced the idea of family support and 'coming out' through qualitative means. In talking about family life with LGBTQ youth, researchers in Washington found that "negative factors were more common than positive factors" as many were "concerned about being kicked out and denied financial support if their parents or guardians found out about their sexual identity" (Higa, Hoppe, Lindhorst, Mincer, Beadnell, Morrison, Wells, Todd, & Mountz, 2014), with financial support a chief concern among many respondents. Though many LGBTQ individuals are subject to incredibly negative experiences when coming out to their families, there are some whose coming out is well received. Gorman-Murray found, for an Australian sample, that "sometimes families do respond positively to sexual difference, revealing fissures in the coverage of familial heteronormativity" (2008).

Many researchers have studied the ways that family rejection impacts LGBTQ individuals, but few actually look at why families reject their LGBTQ relatives. A qualitative study looking at family acceptance patterns found that "families whose behaviors were rejecting were acting out of care and concern to help their children 'fit in,' be respected by others, and have a good life." This research led to the founding of the Family Acceptance Project at San Francisco State University (Ryan, 2010).

Legislation. Although the federal recognition of same-sex marriage occurred in 2015, Texas state laws and codes have not changed accordingly. The Texas Family Code (§§ 153.001 - 153.709) does not protect parental conservatorship, possession, and access to children that come from a marriage (2015). When LGBTQ same-sex couples face a custody case for a child for which one member of the couple is the legal parent, the other member of the couple has no legal relationship with the child. This presents unique legal issues that are not present in most custody disputes between heterosexual parents (O'Neil, 2017). Texas Family Code, Title 5, section § 153.003 states "No discrimination based on sex or marital status" is allowed, yet same-sex parents do not possess the same rights including custody and visitation for their child. that comes from a same-sex marriage.

House Bill 3859 was recently passed by the 2017 Texas Legislature. It allows child placement agencies receiving public funds to claim religious objections to adoption or foster care by certain groups of people. This effectively protects the right to discriminate and deny adoption and fostering opportunities to LGBTQ, single, or non-Christian parents. Law also allows these publicly funded child welfare services to send LGBTQ foster children to so-called "conversion therapy" (Sharp, 2017; TX HB3859, 2017). For the nearly 30,000 children in Texas foster care, the consequences of HB 3859 may be devastating. HB 3859 discourages families who want to foster or adopt in a state that desperately needs more families to do so. Further, the legislation protects an adopting family's right to deny fostering or adoption of a child based on their sexual orientation, gender identity, and religion. Texas' foster care system has been found dangerously inadequate by a recent federal court ruling (Sharpe, 2017), yet HB 3859 is likely to keep children desperately in need of a loving family in the cycle of abuse and neglect they are likely to encounter within the current Texas foster care system.

Conclusion. The literature that covers LGBTQ individuals and family is widespread and inconclusive. Research on the effects of family acceptance, however, is generally more consistent. The nature of how a family reacts to their relative 'coming out' is linked to both physical and mental health, as well as to financial instability and fear. Though some studies articulate the positive experiences of some LGBTQ individuals, the

overwhelming majority suggests that things are rough for family relations. When things go poorly, a number of problems arise for members of the LGBTQ community that need to be addressed.

CI.G Health and Mental Health

HIV/AIDS. According to the CDC, **g**ay men accounted for 54% of the US population living with HIV and 67% of new HIV diagnoses infections in 2014, and the rate of new infections was greatest among black gay men. (https://www.cdc.gov/hiv/group/msm/index.html). If current diagnosis rates continue, 1 in 6 gay and bisexual men will be diagnosed with HIV in their lifetime, including 1 in 2 black/African American gay and bisexual men, 1 in 4 Hispanic/Latino gay and bisexual men, and 1 in 11 white gay and bisexual men (https://www.cdc.gov/hiv/group/msm/index.html). The Kaiser Foundation (2014) conducted a survey to better understand the attitudes that gay men have towards HIV/AIDS. The findings show that about half of the sample surveyed is not overly concerned with the topic of HIV/AIDS. In addition, very few gay men get tested regularly for HIV, and about 56% of gay and bisexual men do not have HIV testing recommended to them by their physician, which suggests that HIV/AIDS is not a large concern in the gay male population (Kates, Ranji, Beamesderfer, & Dawson, 2016; Hamel, Firth, Hoff, Kates, Levine, & Dawson, 2014).

According to the Texas HIV Medication Program (2017), Texas provides a state health plan to cover access to HIV/AIDS medication and treatment for those below 200% of the federal poverty line – $23,040 for individuals and $32,040 for two-person households. Coverage for preventative drugs – Pre-Exposure Prophylaxis (or PrEP) and Post-Exposure Prophylaxis (PEP) – for those at high risk of HIV transmission are not included in this coverage. This coverage is not statewide, and only select providers across the state prescribe PrEP – 34 clinics across 13 cities in Texas (Texas HIV Medication Program, 2017).

Lesbian and bisexual women are much less likely to contract HIV through sexual intercourse with their same-sex partner. In fact, most cases of lesbian and bisexual women having HIV infections were probably caused by intercourse with a male or through injection drug use (Dilley, Simmons, Boyson, Pizacani, & Stark, 2010). Considerably less literature is available on the HIV epidemic as it relates to the transgender population. The most recent study exploring the prevalence of HIV infection in the transgender community is from 2007. The study found that there was a growing threat of HIV exposure among the transgender women population, with more transgender women engaging in risky sexual behavior. The Kaiser Family Foundation study found that 28% of transgender women are HIV positive (Herbst, Jacobs, Finlayson, McKleroy, Neumann, Crepaz, & HIV/AIDS Prevention Research Synthesis Team, 2007).

Health Disparities. Multiple studies illuminate the differences in overall health between members of the LGBTQ community and their heterosexual counterparts. A report published by the Kaiser Family Foundation finds that LGBTQ individuals tend to report higher rates of chronic diseases and earlier onset of disabilities. There is also worse overall physical health between lesbian and bisexual women compared to their heterosexual counterparts (Acquaviva & Krinsky, 2015). Health promotion targeting the LGBTQ community remains predominantly focused on HIV/AIDS, hepatitis, and STI prevention to the exclusion of other health issues. Thus, LGBTQ individuals may be defined solely in terms of their sexuality and not in larger aspects of their community and identity (Drott, Evans, & Oswalt, 2016). Service providers who can prescribe and monitor hormones for transgender people in transition may be completely absent from rural areas (Bockting, Horvath, & Swinburn, 2014). Lack of transportation may pose an additional barrier to services in rural areas (Bockting et al., 2014).

Health Insurance and Access. There is also a disparity for health insurance between LGBTQ individuals and the general population. Approximately 30% of LGBTQ individuals are uninsured (34% gay men, 31% lesbians, and 29% bisexual people), with 48% insured among LGBTQ individuals living in southern states. LGBTQ Americans are more likely to be uninsured, have trouble getting health care, and are more likely to

have unmet medical needs (Buchmueller & Carpenter, 2009). Additionally, it is less likely that available and affordable plans cover their health needs. In Texas, insurers are under no obligation to offer plans that cover transgender and transition-related healthcare. These services are rendered virtually inaccessible without health insurance (National Center for Transgender Equality, 2016). Even when covered by insurance, transgender individuals must often be diagnosed with "Gender Identity Disorder" or "Gender Dysphoria" by a professional to have transition needs covered by insurance (Buchmueller & Carpenter, 2009). Although transition-related care is often neither cosmetic nor optional for transgender individuals, it is difficult to find affordable coverage and capable providers. Under the Affordable Care Act, employers must offer at least one plan that covers transition-related care. However, Texas has chosen not to expand Medicaid coverage nor has it removed bans that exclude transgender people from coverage under Medicaid or Medicare (National Center for Transgender Equality, 2016).

One of the biggest issues associated with the low number of uninsured LGBTQ individuals is medical debt, affecting an estimated 66% of uninsured LGBTQ individuals. In 2012, the LGBTQ State Exchanges Project of the Center for American Progress began a study of this issue; however, the study did not include the transgender population, and it was conducted prior to marriage equality and the full implementation of the Affordable Care Act (Durso, Baker, & Cray, 2013). A follow-up project could assess any recent improvement in health insurance disparities. In 2013, another study examined health disparities between rural and urban LGBTQ communities in Nebraska and found that rural LGBTQ Nebraskans had worse general health, higher rates of smoking and drinking, and were less likely to have health insurance coverage. (Fisher, Irwin, & Coleman, 2014).

Awareness Training for Healthcare Providers. Some health problems within the LGBTQ community appear related to misinformation and lack of proper training of healthcare providers. One survey of oncologists assessed the performance of doctors working with LGBTQ patients and found a lack of knowledge of the LGBTQ health risks. In fact, only about 28% of the oncologists surveyed said that they were well informed, with the most cited reason being a lack of preparation in medical school. Nursing education is also lacking when it comes to LGBTQ health issues. A survey of nurses in the San Francisco Bay area found that approximately 30% of responding nurses were uncomfortable working with LGBTQ patients, not because of discrimination, but because they lacked appropriate training, with 80% of the nurses citing a lack of training to work with LGBTQ patients (Carabez, Pellegrini, Mankovitz, Eliason, Ciano, & Scott, 2015; Shetty et al, 2016). In Massachusetts, a Commission on LGBTQ+ Aging has developed a provider training curriculum on working with elderly LGBTQ individuals (Acquaviva & Krinsky, 2015).

Mental Health. Mental health consequences for LGBTQ people are widely discussed in the research literature and are generally associated with experiences of stigma, social isolation, and discrimination. These factors lead to poor mental health indicators such as higher risk of anxiety, depression, suicidal ideation, and suicide attempts. In addition to the physical toll that chronic social stress has on the body, LGBTQ people are more likely than heterosexual people to experience poor mental health, smoke, use alcohol and other drugs, and experience self-directed violence (Blosnich, Farmer, Jabson, & Matthews, 2016). Anti-gay stigma itself is noted as a structural driver of HIV and a public health threat both because of its association with risky behaviors and its link to poor mental health (Cahill, Valadez & Ibarrola, 2013). Stigma and related stress may also be encountered both in mental health services aimed at the general public and within services targeted toward the LGBTQ community itself (Blosnich et al., 2016).

Stigma and mental health. LGBTQ people in all geographic areas experience discrimination, stigma, and isolation (Fisher et al., 2014). They can also experience rejection at school, work, and in the family all of which increase suicide attempts, drug use, and depression (Cahill et al., 2013). Suicide is of particular concern for LGBTQ youth; suicide is the second leading cause of death for adolescents and adolescents who are sexual minorities have a higher risk of suicide attempts (Austin, McConnell, Moscoe, & Raifman, 2017). Suicide

attempts are the greatest predictor of suicide fatality and are linked with poorer long-term health if the attempt is survived (Austin et al., 2017).

Discrimination does not have to be directly experienced for LGBTQ people to have mental health consequences. Explicit discrimination is only a part of stigma; perceived discrimination carries risks as well, including diminished environmental mastery, a decreased sense of personal growth, and lower self-acceptance (Herdt & Ketzner, 2006). Stigma itself is associated with increased rates of psychological distress, mood/anxiety disorders, and decreased quality of life (Herdt & Ketzner, 2006). Together they create worse mental health outcomes. Stigma also compounds depending on some characteristics of the LGBTQ individual. Being a person of color and having low income is associated with more types of discrimination and enacted stigma resulting in worse mental health consequences (Bockting et al., 2013). Being trans or gender non-conforming further exacerbates these issues. Stigma is pervasive, chronic, and works on many levels.

Mechanisms that impact LGBTQ mental health. People of all ages experiencing harassment suffer mental health problems such as depression, anxiety, low self-esteem, and a greater likelihood of substance use. LGBTQ people, however, also experience both harassment and the chronic fear that they could be harassed, generating worse mental health outcomes (Estell, Marshall, Yarber, Sherwood-Laughlin, & Gray, 2015). The minority stress model is easily the most succinct concept highlighting the primary mechanism that gives rise to poor mental health for LGBTQ people. Minority stress suggests that negative experiences and the constant fear of them happening will increase psychological distress for someone who is a member of a stigmatized group (Bockting et al., 2013). Poor psychological health interacts with physical health. Experiences of discrimination are associated with behaviors that put one's health at risk to a greater degree in the LGBTQ community than in the heterosexual one (Cahill et al., 2013). Stigma acts on health through a multitude of mechanisms that stem from minority stress.

Living as a stigmatized person will often motivate identity concealment and further impair mental health (Bockting et al., 2013). Anxiety stems from the fear of rejection and discrimination that could be brought about by openly identifying with a stigmatized group. Poor mental health and a fear of rejection is one thing, but chronic exposure to them can motivate both suicidal ideation and suicide attempts (Austin et al., 2017).

Stigma is one of the many cited mechanisms driving suicidal ideation and attempts (Austin et al., 2017). Bullying, for instance, is associated with higher rates of depression, loneliness, anxiety, suicidal ideation, and decreased self-esteem (Chapman & Evans, 2014). These mental health issues can become chronic when LGBTQ people expect the social world to discriminate against them. Bullying and discrimination cover a wide range of experiences that encompass everything from physical violence to name-calling. LGBTQ people regardless of geographic location experience bullying, but it appears to be significantly higher in rural areas. Research has found that youth who are perceived as LGBTQ are bullied in multiple ways. Kids who are bullied have worse psychological outcomes such as increased rates of depression, anxiety, and negative perceptions of school. This does not have to be explicit bullying and the simple presence of name calling can motivate poor mental health (Chapman & Evans, 2014).

Non-LGBTQ youth can still be bullied by being called names like *gay.* This interacts with the mental health of LGBTQ youth who hear their group membership used as a casual insult (Chapman & Evans, 2014). Roughly 70% of secondary school students report hearing homophobic remarks, 80% of LGBTQ students report verbal harassment because of their orientation, over two-thirds feel unsafe because of their orientation, and more than half of students in one study report hearing homophobic remarks from school *personnel* (Estell et al., 2015). This is extremely troubling as LGBTQ students, regardless of geographic location, can encounter stigma within their home with their family, from their peers with whom they share space with, and from school personnel who demand compliance. Some LGBTQ youth may lack access to accepting, safe spaces. The persistence of bullying seems to reduce after 9th and 10th grade, but the experience of bullying and its consistent presence in the school is documented while its interaction with mental health is clear (Chapman & Evans, 2014).

Youth also may experience stress from state and federal LGBTQ public policies. State same-sex marriage bans share an association with increased psychiatric disorder rates, and other anti-LGBTQ policies may have a similar effect on mental health (Herdt & Ketzner, 2006).

LGBTQ people experience bullying motivated by prejudice from outside their community, but gender non-conforming and transgender persons may also encounter discrimination from other LGBTQ persons (Chapman & Evans, 2014). LGBTQ individuals of color may also be exposed to other forms of prejudice as well. Experiences of explicit discrimination are not limited to sexuality, but LGBTQ sexuality is attached to observable indicators such as how one behaves relative to the 'normative' behavior of their peers, weight, size, color, ethnicity, gender expression, hair, and clothing choice (Chapman & Evans, 2014). Bisexual, trans, and gender non-conforming individuals appear to have more negative mental health indicators than gay men and lesbian women (Blosnich et al., 2016). They are at a higher risk of depression, anxiety, and chronic social stress (Blosnich et al., 2016). There seem to be lower levels of understanding both within the LGBTQ community and society at-large in reference to these groups, and they can experience discrimination from both the heterosexual community and within the gay/lesbian community (Drott et al., 2016).

Trans and gender non-conforming community members will also experience greater challenges to social integration. People who do not identify as male or female may feel less connected to the LGBTQ community and may not feel supported by them. They also face the challenge of fitting into institutions that engage in gender binary distinctions, such as residence halls, athletic teams, locker rooms, bathrooms, and the Greek system that are all segregated by gender (Drott et al., 2016).

Accessible mental health services in rural areas may pose particular problems. Post-therapy relationships, for instance, are unavoidable in small communities, and consultations between doctors with differing philosophies can put an LGBTQ client at risk of exposure to discrimination even within the context of mental health services (Gallardo, Haldeman, Helbok, & Schank, 2010). Rural LGBTQ residents desperately need quality community services that may be absent in their localities. (Fisher et al., 2014). However, rural LGBTQ people, in general, do not appear to have worse mental health than those in urban areas (Blosnich et al., 2016). Some rural LGBTQ people appear to find identity in their geographic location and the specifics of their rural culture, while suburban and urban LGBTQ people may not have this identity anchor to protect them from social stress. Further research is needed on the protective effect of rural living on LGBTQ mental health. For some, a rural community may provide space for the development of healthy identity. However, rural LGBTQ people have severely limited access to relevant services, and their ability to socially integrate into either the LGBTQ community or the community at-large will be strained by stigma, and their mental health will suffer (Fisher et al., 2014).

What works. Mental health for LGBTQ community members can be a struggle, but the literature does have examples of mechanisms that can combat the poor mental health LGBTQ people commonly experience. Social support can moderate the impact of stigma on psychological functioning and foster personal growth, a sense of purpose, and engagement in life challenges (Herdt & Ketzner, 2006). Cultural factors such as LGBTQ role models have been found to have influence on psychological health including positive self-perceptions (Giuliano & Gomillion, 2011). Starting early by exposing kids to strong LGBTQ role models through media such as story books has proven effective in enhancing positive self-concepts, but efforts to target kids with pro-LGBTQ material should be prepared for being accused of propagandizing (Giuliano & Gomillion, 2011). Social marketing campaigns have been found to be effective at reaching families with LGBTQ members; educating them on keeping stigma outside of the home (Cahill et al., 2013). External support is important, but research suggests that building the LGBTQ community and connecting people to it can promote positive results. Non-stigmatizing environments and positive self-assessments are both found through connecting to the LGBTQ community (Cahill et al., 2013).

The avoidance of stigma combined with social isolation and a desire for integration can create circumstances where one's poor mental health promotes risk behaviors that can impact one's physical health. Health risk behaviors may be engaged in because of feeling isolated, but there are ways outside of the specific social realm that can help to improve mental health for LGBTQ people. Smoking, for example, has been cited in studies of LGBTQ people as a vessel through which one can integrate into one's social context, especially in rural areas (Bennett, Ricks, & Howell 2014).

Protective factors from the mental health consequences of stigma found in the literature specific to LGBTQ *youth* are anti-bullying policies specifically protecting LGBTQ students, inclusive policies that do not discriminate against LGBTQ people, having support organizations, school personnel training for bullying intervention, increasing access to LGBTQ issues, individuals, history, and events through curriculum and school resources, and of course peer and teacher social support (Estelle et al., 2015). These processes and procedures are important because LGBTQ students feel good when school personnel intervene in bullying, or when they provide a safe space for those who are upset due to the treatment they experience (Estell et al., 2015). Even the simple inclusion of language supporting LGBTQ students in school policy has been shown to be effective at mitigating social stress in school (Estell et al., 2015). Social integration and engagement are the most common factors associated with strong mental health for LGBTQ people, and the most commonly cited intervention for youth to enhance these two factors are gay-straight alliances (Cahill et al., 2013). GSAs can improve the sense of physical safety and increase a sense of belonging to the school community, both of which are associated with better mental health (Cahill et al., 2013). Accepting LGBTQ adolescents, both interpersonally and structurally, is associated with greater physical and mental health for them; *predicting* higher self-esteem, social support, and general health status in addition to *protecting* against depression, substance abuse, suicidal ideation, and suicide attempts (Drott et al., 2016). Structural factors like the adoption of pro-LGBTQ public policies have a strong base of evidence in the literature for improving the mental health of LGBTQ people of all ages. State same-sex marriage policies are associated with reductions in suicide attempts among LGBTQ adolescent youth (Austin et al., 2017), although it is unclear whether such beneficial effects extend to rural areas, where some fear pro-LGBTQ policies may increase social homophobia (Fisher, Irwin, & Coleman, 2014).

Access is another issue, especially for rural transgender individuals who may lack ready access to appropriate services. Even if there are providers available, small community practices can be hostile to LGBTQ people. Telemedicine has been suggested for LGBTQ people who experience difficulties accessing equitable health care so they can engage with a preferred provider with whom they feel safe and free from stigma (Bockting et al., 2014). The literature suggests rural mental health professionals can attempt to minimize the risk to their vulnerable clients by obtaining informed consent, thorough documentation, setting clear boundaries, paying careful attention to confidentiality, and getting involved in continuing education and consultation especially as it relates to LGBTQ mental health issues (Gallardo et al., 2010). Best practices for mental health professionals serving gender non-conforming people are accepting preferred names, being proactive about understanding preferred pronouns, understanding that identity is fluid and can change each meeting, maintaining focus on the reason for a visit as opposed to one's sexual identity, and separate discussions of sexual behaviors from identity (Drott et al., 2016).

Healthy identity tends to be found in socially integrated individuals bringing us full circle to mechanisms that can improve feelings of social integration, including pro-LGBTQ public policies, organizations bridging the LGBTQ and heterosexual communities, clear guidelines for support professionals servicing LGBTQ people, and school guidelines that combat bullying and harassment. If there is bias and explicit discrimination against a specific group then those who hold prejudices toward that group will view the experiences of discrimination as justified and invited due to membership. Changing hearts and minds is one thing, but providing tangible, relevant services to people most affected by the hearts and minds of mainstream society is extremely important in the interim (Chapman & Evans, 2014). The process of labeling and defining happens in tandem with the evolution of culture, so getting ahead of the wave is important considering health professionals are ill prepared

to deal with the LGBTQ community, let alone other identities coming to the forefront such as pansexual, intersex, and the evolution of being 'queer' (Drott et al., 2016).

CI.H Civic, Legal, and Economic Participation

To examine the economic contributions of the LGBTQ community in the United States, one of the best measures is their combined buying power or disposable personal income. According to The Association of LGBTQ Journalists (NLGJA), in 2015, the LGBTQ community's buying power was about $920 billion (NLGJA, 2016). Buying power represents the amount of money an individual has after tax and pension contributions have been made and is a measure of an individual's contributions to the economy. Witeck highlights three ways in which the LGBTQ community has seen an increase in its economic presence: workers, business, and consumers (NLGJA, 2016). However, small progress made in LGBTQ protection policies has led to inroads in the economic power of the LGBTQ community as a whole. With the shift in attitudes seen in millennials, consumers are now more willing to be loyal to businesses that are LGBTQ-friendly or equality-focused (NLGJA, 2016). While the combined buying power provides a decent overview of the economic standing of the LGBTQ community in the present, there are several issues still present. Justin Nelson, President of the National Gay & Lesbian Chamber of Commerce, points out that contrary to popular belief, the LGBTQ community is not any more affluent than the rest of the U.S. population and, in many scenarios, faces harsher economic penalties not always seen in income or wealth measures (NLGJA, 2016).

According to the Center for American Promise (CAP) and the Movement Advancement Project (MAP), members of the LGBTQ community are more likely to be unemployed, less likely to have healthcare, and more likely to be discriminated for housing (2015). The lack of LGBTQ rights can lead to an average of $3658 in additional healthcare costs for a partner, $3760 in additional income taxes, and $2525 lost via safety-net programs (CAP & MAP, 2015). The numerous economic inequalities and harms for LGBTQ individuals can be allocated to two major factors: lack of legal protection from discrimination and lack of LGBTQ family recognition (CAP & MAP, 2015).

Legal discrimination leads to two major impacts: higher costs and lower income. There are four ways in which legal discrimination leads to both higher costs and lower income: health care discrimination, credit discrimination, and refusal of accurate identity documents lead to both higher costs and lower income (CAP & MAP, 2015). As would be expected, employment discrimination leads to lower income levels while housing discrimination leads to higher costs for the LGBTQ community (CAP & MAP, 2015). The second major legal failure is the lack of family recognition. Lack of employer healthcare, limit access to government social programs and safety nets, unfair taxation, denial of Social Security benefits, lack of access to retirement savings, and the inability to inherit all lead to higher total costs and lower relative income levels for the LGBTQ community (CAP & MAP, 2015). These economic costs of a lack of legal recognition add up in a significant manner monetarily with some estimates approaching nearly $70 thousand over a lifetime (CAP & MAP, 2015). Unfortunately, these issues are amplified by the fact that 23% of the LGBTQ population lives in the thirteen states considered to be low equality states (CAP & MAP, 2015).

Societal Costs. From a purely economic standpoint, it does not serve anyone well for the LGBTQ community to be discriminated against. In a 2014 article for *The Atlantic*, Badgett highlights how much is lost when the LGBTQ community is discriminated against especially when considering the potential benefits that could be gained. Discriminatory policies are therefore best viewed as a doubled edged sword: not only are the policies creating harms for the LGBTQ community, they are also creating unnecessary economic costs for society as a whole while also removing the potential for numerous economic benefits at the same time. Perhaps most impactful for those who do not recognize the benefits of removing discriminatory policies is this: "… inclusive policies can boost a country's GDP [Gross Domestic Product]" (Badgett, 2014b). Depending on the type of discriminatory policy in play, the impacts can either directly or indirectly affect macroeconomic outcomes. Stigma can cause poor mental and physical health leading to lowered productivity in the workplace (Badgett, 2014b). Similarly, LGBTQ-targeted discriminatory policies can lead to loss of skill and knowledge causing a loss of construing members to the economy creating both a loss in productivity and a gain in welfare spending (Badgett, 2014b).

Businesses. Individual businesses stand to gain a plethora of benefits by supporting LGBTQ rights within the workplace. An examination of 36 studies on the impact of pro-LGBTQ policies on business outcomes found some probable and potential benefits that businesses may see. Some of the more likely benefits include better health outcomes, higher job commitment, and increased job satisfaction (Badgett et al., 2013b). When examining some of the possible benefits, there are several key incentives for businesses to move toward embracing the LGBTQ community within the workplace. Perhaps most importantly, little to no harms that come from embracing LGBTQ-supportive policies suggesting a move that is fairly low risk, high yield for businesses. The cost of supporting pro-LGBTQ policies is essentially limited to increasing health benefits for the partners of LGBTQ employees which is a relatively large initial cost (Badgett et al., 2013b). However, that initial cost is offset by the probability of increased production by healthy and committed LGBTQ employees (Badgett et al., 2013b). To better understand the relationship between LGBTQ-policies and workplace outcomes, the study examines the effects in two major categories: immediate and secondary.

Immediate and explicit effects on the workplace are two-fold. First, there is less discrimination in the business; however, perhaps most importantly is that LGBTQ employees found these organization level policies to be more impactful than state-level policies on discrimination in the workplace (Badgett et al., 2013b). As expected, support for LGBTQ protective policies is associated with an increased openness regarding LGBTQ individuals in the workplace (Badgett et al., 2013b).

The secondary or indirect effects are more numerous and bode very well for both LGBTQ individuals and the employing companies. The benefits gained by the aforementioned immediate effects help to maximize the indirect effects. First, and arguably most important, is an improved health outcome seen in LGBTQ workers in a LGBTQ-supportive workplace (Badgett et al., 2013b). Both in terms of physical and mental health, LGBTQ individuals have better health outcomes as illustrated by the difference in depression rates between LGBTQ workers in a nondiscriminatory workplace (26%) versus those in a workplace without LGBTQ protection (42%) (Badgett et al., 2013b). Furthermore, stress is vastly decreased when health benefits are provided for LGBTQ employees and their spouses – in turn, also improves workplace productivity (Badgett et al., 2013b). Another benefit is increased job satisfaction, an impact that is significant to both LGBTQ employees as well as the businesses for which they work (Badgett et al., 2013b). Workers who are more satisfied are more likely to be more productive and more creative in the workplace leading to increased outcomes for the business as a whole. An additional major benefit is an improvement in relationships with coworkers and management. In workplaces with LGBTQ-supportive measures in place, LGBTQ employees are more likely to be engaged, increasing communication among all levels of the organization (Badgett et al., 2013b). That increased communication and engagement leads to improved organizational outcomes and productivity. Finally, and for businesses, most importantly, LGBTQ-supportive workplace policies lead to greater job commitment by employees (Badgett et al., 2013b). Beyond the other economic and business

benefits seen with other policy effects, the increase in job commitment leads to greater organizational stability where employees are less likely to leave their job and more likely to put maximum effort into their work (Badgett et al., 2013b).

CI.I Religion

Religion and spirituality are essential aspects of identity for many Texans, including LGBTQ individuals. Like other Texans, LGBTQ people in Texas are often Christian, but many perceive themselves to be at odds with Christianity as practiced in the state. Many religious institutions have negative views of homosexuality, usually related to a few passages of scripture that seem to prohibit same-sex activities (Moon, 2014), and conservative religious ideologies tend to oppose homosexuality. For example, the following religions prohibit same-sex marriage: the American Baptist Churches, Assemblies of God, Church of Jesus Christ of Latter-day Saints, Islam, Lutheran Church-Missouri Synod, National Baptist Convention, Orthodox Jewish Movement, the Roman Catholic Church, Southern Baptist Convention, and the United Methodist Church (Masci & Lipka, 2015). Some major religions do, however, sanction same-sex marriage: the Conservative Jewish Movement, Episcopal Church, Evangelical Lutheran Church in America, Presbyterian Church, Reform Jewish Movement, Society of Friends, Unitarian Universalist Association of Churches, and the United Church of Christ (Masci & Lipka, 2015). While many LGBTQ individuals struggle with their religious or spiritual identity, and may no longer wish to affiliate with congregations within their faith, it, other LGBTQ people wish to continue to express their religiosity.

Religion and conservatism. Within the Bible Belt, religiosity and conservatism often go hand in hand. Many LGBTQ individuals struggle with conservative religious ideologies and fear the reactions of heterosexual community members for this reason (Drumheller & McQuay, 2010). One study looking at college students in the United States, Italy, and Spain found conservatism to be the most reliable predictor of attitudes toward LGBTQ individuals (Worthen, Lingiardi, & Caristo, 2016). The study suggests a significant link among conservative political ideology, biblical literalism, and sentiments toward LGBTQ people. Southern conservatism, especially, is strongly linked to religion (Swank, Frost, & Fahs, 2012). In Texas, 39% of adults self-identify as conservative, 32% as moderate, and 21% as liberal, with 7% choosing none of these (Pew Forum). While Texans are split on many social and political issues, those who are especially religious may also be especially conservative. In the religious, evangelical South, individual views are often mixed into politics, and political arguments against homosexuality are rooted in religious morality (Rhodes & Stewart, 2016). In 2012, Rick Perry, the former governor of Texas, said, "I'm not ashamed to admit that I'm a Christian. But you don't need to be in the pew every Sunday to know there's something wrong in this country when gays can serve openly in the military but our kids can't openly celebrate Christmas or pray in schools" (Etengoff & Daiute, 2015). Not only did Perry pose homosexuality and religion as antagonistic towards one another, he also used religion as a tool to oppose gays in the military. Religious people are more likely to oppose LGBTQ rights, and those who oppose LGBTQ rights may feel or say that their own rights are being violated (Harrison & Michelson, 2015). Recently, laws have been passed in several Southern states to ensure "religious freedom," by allowing discrimination against LGBTQ individuals (Rhodes & Stewart, 2016).

Religious perspectives opposing LGBTQ identity. Sociologist Dawne Moon describes multiple negative perspectives on homosexuality. There is the "God Hates Fags" view, which posits that same-sex attraction is simply evil. In this framework, LGBTQ people may be kicked out of communities and isolated (Moon, 2014). In the Bible Belt, which is often staunchly religious and evangelical, Christianity is an expectation and LGBTQ people are seen as an out-group who are sinful, unnatural, and against traditional beliefs (Rhodes & Stewart, 2016). These beliefs are clearly negative toward LGBTQ people and can take on the form of "God Hates Fags" or other negative perspectives. There is also the "Love the Sinner, Hate the Sin" view. This perspective claims that same-sex behavior is sinful, but does not condemn the individual sinners because all people are sinners. This view may present homosexuals as having chosen their sexuality, experiencing some pathology, or having

an inherent disposition that is presented in a sinful way. They could also view this outcome as the result of parental behavior and may promote ex-gay therapy. This is the perspective commonly adopted by the Roman Catholic Church, which sees homosexuality as a fixed characteristic, but believes that homosexual behavior is a choice. To the Catholic Church, this is not necessarily any worse than any other sin (Moon, 2014). There are also more moderate views that may still promote homonegativity. The "We Don't Talk About That" view simply does not acknowledge homosexuality, which could allow for homonegative attitudes and cause LGBTQ people to be essentially invisible in their communities (Moon, 2014). The "They Can't Help It" view can be a more positive perspective, but it relies upon the innate nature of homosexuality and portrays it as something negative that cannot be helped (Moon, 2014). Moon presents a standardized range with which to view negative perceptions of homosexuality.

Well-being within religions. Religion is generally thought to have a positive impact on well-being, but these effects may be different for LGBTQ individuals. The different forms of opposition to homosexuality have both internal and external effects on LGBTQ people. Individuals experience conflicts in their communities, which then have an impact on their individual sense of well-being and belonging. The most significant impact of these external conflicts is on mental health.

Benefits and detriments of religiosity. Religiosity generally helps to protect individuals against poor mental health outcomes (Gibbs & Goldbach, 2015). In fact, in the general population, religiosity may promote healthier lifestyles and delayed mortality. It may also be associated with decreased risky sexual behaviors among HIV-infected people (Jeffries, Okeke, Gelaude, Torrone, Gasiorowicz, Oster & Bertolli, 2014). Broadly, religion should positively impact mental health. However, religiosity is also associated with homonegativity, as is evident by the discrimination against LGBTQ individuals (Gibbs & Goldbach, 2015). Therefore, religion has the potential to be both a source of stress and a source of support, depending on individual experiences (Lytle, Luca, Blosnich, & Brownson, 2015). According to a study on LGBTQ college students, some religious affiliations were associated with greater odds of passive suicidal ideation than others—Jewish students were less likely than Christians to demonstrate "wishing it would end," "wished they were dead," or lifetime suicidal ideation. However, atheist or agnostic LGBTQ students had higher odds of "wishing they were dead." (Beck, Rausch, Lane, & Wood, 2016). This would indicate that detrimental effects of religiosity could depend upon the religious experience of the individual.

There are also racial and ethnic differences in suicidal ideation that would contribute to religious experiences as well. Non-Hispanic white LGBTQ people who categorized themselves as "Other" racial groups were more likely to report suicidal ideation. Black and non-Hispanic white LGBTQ individuals more strongly reported suicidal ideation than Latinos (Lytle, et al., 2015). Race contributes to religion and complicates associations between religion and mental health issues. While religion has been shown to have an impact on mental health results, it can also be positive. High levels of cohesion generally indicate strong norms, possibly leading to better wellbeing. However, low levels of social cohesion indicate weak norms, which would allow individuals more freedom (Barringer & Gay, 2017). Therefore, it seems that there may be no set rule on the benefits or detriments of religion, besides evidence pointing to religious struggles for LGBTQ individuals.

External conflicts and abuse. LGBTQ individuals may suffer a broad range of issues within their religions. Sometimes, these are internal conflicts regarding their beliefs. Other times, however, these are external conflicts perpetrated by people within their communities. Wood and Conley outline the different kinds of spiritual abuse that may take place for LGBTQ individuals (2014). First, LGBT individuals may struggle with the idea that their religious leaders are speaking the word of God. If a leader is denouncing homosexuality, it then seems like God is denouncing homosexuality (Wood & Conley, 2014). Leaders or peers may pressure or harass them to conform through spiritual bullying, or they may be neglected when they are in pain. They may also deal with sexual microaggressions from those around them. Problems within religious institutions exist at various levels. Some problems are inherent in an institution and are then established within a community, while others are more individual (Etengoff, 2016). These problems, however, are clearly linked. Institutional issues

impact individuals. Religious conflict over homosexuality is also linked to family conflict. Generally, more religious people place more emphasis on family, but also have difficulty accepting their LGBTQ relatives (Etengoff & Daiute, 2015). In a qualitative study on family support for LGBTQ youths, seven LGBTQ adolescents were interviewed. Each of the seven youths saw religion as a barrier to gaining acceptance from their parents and many chose not to go back to church as they became aware of their sexuality (Roe, 2017). External conflicts within religious groups impact the lives of LGBTQ individuals and often cause internal, individual issues.

Individual struggles. External religious conflicts, such as those described above, are often related to internal conflicts. Significantly, these religious struggles are often linked to poor mental health. Homonegative religious views, as described by Moon, can have negative mental health results on individuals (2014). LGBTQ individuals experiencing spiritual abuse may experience stress, anxiety, depression, or suicidal ideation related to religious experiences (Wood & Conley, 2014). For a sample of bisexual Latinos, religiosity was found to be positively correlated with homonegativity, high levels of loneliness, higher frequency of violence and discrimination, and lower condom efficacy. Minority stress is linked to low condom efficacy and HIV-risk behavior, meaning that mental health issues can lead to physical, sexual health issues for LGBTQ individuals (Severson, Muñoz-Laboy, & Kaufman, 2014). The study of college-aged students found that, across most religions, LGBQ students were more likely to report suicidal ideation than non-LGBTQ students (Lytle et al., 2015). These kinds of struggles occur across demographics. In a study of 44 HIV infected gay and bisexual men in which 28 participated in qualitative interviews, men discussed negative aspects of their faith. Sixteen percent (16%) believed that they could be open about their sexuality at church and 61% said that members of their community did not know they had sex with men (Jeffries, et al., 2014). Some of them viewed their sexuality as a sin or felt that their life experiences were punishment for their actions. Institutional religious struggles may lead individuals to have mental health issues and, therefore, poor sexual or physical health.

Prioritizing conventional faith over sexuality. One possible outcome of religious or spiritual struggles is rejection of sexual identity (Wood & Conley, 2014). This means that some LGBTQ individuals may attempt to repress their sexuality in order to fit into their religious community, which may reject their sexuality. This may result in the use of reparative, or conversion, therapy, which is generally harmful to LGBTQ individuals and can exacerbate mental health issues. The "ex-gay" movement encourages religious people to welcome LGBTQ individuals into their communities and help them move past their perceived sin. An ex-gay ministry called New Hope Ministry focused on the connection between religious and sexual conversion, using faith as a tool to rid individuals of homosexual behavior (Erzen, 2006). According to Erzen, the tight community formed through such a ministry can actually provide a sense of camaraderie and unity. Erzen takes a more positive position on the "ex-gay" movement than many other scholars, describing it as an incomplete form of conversion with a focus on religious growth and belonging. However, the suppression of sexuality is generally a negative experience, which contributes to poor mental health (Jeffries, et al., 2014). Identity conflict, which may occur when individuals suppress their sexuality, is associated with depression and higher rates of suicide (Gibbs & Goldbach, 2015). Some people fight against their sexuality and some simply feel that their religion is a higher priority. However, this suppression automatically exists under the assumption that sexual identity and religious identity are in conflict with one another.

Compartmentalizing faith and sexuality. Perceiving them to be in conflict, some LGBTQ individuals may compartmentalize their religion and their sexuality. Within religious communities, they may "pass" for straight in order to maintain their position in the community (Rhodes & Stewart, 2016). This pressure to perform in a certain way may come from broader communities or religious institutions. LGBTQ people may act in culturally desirable ways because they fear religious leaders or their communities (Wood & Conley, 2014). Additionally, they may not feel comfortable expressing their individuality because of their group identity. If LGBTQ people are unable to reconcile the faith and sexuality aspects of their identity, they may experience internalized conflict and compartmentalize or suppress their sexuality (Rockenbach, Lo, & Mayhew, 2017). Religious struggle can lead an LGBTQ individual to essentially live two separate lives: they keep their identities separate, leading to

negative mental health outcomes (Wood & Conley, 2014). In a study looking at behaviorally bisexual Latino men, some men were unwilling to identify themselves as bisexual in interviews (Severson, et al., 2014). Even within an LGBTQ-affirming church, it is possible to prioritize religion above sexuality. Working class lesbians at Faith Church, a small, evangelical church in a Southern city, avoided talking about their sexuality within the context of faith and many hid parts of their identity outside of this space. Some even attended another church after services in order to maintain their positions within their faith community (McQueeney, 2009). Despite accepting themselves, they minimized their sexuality within the exterior context of faith.

There is a wide range of ways to suppress sexuality in favor of conventional religious identity. There is a common perception that sexual orientation and religion are incompatible, especially for Black same gender loving men (Lassiter, 2015). It can be difficult to separate individual sentiments from cultural perceptions, especially when one's family, church, and community have a negative view of homosexuality. The idea that the two facets of identity are incompatible has the potential to cause LGBTQ individuals to keep these identities separate. Through this outcome, LGBTQ people of faith still experience these parts of their identity, but completely separately.

Prioritizing Sexuality over Conventional Faith. Another possible outcome of religious struggle is the rejection of religion while embracing one's sexuality. LGBT individuals who cannot integrate their faith and sexuality may reject their faith, feeling that they must "choose one" and finding their sexuality to be a bigger priority (Rockenbach et al., 2017). Negative faith experiences can impact an individual's engagement with their faith. Many of the LGBTQ youths interviewed in a Pennsylvania study saw religion as an obstacle between themselves and their parents and chose to stop attending church (Roe, 2017). If an individual is raised within a religion that does not accept their sexuality, they may feel disconnected from their faith and may either not attend services at all or may practice differently (Jeffries, et al., 2014). LGBTQ people raised in faith may, therefore, feel a sense of conflict or shame and choose not to participate based on past experiences. In general, LGBTQ Americans are much more likely than non-LGBTQ Americans to be not religious, which could be related to a feeling that they are not welcome within traditional religions (Newport, 2014). Of course not all LGBTQ people were raised religious, so some may not even encounter this struggle. In 2016, Gallup found that more than half of LGBTQ adults are not religious, while 32% of the general population is not religious (Gates, 2017a). Whether or not they are raised in a religion, LGBTQ individuals in general are less likely to identify with a religion.

Integrating Faith and Sexuality. The final possibility for religious LGBTQ individuals outlined in this literature review is the integration of faith and sexuality. This can be done in multiple ways. Some LGBTQ individuals engage in religious or spiritual behavior that is not necessarily linked to a traditional religion. For example, among the 28 HIV-infected gay and bisexual men interviewed, 17 said that they communicated with a higher power; ten out of twenty said that God helped them cope with adversity, and eight out of twenty-eight expressed their spirituality in non-traditional ways (Jeffires, et al., 2014). It is not necessary to be a part of a traditional religion to communicate with God or turn to God in times of hardship. In fact, some of the men felt that God had been there for them when others had not. Another option is to remain a member of a religious group and embrace ones' sexuality as a person of faith. Fruist describes those who integrate their religion with their sexuality as never having felt that the aspects of their identity are conflicting (2017). In this literature review, integration of faith and sexuality refers to the act of allowing faith and sexuality to inform one another and exist together. According to Fruist, many of the people he interviewed felt that they had integrated their faith and LGBTQ identities a long time ago. Many had never had an issue with these identifiers or were able to dismiss contrary judgments because they simply believed those opposing them were wrong (Fruist, 2017). Some people who are in conservative churches may feel that their faith is integrated with their sexuality and may express this through trying to change the institution from within (Etengoff, 2016). People who have previously struggled with their faith may feel a need to reconcile their sexual orientation or gender identity with their religion. Three people interviewed by Fruist discussed overcoming identity crises related to their sexuality and faith (2017). One, Alice, converted from a fundamentalist Christian faith to Catholicism and then

joined an LGBTQ affirming Catholic organization. This allowed her to connect her faith and sexuality in a meaningful, spiritual way while also providing her with resources, community, and support (Fruist, 2017). Alice was able to find meaning in her faith and sexuality together, allowing her a nuanced sense of identity.

Religion and homopositivity. The homopositive perspective on religion posits that homosexuality can be a good thing and that the passages used to defend homophobia should be considered in context (Moon, 2014). Moon calls the first viewpoint "God's Good Gift." This perspective believes that same-sex relationships are intentionally created by God and are, therefore, natural and good. It sees homonegativity as a human fault and as against God. It does not see same-sex behavior as sinful, but it does rest on assumptions about being born gay, which Moon questions. The final perspective is the "Godly Calling" view. This viewpoint is newer and, therefore, rare. It focuses on the idea that same-sex activities can be "righteous choices" and that all human institutions, like sexuality and marriage, are inherently flawed. This argument is more activist-based and argues that standing up against unjust institutions can provide truth and clarity (Moon, 2014). As stated above, religion can be a positive factor in individuals' lives. It has been found to decrease HIV risk behaviors for HIV-positive people and can increase well-being by leading them to engage in better health behaviors. Positive treatment in religious organizations can increase gay and bisexual men's feelings of self-worth (Jeffries et al., 2014). Moon's categorizations suggest that it is possible to interpret homosexuality and gender variations in a positive way. This positive interpretation could lead LGBTQ people of faith to see themselves in a more positive way.

Inclusive religious communities. As of 2000, Texas had sixteen Metropolitan Community Churches, an LGBTQ-affirmative denomination, the third highest of any state in the U.S. (Kane, 2013). LGBTQ churches and inclusive mainstream churches can provide LGBTQ individuals with a community that allows them to be both LGBTQ and religious or spiritual. Fuist conducted 32 interviews with members of LGBTQ religious groups in Chicago and Seattle. For some participants, LGBTQ religious communities provided them with a kind of family that allowed them to fully be themselves (Fruist, 2017). When previous relationships related to faith fell apart, members of these religious groups were able to form new relationships, including romantic partnerships, which fulfilled their faith needs.

Many LGBTQ-affirmative churches or communities allow LGBTQ individuals to integrate their sexual and moral identities, rather than putting the two in conflict with one another. In this space, at least, they are allowed to be themselves. LGBTQ religious spaces may provide resources through queer theology, allowing them to combat those who use the Bible to condemn them (McQueeney, 2009). In some cases, these communities have also led members to social activism. However, Krista McQueeney focused on two cases, which show the accomplishments and failings of LGBTQ and LGBTQ-affirmative churches. She looked at Faith Church, an evangelical, 60-person church made up mainly of Black, working class lesbians, and also at Unity Church, a 550-person, middle class, white, liberal Protestant church, which was mostly heterosexual but gay affirming (McQueeney, 2009). Faith Church emphasized liberationist language and individual relationships with Jesus, while Unity Church focused on the New Testament and modeling oneself after Jesus. The affirmative churches described by McQueeney are only two examples of possible LGBTQ-supportive religious communities. However, they do represent the ways in which communities can be intended for LGBTQ individuals, or accepting of LGBTQ individuals. They also show the ways in which LGBTQ people of faith may struggle to juggle their faith and sexuality.

Complications within LGBTQ churches. Within LGBTQ churches, individuals have the opportunity to explore their faith in an accepting environment. However, many of the same problems that exist outside of LGBTQ churches also exist inside of them. McQueeney looked at some of these complications. In Faith Church, sexuality was often minimized and not spoken about. It was acknowledged that members were LGBTQ, but sexuality in any form was almost taboo, from the pulpit to post-church potlucks. To them, their Christian identity was the most important priority. This was, in part, an effort to legitimize the church within the African-American community in the area. In fact, some members also attended other churches and did not acknowledge that they attended Faith Church (McQueeney, 2009). This reflects previously mentioned efforts

by some LGBTQ individuals to compartmentalize their faith and sexuality; however, this issue is more focused on community perceptions of faith.

Even within the communities McQueeney studied, there was an effort to normalize sexual identities within the context of a heterosexually dominated society. Some members of Faith Church and Unity Church saw non-religious LGBTQ individuals as immoral and focused on the fact that they had "settled down." Churchgoers also used masculinity as a way to "normalize" themselves. McQueeney noted that working class black gay men, in the context of Faith Church, do not have many of the privileges of masculinity that middle class gay men do. However, Faith Church emphasized masculine authority as the natural order, referring back to Biblical literalism. Faith Church struggled to be seen as legitimate in the community and, over time, nearly every man in the congregation left, further delegitimizing the church. Church members also used motherhood as a way to normalize themselves. White lesbians used the narrative of a "good mother," but black lesbians did not use motherhood to define themselves in the same way. This is in part because the white lesbian women of Unity Church had the resources to be mothers and to identify as such. Finally, some churchgoers moralized their sexuality, feeling that it gave them a special ability to convert and save the souls of LGBTQ people (McQueeney, 2009). Being a part of an LGBTQ-affirming church does not necessarily mean that ones' problems with faith have disappeared; however, they do provide a space for LGBTQ people to openly reconcile their faith and sexual identity.

Limitations. It is important to acknowledge the many facets of religious and LGBTQ identity, and religious perceptions and identities are largely contingent upon race, gender, and location (Lassiter, 2015; McQueeney, 2009; Smallwood et al., 2017; Severson et al., 2014). Religious judgments and practices regarding homosexuality vary by faith and by demographic group. More research on religious or spiritual LGBTQ members of minority groups is necessary. Further, very little of the research discussed above looks at Transgender identity and faith, instead using the broad term "LGBTQ" or focusing entirely on homosexuality. This is also an area that would benefit from more research.

Moving forward: solutions and improvements. In general, LGBTQ people who seek faith would benefit from affirmative religious communities and general attitudes. Becoming educated on queer theology and various interpretations of the Bible or other religious texts could also be helpful. Change comes from within religious organizations. Therefore, it is also important that members and leaders of religious groups listen and learn about the needs of their LGBTQ congregants. Because religion is so entrenched in society and it is so difficult to dictate the actions of religious groups, it is important to provide exterior resources that can apply to religious LGBTQ individuals. It is also important to provide education to the general public that normalizes religious LGBTQ people.

CI.J Safety

Though LGBTQ rights have progressed in the last decade, violence against members of the LGBTQ community in the form of hate crimes still occurs today. These crimes cause a variety of compounding problems and negative outcomes for the victims of these crimes, as well as community members who may or may not know them. Because of this, a wide array of disciplines have sought to study how anti-LGBTQ hate crimes affect the community at large, ultimately aiming to find ways to improve systems to address the ever-present need for help.

The victims. Because the LGBTQ community is made up of a diverse group of people in terms of demography, it is important to understand whom the victims of anti-LGBTQ hate crimes generally are. In analyzing patterns of anti-LGBTQ homicides through the lens of victim selection, two patterns arose - "predatory anti-LGBTQ+ homicides were generally more likely than responsive homicides to involve white victims," while "gay bash victims were proportionately the least likely to be white" (Gruenewald & Kelley, 2014). Another racial

difference was found in how victims of anti-LGBTQ hate crimes view their experiences following the crimes. Meyer found that "low-income people of color sometimes downplayed the brutality of their violent experiences, [while] middle-class white respondents almost always highlighted the severity of theirs," which the researchers believed were tied to the expression of "entitlement concerning rights to their personal space" by middle-class white respondents but not by low-income people of color (Meyer, 2010). Such racial disparities in intensity of crimes may be reflected in other aspects of safety and victimization.

In addition to racial factors, gender identity can play a role in LGBTQ hate crimes. In an intentionally focused study, researchers looking at the hate crimes committed against transgender individuals in Los Angeles County found that "nearly all crimes based on gender identity were against male-to-female (MTF) transgender persons" (Stotzer, 2008). This finding, like the Gruenewald and Kelley study, suggests that not all LGBTQ individuals are equal when it comes to hate crimes. The distinction between MTF and female-to-male (FTM) transgender individuals is important to consider when thinking about both safety and the needs of transgender people in general.

The importance of place. Spatial analysis has produced some interesting results on hate crimes and safety. One study examined how marijuana use may be related to the prevalence of LGBTQ assault hate crimes in different neighborhoods. The analysis found there was "a significantly greater prevalence of marijuana use among sexual minority youth" occurring in neighborhoods with a high prevalence of LGBTQ assault hate crimes (Duncan, Hatzenbuehler, & Johnson, 2014). This relationship was unique to LGBTQ individuals, as further analysis showed that marijuana use by heterosexual youth was generally unaffected by the presence of LGBTQ hate crimes. The overall importance of this is that the link between place, safety, and drug use is an important way to look at issues related to the LGBTQ community, especially in a state as large as Texas. A follow-up study looked at how bullying may have been related to the number of LGBTQ hate crimes in certain neighborhoods, finding that "relational and electronic forms of bullying among sexual minority youths were significantly more likely to occur in neighborhoods with a greater prevalence of LGBTQ assault hate crimes" (Hatzenbeuhler, McLaughlin, & Slopen, 2015). As with the Duncan et al. study, these findings were not found to apply to heterosexual youth, thereby reinforcing the concepts that place is an important factor to consider when studying LGBTQ safety issues and their impacts.

Types of crimes. A systematic review of over seventy peer-reviewed articles found that "[gay, lesbian, and bisexual] individuals may be at increased risk for sexual violence victimization as compared to their heterosexual counterparts" (Rothman, Exner, & Baughman, 2011). Analyses of violent crimes against the LGBTQ community suggest differences between homicides committed against LGBTQ individuals and those against heterosexuals. In comparing the two groups, one study found that "anti-LGBT homicides were proportionately more likely to involve multiple offenders (42.7%) compared to average homicides (15.7%)" and that "less than 10% were linked to formal hate groups or extremist ideologies" (Gruenewald, 2012).

Mental health outcomes. In a meta-analysis of the effects of hate crimes on the mental health of LGBTQ individuals, a consistent theme arose - that "hate crimes are typically more violent than nonhate-motivated crimes and have more deleterious mental health consequences" (Hein & Scharer, 2012). Other studies have looked at the emotional and behavioral responses to LGBTQ hate crime victimization. One identified five *in terrorem* effects, finding "five principal themes [emerging] out of the surveys and focus group: shock; anger; fear/vulnerability; inferiority; and normativity" that resulted in "two related responses: behavioral change and mobilization" (Perry & Alvi, 2012). An analysis of the normalization of anti-LGBTQ hate crimes offered three recommendations: a need for "broader and more appropriate support to address the effects of abuse," "proper resourcing and support" for organizations that know the best ways to help, and "the formulation of safety policy [needing] to involve a broad range of LGBTQ+ actors and organizations" (Browne, Bakshi, & Lim, 2011).

Legal and societal responses. In 2009, Congress passed the Matthew Shepard and James Byrd, Jr. Hate Crimes Prevention Act, which offered an enhanced legal remedy to hate crimes. However, this federal statute does not apply to state-level policies. One legal scholar has stated that "as long as hate crimes continue to be a problem, a more complete set of state laws are needed to reinforce Shepard-Byrd" (Trout, 2015).

CII Populations of Interest

CII.A People of Color

A joint report created in 2015 by the Center for American Progress (CAP) and the Movement Advancement Project (MAP) examines the situation of LGBTQ people of color in the United States. The report found that one out of every three LGBTQ persons self-identifies as a person of color, while a another recent poll suggests that people of color in the U.S. are more likely than white Americans to identify as LGBTQ (Brown, 2017; CAP & MAP, 2015; Gates, 2012). Queer people of color face several unique obstacles to mobility and barriers to life satisfaction not encountered by their white LGBTQ peers.

Among survivors of anti-LGBTQ hate crimes, 60% identified as being a person of color (Wade, 2016). These crimes affect a large portion of undocumented queer people as well, with 17% of hate crime survivors report being undocumented (Wade, 2016). Latinos and African Americans are disproportionately represented, making up 28% and 21% respectively of survivors of LGBTQ hate crimes (Wade, 2016). Queer people of color can face discrimination and harassment anywhere for a number of reasons.

LGBTQ people of color, in particular LGBTQ people who are black, are at a greater risk for poverty than both straight people of color, and white LGBTQ community members (Akerlund & Cheung, 2000; Center for American Progress, Human Rights Campaign, & Movement Advancement Project, 2013). For example, 28% of the trans Latino population and 34% of the trans black population experience poverty (CAP & MAP, 2015). Further, 55% of the Native American LGBTQ population suffer from food insecurity (CAP and MAP, 2015). Level of education and socioeconomic status are two components causing social problems and emotional distress for ethnic minorities. Lower levels of education and socioeconomic status among Latinos, for example, can be attributed to problems with immigration, age, location, discrimination, lack of skill, language barriers, and inadequate schooling (Akerlund & Cheung, 2000). The same study found economic issues contribute to the reality that gay, black men lack opportunities for play, work, and love in both queer spaces and in mainstream society (Akerlund & Cheung, 2000).

LGBTQ people of color face barriers when trying to fit into mainstream, white social settings whether the space is queer or not. They are not as roundly accepted as white LGBTQ people in the mainstream, nor are they welcomed by them in predominantly white owned, queer spaces (Jones, 2010). One study in Chicago and another in Philadelphia found that queer spaces are not welcoming, and often hostile toward, black gay men (Jones, 2010; Philadelphia Commission on Human Relations, 2016). One respondent was accused of loitering and threatened with removal from an LGBTQ establishment with exclusively white patrons while simply waiting for a friend (Jones, 2010). The same respondents are either fetishized for sexual pleasure or viewed as undesirable in mainstream queer space, making dating problematic and socialization a draining experience (Jones, 2010). Queer white people may be sexual minorities, but they have the privileges and can follow norms of the racial majority. This creates a unique identity for the LGBTQ community considering it touts itself as all accepting, but practices rejection along the lines of heterosexism, racism, and gender expression with people of color as the biggest targets. There can be few places to fit in.

Queer people of color can experience conflict between their ethnic/racial and gender/sexual identities, although both can motivate involve from the communities to which they are attached (Akerlund & Cheung, 2000; Balsam, Beadnell, Molina, Simoni, & Walters, 2011). Racism can exist in predominantly white gay and lesbian queer communities, anti-LGBTQ attitudes can exist in racial/ethnic communities, and both can be experienced by queer people of color when navigating society at-large. Such discrimination can make it difficult to obtain resources, maintain sanity, and access support that can assist in constructing a healthy identity (Akerlund &

Cheung, 2000) Cooperative interaction with people outside of an individual's ethnic group are not frequent for many, and the LGBTQ community should not be expected to operate differently (Elias, Jaisle & Morton-Padovano, 2017; CAP, HRC, & MAP, 2013).

Minority stress, like racism, exists both in mainstream and queer spaces impacting dating, relationships, and social networks (Balsam et al., 2011). Being denied entry and receiving poor service in queer establishments and racism within social networks are common experiences for queer people of color, especially those that are black (Balsam et al., 2011; Jones, 2010), creating a toxic community for queer people of color (Balsam et al., 2011). Queer people of color are also underrepresented in diverse, public LGBTQ organizations because these groups often cater to and shape their ideas around the typical white gay male (Balsam et al., 2011). Harassment and even the knowledge that it might occur can prevent queer people of color from disclosing their orientation, further isolating them from the social world while internalizing negative attitudes (Balsam et al., 2011). Internalized homophobia shares a relationship with coming out, and is common in queer people (Schwartz, 2009). The most important factor influencing the comfort of coming out was the support of LGBTQ members and friends (Brooks, 2016; Schwartz, 2009). Making sure queer people of color feel safe, supported, and seen in their communities is crucial for the LGBTQ community at-large.

Black LGBTQ members are beginning to feel more comfortable with their sexuality in "straight" areas that are predominantly black as queer visibility increases and pro-LGBTQ policies such as marriage equality are adopted (Brooks, 2016; Paluk & Tankard, 2017). This new-found acceptance of queer expressions in communities of color allows black LGBTQ members to access spaces with which they are comfortable, rather than being forced into areas where their sexuality is accepted, but their race is not. Healthier queer identities of color can be both developed and managed leading to better physical and mental health outcomes (Brooks, 2016). One participant in a study by Brooks still attends a non-affirming church both because she does not want to be seen as "just gay," and to affirm her identity and culture (Brooks, 2016). Some communities feel LGBTQ identity can diminish ethnic authenticity (Elias et al., 2017). Research concludes that the most important part of identity management is community education that can allow queer people of color to have the safe and supportive space which their white peers take for granted (Brooks, 2016).

The term 'queer people of color' encompasses substantial ethnic variation and racial diversity. Traditional family values can play an integral role to sexual identity amongst LGBTQ Latinas and Asian-Americans. The Latino community emphasizes the family unit; the nuclear, extended, and distant families are all crucial members within the family system (Akerlund & Cheung, 2000). LGBTQ people may experience conflict between traditional gender roles, expectations and their sexual identity. Asian-American families are less likely to address homosexuality and the community can view LGBTQ identity as a rejection of traditional family values and gender roles (Akerlund & Cheung, 2000). Safe, educated, affirming communities are important to the social integration of queer people of color, but other diverse resources are needed.

Economic mobility and opportunity. *A broken bargain: Discrimination, fewer benefits, and more taxes for LGBT workers* (2015) found higher rates of unemployment amongst queer people of color than straight people of color (CAP, HRC, & MAP, 2013). In 2011, unemployment for nonwhite trans people was around four times greater when compared to the national unemployment rate. Unemployment rates for black trans people are approximately 2.5 times greater than white trans people. LGBTQ people of color are more likely to be subjected to background checks, biases in hiring and other discriminatory practices, in addition to experiencing harassment from customers and coworkers at a higher frequency (CAP, HRC, & MAP, 2013). LGBTQ workers of color often face obstacles when filing complaints. LGBTQ workers in states without explicit protections for identity and expression must first go through the Equal Employment Opportunity Commission (EEOC), which can have a long wait list and strict requirements for reporting discrimination (CAP, HRC, & MAP, 2013).

HR departments and even workplace programs addressing diversity and inclusion can be culturally illiterate, making it difficult for queer people of color to explain their experience (CAP, HRC, & MAP, 2013; John-Baptiste, 2014). Employee resource groups geared towards queer employees often lack the resources to confront cultural competence and racism resulting in many LGBTQ people of color getting involved with resource groups geared towards race/ethnicity as opposed to queer identity (John-Baptiste, 2014). LGBTQ workers of color are more likely to be paid less than other workers, have access to fewer job-related benefits, and are more likely to have positions without opportunities for advancement (CAP, HRC, & MAP, 2013; Douglas & Steinburg, 2015; John-Baptiste, 2014). A recent study conducted by Douglas and Steinburg (2015) found that lesbians of color had the highest wages, while wages for nonwhite LGBTQ men were lower. LGBTQ immigrants specifically lack workplace protections, the ability to formally claim unfair working conditions, or legal violations (CAP, HRC, & MAP, 2013). This is especially true for undocumented LGBTQ immigrants, who are unable to access health insurance through work (Movement Advancement Project, 2013). Resources are lacking for queer people of color in addition to the ability to earn a living through work.

Legal discrimination. The impact of legal discrimination on LGBTQ people is severe, and has consequences both for employment and access to health insurance. In both respects, LGBTQ people of color are worse off than the general population (CAP & MAP, 2015). The national unemployment rate is 8%, but LGBTQ people of color face higher rates with Asians at 11%, Latinas at 14%, and African Americans at 15% (CAP & MAP, 2015). Around 20% to 40% of homeless youth self-identify as LGBTQ with disproportionate numbers of African American and Native Americans; only 5% to 7% of the American youth as a whole self-identify as part of the LGBTQ community meaning queer youth of color can be particularly susceptible to homelessness (CAP & MAP, 2015).

Health care measures do not paint a better picture for LGBTQ people of color. Compared to heterosexuals, the LGBTQ population as a whole has lower health insurance rates; however, within the queer community, people of color suffer from even lower rates (CAP & MAP, 2015). Where white LGBTQ individuals have an 82% insurance rate, people of color have the following: African Americans with 74%, Latinos with 61%, Asians with 71%, and American Indians with 75% (CAP & MAP, 2015). Among those with health care, many LGBTQ people of color report discrimination from healthcare providers, ranging from physically abusive treatment to denial or refusal of care (CAP & MAP, 2015).

Another major concern is credit discrimination experienced by the LGBTQ community combined with the general difficulties people of color face in obtaining credit. With no federal law to protect the queer community from discrimination, there are little to no general protections from credit discrimination. Only 42% of African Americans have a bank account and are independent of alternative financial institutions compared to 77% of whites (CAP & MAP, 2015).

A final major legal obstacle is the difficulty in acquiring accurate identification documents. White LGBTQ members are more able (62%) to update legal documents like driver's licenses, whereas just 42% of African American respondents were able to update theirs (CAP & MAP, 2015). Only 7% of American Indian LGBTQ members and 16% of LGBTQ Asians were successfully able to update their birth certificate as compared to 25% of white LGBTQ community members (CAP & MAP, 2015). This becomes especially important when LGBTQ people of color seek employment or government assistance as both rely on proper and accurate documentation. Potential impacts include lower wages, unemployment, underemployment, or lack of needed government assistance.

School environments and queer youth of color. There are important issues preventing LGBTQ students of color from experiencing a proper and effective educational environment. Explicit discrimination is a primary barrier. In terms of verbal harassment, 47% of LGBTQ Latina students, 39% of Asian LGBTQ students, and 35% of LGBTQ African American students reported at least one instance of bullying for their sexual orientation, gender identity/expression, and race (CAP & MAP, 2015). Avoiding abuse is a natural response

leading to 57% of LGBTQ students of color stating that they have skipped school (CAP & MAP, 2015). Institutional discrimination, such as lack of school support systems, LGBTQ organizations/clubs, and issues within the juvenile justice system all serve as serious detriments to the wellbeing and educational attainment of LGBTQ students of color (CAP & MAP, 2015).

The top concerns for LGBTQ youth include family acceptance, coming out to family and friends, and bullying in schools (CAP, HRC, & MAP, 2013). LGBTQ students of color are at risk of experiencing multiple forms of harassment based on their gender identity, sexual orientation, race, and ethnicity. Nearly half of LGBTQ students of color report verbal harassment and fifteen percent of them have experienced physical harassment or assault based simultaneously on race, ethnicity, orientation, and expression (CAP, HRC, & MAP, 2013). Harassment and violence negatively impact young, queer people of color resulting in poor mental, physical and emotional health, poor education, and reduced job readiness (CAP, HRC, & MAP, 2013). LGBTQ students of color who are not engaged in school are also at greater risk of using poor coping mechanisms, getting expelled, suspended or removed, skipping, and being placed into the juvenile justice or broader correctional systems (CAP, HRC, & MAP, 2013). The CAP and MAP study (2015) found that LGBTQ students of color were more likely to be punished for minor offenses. School can be an unhospitable environment for queer youth of color, discouraging attendance. Many are pushed out by discrimination and violence to the streets, increasing the likelihood they will experience housing insecurity, and reducing their ability to experience well-being.

Conclusion. LGBTQ people of color are resilient, but their unique experiences are not acknowledged by queer, ethnic, and mainstream communities. They simply have more contexts to assimilate into, more trouble assimilating into them, and are more likely to experience harassment, discrimination, and violence doing so. Their underrepresentation damages the queer community and the organizations tasked with serving it. Deference to the experiences queer people of color have, and the knowledge those experiences produce, is important not just in words and gesture, but in concrete power and the ability to steer priorities of organizations serving the LGBTQ community. Board representation, positions as managers, coordinators, and directors, followed by diverse workforce representation in organizations serving the LGBTQ community and its priorities would be a good starting place. The LGBTQ community at-large needs to insert queer people of color in positions where their voices will not just be heard, but can be the final say in what gets done and how to do it. The LGBTQ community will be all the better for it considering the knowledge queer people of color have is absent in organizations serving it.

CII.B Rural Residents

Traditional narratives and research on queer Americans focus on those living in urban areas (Connolly & Leedy, 2007). The rural population is often overlooked and under-studied. Rural areas can be characterized as hostile and cruel in research—places to flee from in search of a better life in cities (Fahs, Frost, & Swank, 2013). LGBTQ people in rural contexts often find comfort with the way of life and enjoy the rurality of their identities (Kazyak, 2011). Individual satisfaction and subjective well-being tends to be equal between queer people in urban and rural areas, but some rural LGBTQ residents report higher or similar levels of subjective well-being, happiness, health, and work/life satisfaction (Bourassa, Galrza, Lane, & Shupp, 2017). The line of logic that seeks to free queer people from stereotypically oppressive, rural contexts further distances those who prefer the life from communities that may accept them (Hill & Weinke, 2013). Research often suggests that rural and urban queer residents experience similar levels of discrimination, but the lack of community, resources, and services in rural areas can intensify both the experiences of discrimination, and the stress associated with living in a context where it can be prevalent (Ball, Barker, & Dwyer, 2015). Researchers find

the common narrative of extreme violence and aggression toward rural queer people is not as common as it seems (Abelson, 2016).

Issues faced by queer people in rural areas include distance from urban spaces, hard-to-find and limited support networks, lack of privacy, increased exposure in the community, negative attitudes toward the LGBTQ community at large, and discrimination when accessing support resources (Bourassa et al., 2017; Cohn, Glass, & Stroup, 2014). The lack of resources combined with the hostility experienced when accessing them can create a unique experience of social isolation (Boone, Cohn, & Whiting, 2012; Anderson, Giunta, Grudowski, & Rowan, 2013). Queer people in rural space can report a bleak and inhospitable climate made worse by forced silence, isolation, and the fear of hate crimes (Fahs, Frost, & Swank, 2013). Trans community members in rural space experience the greatest levels of discrimination from the rural and LGBTQ community (Cohn, Glass, & Stroup, 2014; Galletly, Hermann, Hollander, & Turrell, 2012).

Population demographics. Nearly 30% of all Americans live in a rural area or small city (Harley, 2016). As of 2010, Texas had a rural population of 15.3% and 96.65% of its total area was considered rural (United States Census Bureau, 2010). According to the Williams Institute, there are 46,401 same-sex couples living across Texas, some of them in rural areas (Gates & Cooke, 2010). "Rural" can be defined in multiple ways. Generally, an area is classified as rural if it encompasses fewer than 2,500 people or is not included in an urban area (United States Census Bureau, 2010). Rurality can also be associated with a set of cultural characteristics. Rural areas are characterized by the strong role of faith and family - and therefore an emphasis on conformity and cohesion (Reeves & Quinn, 2009). There is a persistent loss of educated young people in rural areas as they migrate toward more resourced areas considering those who do not conform may be seen as a threat to the community (Ableson, 2016; Culton & Oswald, 2003). Rural areas tend to be conservative, have fewer social support services, and have less educated residents as a result, but they can be more connected and experience less crime (Dabelko-Schoeny & King, 2009). While these communities may be beneficial to those who are a part of them, LGBTQ+ individuals may be kept out of close ones.

Resources and services. Within rural communities, queer people often do not have the resources or services they need to thrive and lack the social and institutional support that they could have in urban areas (Hill & Wienke, 2013). Many LGBTQ individuals in rural areas travel long distances to access the resources they need (King & Dabelko-Schoeny, 2009). Vulnerable groups, such as the elderly, are in special need of certain services. Queer rural seniors identified housing, transportation, legal services, social events, and support groups as the most needed services and programs (Harley, 2016). Older LGBTQ individuals can be less inclined to access support services than younger ones and may not use services that are available due to stigma (Harley, 2016; King & Dabelko-Schoeny, 2009). If resources exist, it may be difficult to encourage queer people in rural areas to use them because some conceal their orientation or identity. Community resources do not last if they are not used. Social support plays a role in enabling the use of these services (King & Dabelko-Schoeny, 2009).

Lack of community. Queer people may not always fit into rural communities. Community, family, and religion work together to increase cultural cohesion in rural areas; LGBTQ people can have trouble in these areas (Culton & Oswold, 2003). Rural communities may not actually accept behaviors or beliefs that differ from their moral conceptions (Drumheller & McQuay, 2010). Tolerance often falls along the lines of expression. The queer people most commonly integrated into rural communities are generally those who can reflect the 'sameness' of the context: working class, white, and heteronormative (Abelson, 2016). Transgender men who can assert this identity seem to have the most success in rural areas, but this is only because they are difficult to identify in shared spaces – entrenching isolation (Abelson, 2016). Queer people in rural areas who do experience stereotypical rural rejection and resulting chronic stress are those who openly express their queer identity, those who do not present as traditionally masculine or feminine, and those who are not white (Bourassa et al., 2017).

Racism and racial exclusion can be common in predominantly white rural areas. Queer people of color can have the most difficult time integrating into the local LGBTQ community and the community at-large, especially if they are gender-nonconforming or transgender (Abelson, 2016). Heterosexism and discrimination in the social world and in services are the most prominent barriers to well-being faced by rural LGBTQ people and they are amplified when one presents as queer (Anderson, Giunta, Grudowski, & Rowan, 2013). The prevalence of felt stigma among some queer people in rural areas reflects the way judgment and hostility within communities may not always be overt (Fahs, Frost, & Swank, 2012). LGBTQ people may remain closeted and refrain from using available resources.

The most common survival strategy for LGBTQ rural residents is to keep a low profile (Boone, Cohn, & Whiting, 2012). Keeping a low profile when queer can be associated with social isolation. Transgender and gender non-conforming people, especially if they are not white, will experience greater levels of social isolation and receive less formal support in rural areas when living openly (Ball, Barker, & Dwyer, 2015). LGBTQ residents may be routinely cut out of their rural community if they choose to self-identify and fear rejection if they do not (Abelson, 2016). Feelings of isolation and the absence of like-minded individuals is a commonly reported issue among LGBTQ rural residents (Ball, Barker, & Dwyer, 2015). Rural residency and the subsequent exposure to higher levels of heterosexism was a significant predictor of both housing discrimination and property damage in one study (Fahs, Frost, & Swank, 2013). This is not to say that rural life is not desirable, but that the potential for discrimination is heightened when living openly. Being out is related to higher victimization, but it is also linked to higher self-esteem and lower levels of depression (Kosciw, Kull, & Palmer, 2015). The situation is lose-lose for queer people in rural areas – living openly leaves one susceptible to discrimination, or chronically fearful of it at a minimum, and being closeted worsens social isolation. They experience social isolation regardless of their decision to disclose.

The 'matrix of oppression' suggests race, class, and gender hierarchies will produce different experiences for someone who is white and lesbian, versus black and lesbian, and versus gay men (Fahs, Frost, & Swank, 2013). Rural gay men, for example, tend to experience more threats, fights, and homophobia than rural lesbians, but the literature simply finds that queer African American, Latino, and Asian American people face greater stigma and overt hostility about their sexual orientation than queer white people will (Fahs, Frost, & Swank, 2013). This is not just in heteronormative social settings, but within the LGBTQ community itself where queer people of color have reported racism in various domains such as the dating scene (Fahs, Frost, & Swank, 2013). *Minority Stress*, a recurring theme in the literature, speaks to the stress individuals experience when they are required to adapt intrapersonally, interpersonally, or in their environments (Fahs, Frost, & Swank, 2013). *Minority Stress* encompasses objective stressors, such as prevailing stereotypes, prejudices, and discrimination, but also deals with internalizations of these attitudes towards both themselves and their minority group (Fahs, Frost, & Swank, 2013). Minority stress impacts institutional engagement in rural life.

Discrimination in rural institutions. Social isolation does not stem from *being* queer, but rather from experiences of discrimination, or the awareness that to be discriminated against is a moment-to-moment reality. Discrimination and the constant threat of it have been found to impact institutional engagement in various arenas for rural LGBTQ people. The literature touches on this institutional reality in various arenas and comments on how it impedes social integration for queer people in rural areas.

Policing. There have been very few scholarly attempts to understand police-LGBTQ relationships in rural areas (Ball, Barker, & Dwyer, 2015). Some research has shown victimization of them through the interplay of the public and police. Rural police, for instance, may not respond if a queer resident is experiencing victimization, or they may target them (Ball, Barker, & Dwyer, 2015). LGBTQ people report being targeted by the police for being 'visibly queer' and for offending public decency when engaging in intimacy like hand holding (Ball, Barker, & Dwyer, 2015).

Rural officers tend to have more direct involvement with the community which can be a cause of concern for queer residents choosing to disclose their orientation or expression (Ball, Barker, & Dwyer, 2015). These issues compound when the LGBTQ person is not white because racism in policing happens more frequently regardless of context (Ball, Barker, & Dwyer, 2015). Indigenous LGBTQ residents are a special population that have received little attention in the literature, but is a great cause of concern for scholars working on LGBTQ experiences with police in rural areas considering the history of treatment of indigenous people by police in America (Ball, Barker, & Dwyer, 2015). There is a gap in the literature about the relationship of police to queer rural individuals, but we can clearly see how the threat of discrimination can isolate LGBTQ rural people from social engagement.

Education. Many young community members in rural areas report a refusal to attend school, and contemplate suicide due to experiences of harassment and ostracism (Boone, Cohn, & Whiting, 2012). Studies of education in rural areas suggest that young people are at an increased risk of experiencing violence and bullying, and can experience problems when coming out (Ball, Barker, & Dwyer, 2015). Verbal threats and homophobic statements are the most commonly reported experiences of explicit discrimination in some studies (Fahs, Frost, & Swank, 2013). Experiences of bullying can interact with academic success, but these effects can last for much longer than the school years (Boone, Cohn, & Whiting, 2012). Compared to young, queer people in other areas, rural LGBTQ youth are just as likely to be out, but tend to have a lower sense of well-being and lower academic success—in fact, outness is associated with GPA due to high rates of victimization and depression (Kosciw et al., 2015). Again, we find disclosure as the primary driver of experiences of social isolation.

Work. Lower income levels and fewer available jobs are issues for all rural residents, including queer people, but the persistent threat of discrimination at both work and home can strengthen these stressors for LGBTQ people (Lee & Quam, 2013). There is very little research that touches specifically on being queer and working in rural America. One study found that rural residency for queer people is a significant predictor of economic employment discrimination (Fahs, Frost, & Swank, 2013).

Researching rural contexts can pose significant challenges for scholars due to time, travel, and resource constraints. Understanding how discrimination functions in the rural work arena for queer people is crucial, but absent from the literature. The literature is clear, however, on the threat of discrimination having an impact on institutional engagement. The fear of disclosing, or the pressure of working in rural areas as openly LGBTQ contribute to feelings of social isolation.

Health. Logistically, like many living in rural areas, queer people may have trouble getting to a doctor and there may not be many providers nearby (Blosnich, Farmer, Jabson, & Matthews, 2016). Social support plays a role in enabling access to health care services, while limited access leads to poor health outcomes (King & Dabelko-Schoeny, 2009). Queer individuals are less likely to be insured, are less likely to be able to afford health services, and show lower rates of primary care utilization (Shaver, Stephenson, & Whitehead, 2016). Experiences of discrimination and the threat of discrimination can adversely impact mental and physical health in a number of ways. Queer youth in rural areas, for example, can experience greater levels of self-harm and attempted suicides (Ball, Barker, & Dwyer, 2015). One study found that LGBTQ students in rural colleges are at a higher risk for substance abuse, depression, and suicide if they are unable to form healthy support networks in these contexts (Cohn, Glass, & Stroup, 2014). Not disclosing one's orientation or gender identity has a negative impact on the physical and mental health of LGBTQ people, but to disclose in rural settings is to invite victimization and discrimination, or the fear of both at a bare minimum (Anderson, Giunta, Grudowski, & Rowan, 2013).

Concealment of one's sexual minority status limits access to resources that enhance one's social integration and improve mental health (Fahs, Frost, & Swank, 2013). A queer person living in a rural area may experience less property damage, employment discrimination, homophobia, overt discrimination, housing discrimination, and 'being chased' if they conceal their orientation, but this concealment is also linked to negative mental

health outcomes and greater levels of social isolation (Fahs, Frost, & Swank, 2013). Fear of disclosure in rural contexts can even impact how queer people talk about HIV, or their willingness to arrange HIV tests with medical personnel (Ball, Barker, & Dwyer, 2015). Living out, or closeted can result in social isolation and contribute to poor physical and mental health because of the absence of formal support networks in these areas and the potential for discrimination within existing networks, whether they are queer or not.

Higher rates of suicide attempts and poor mental health in general is associated with living in stressful contexts and is common for LGBTQ rural residents (Ball, Barker, & Dwyer, 2015). Rural queer people, unsurprisingly, were less likely to access mental health services due to both the stigmatization of mental illness as weakness and financial considerations (Ball, Barker, & Dwyer, 2015). People working in the helping professions in rural areas are more likely to harbor negative beliefs about queer people than those in urban areas (Boone, Cohn, & Whiting, 2012). Rural LGBTQ people who do seek help run the risk of being further stigmatized doing so. Research has found many mental health professionals do not know how to work affirmatively with the queer community and special difficulties have been reported exist when supporting gender non-conforming and transgender community members (Benson & Johnson, 2014). Rural transgender individuals experience significantly poorer mental health than rural lesbians, gay, and bisexual people (Ball, Barker, & Dwyer, 2015). Rural queer residents have been found to seek mental health services through informal outlets because of a lack of relevant mental health services and the fear of bias (Ball, Barker, & Dwyer, 2015). This is one of the most crucial areas because seeking support for experiences of victimization may be needed for queer people in rural spaces, but the people they need support from may further victimize them (Ball, Barker, & Dwyer, 2015).

Family. Research has not found a significant difference between rural and urban queer residents along the lines of familial and social supports (Lee & Quam, 2013). These same rural respondents, however, showed higher levels of guardedness when discussing their sexuality with their supports (Lee & Quam, 2013). Rural LGBTQ people still experience the threat of discrimination that contributes to social isolation when engaging with family, but the literature has found families that openly accept and support their queer members in rural settings can find similar rejection. Supportive families face challenges that run parallel to the queer members they support. These issues include being stigmatized for their parenting decisions, lacking informal and formal social supports within the community, and mental health professionals who question the acceptance of gender non-conformity or transgender identity when this type of support is sought. (Benson & Johnson, 2014). Supporting family of queer youth in rural areas can experience discrimination and isolation in similar ways and report lower levels of social connectedness to both the LGBTQ community and their rural one (Ball, Barker, & Dwyer, 2015). This is a big issue considering accepting family members can feel similar social pressures, fears of disclosure, can be discriminated against for openly accepting their queer family member, and can feel similar experiences of social isolation.

Elders. Queer seniors in rural areas face a range of issues stemming from their age, sexuality, and location. They tend to have worse health outcomes, less access to resources and support, economic issues, and safety risks (Harley, 2016; King & Dabelko-Schoeny, 2009). Lee and Quam estimate that there are 4-8 million queer members of the baby boom generation (2013). Many of them have experienced discrimination and grew up hearing that queer identity is a sin or a mental disorder (Lee & Quam, 2013). A 2001 Gallup poll indicated that support for queer Americans had slowly, but steadily, increased since 1977 (Newport, 2001). A 2012 poll showed a slight majority of American adults considered gay or lesbian relationships morally acceptable (Saad, 2012). The legalization of same-sex marriage across the country in 2015 also remains significant. Queer baby boomers have seen a distinct shift in their lifetime. Key groups continue their opposition including Republicans, those 55 or older, Protestants, residents of the South, and some men (Saad, 2012). Many residents of rural areas fit this description.

Many seniors choose to age-in-place, defined as “aging in one’s current, familiar setting” (King & Dabelko-Schoeny, 2009). This choice can be complicated for queer people in rural space. In a qualitative study on

elderly rural LGBTQ individuals, the authors identified the themes of transportation and distance, lack of healthcare choices and plans, the cost of healthcare, a fear of leaving home due to medical debt, and a lack of social support as reasons for these barriers to aging-in-place (King & Dabelko-Schoeny, 2009). Similar barriers can be experienced by heterosexual rural seniors, but fear of discrimination complicates concerns for queer people (Harley, 2016).

Healthcare. Queer seniors are at risk for health disparities such as depression or loneliness, high levels of victimization or discrimination, barriers to care, and limited federal benefits (Bourassa et al., 2017). These disparities affect physical and mental health and are further complicated by non-disclosure. In a study comparing supports for queer aging in rural and urban areas, Lee and Quam found that rural respondents reported lower levels of outness and indicated that they were more guarded about their sexuality (2013). This has implications for aging-service providers, as it indicates that queer seniors may be less likely to disclose their sexual orientation to providers (Lee & Quam, 2013). Many older LGBTQ individuals fear discrimination in their health care services and, because they live in rural areas, have few choices of providers (King & Dabelko-Schoeny, 2009). Rural adults are more likely to seek physicians outside of their geographic area and are less likely to receive preventative care (Harley, 2016). Transportation, then, is a primary issue. In terms of mental health, queer seniors in rural areas have more issues than their urban counterparts, tend to get worse treatment and may, again, feel the need to hide their identity (Harley, 2016). This fear of disclosure in health care settings indicates a need for more education for providers, greater general understanding, and comprehensive programs (Harley, 2016; King & Dabelko-Schoeny, 2009; Lee & Quam, 2013).

Financial security. Queer seniors in rural areas also tend to face a number of concerns regarding economic status and security, often in relation to health care. Respondents in King and Dabelko-Schoeny's study expressed fears of not being able to afford health care or transportation (2009). Queer seniors in rural areas are more likely have lower incomes compared to urban ones (Lee & Quam, 2013). Older LGBTQ individuals may also have financial worries linked to isolation and being unable to care for themselves. This is likely a concern for many rural individuals, but queer people also face discrimination and may not have family around to care for them (Lee & Quam, 2013). These worries may also be because of institutionalized differences: certain state and federal policies may fail to protect LGBTQ people equally (Lee & Quam, 2013; Harley, 2016). Like many rural residents, elderly LGBTQ individuals worry about their finances. Their worries, however, are further exacerbated by discrimination.

Community. Finding community is an issue for the queer seniors. LGBTQ seniors may not be welcomed into the larger community, although there are exceptions. Over half of the respondents in King and Dabelko-Schoeny's study said that they do not have close family or friends who they can rely on. Some are essentially alone and feel that they are isolated in part because of stigma, especially for those who are HIV positive (2009). Some queer people create a "family of choice" or a group of close-knit friends who serve in the role of family. Friendships and relationships with other LGBTQ individuals, too, can provide support (Lee & Quam, 2013). However, even within queer communities, elders may face ageism and exclusion from younger members (Harley, 2016). Fear of stigma may prevent them from openly forming even familiar communities. For seniors, this can mean that they have no one to turn to. For the most part, queer seniors in rural areas face serious obstacles to gaining effective care and support. Not only do they face problems that are expected for elderly people in rural areas, they also have an added burden of fear of discrimination based on their sexual identity or gender expression. Many LGBTQ individuals struggle to find a sense of identity in communities that may reject them.

Promotion of resources. Research suggests that the most important things for LGBTQ residents in rural areas are a match between one's personal needs and the resources available to them, but this interplay can change with the decision to disclose one's orientation, or not (Bourassa et al., 2017). To combat minority stress, some rural queer individuals may band together to create belonging and support (Fahs, Frost, & Swank, 2012). Promoting LGBTQ community centers, educating residents, forming support groups and training peer

advocates have the potential to build rural queer communities and improve mental health (DeMaria, Israel, Joplin, Ley, Smiley, Trott, & Willging, 2016; Drumheller & McQuay, 2010; Fahs, Frost, & Swank, 2012; Harley, 2016). Combatting discrimination is one thing, but wellbeing and satisfaction come down to disclosure and integration for queer rural residents (Anderson, Giunta, Grudowski, & Rowan, 2013). This suggests that the most effective method to help them is in building community for those who will experience, at a minimum, the persistent threat of discrimination which takes a toll on physical and mental health (Anderson, Giunta, Grudowski, & Rowan, 2013). Members of the queer rural community report lower protective factors, defined as a feeling of belonging and connectedness to various institutions, than their heterosexual counterparts (Boone, Cohn, & Whiting, 2012).

There are studies suggesting that groups and services embedded within existing institutions can help rural queer people. Gay-straight alliances in rural colleges for example have been linked with lower victimization and decreased suicide rates (Boone, Cohn, & Whiting, 2012). One of the most potent single factors found in the literature that specifically helps transgender youth, the most prone to negative outcomes associated with being openly queer, is the 'presence of an adult who is interested in their well-being and accepts them unconditionally' . (Benson & Johnson, 2014).

Affirming communities need safe, physical spaces for groups, meetings, and volunteer projects (Lee & Quam, 2013). Drumheller and McQuay researched how to best promote an LGBTQ Outreach Center in the Bible Belt (2010). Their study took place in a small city; however, the general community beliefs in this city reflect those found in rural areas. They found that the biggest struggles faced by the organization were 1) balancing the conservative religious ideology of the area, 2) handling finances and fundraising, and 3) providing resources to members without alienating those who give money (Drumheller & McQuay, 2010). The researchers suggest community education and engagement by creating an explicit internal identity and implicit external identity that is familiar in rural contexts to reflect struggles faced by rural service providers (Drumheller & McQuay, 2010). Leedy and Connolly suggest that programs should be based upon the existing strengths of rural communities (2007). They also call upon service providers to be cognizant of the needs of queer people by curbing their own heterosexism and homophobia (Leedy & Connolly, 2007).

Connecting queer people in rural areas to individuals and services is a task in and of itself considering how important concealment of sexual minority status can be to avoiding harrassment. Willging, Israel, Ley, Trott, DeMaria, Joplin, and Smiley looked at the process of coaching mental health peer advocates in rural areas. They faced challenges such as finding safe places to meet with queer individuals and systematic difficulties with bureaucracies (2016). Coaches often had trouble being continually available to educate the advocates; however, by the end the advocates were able to help each other (DeMaria et al., 2016). This study demonstrates some of the challenges in educating advocates, but also shows the benefits in taking such a step forward. Advocacy is important for strengthening LGBTQ identities by reducing the stress that living openly produces. They just need to feel safe.

The internet seems to be a safe place, especially for rural gay men, to speak about sexuality (Ball, Barker, & Dwyer 2015). Researchers have found online recruitment strategies to be effective if they use images that are relevant to the target population, monitor the performance of ads used to recruit, and modify the ads to meet recruitment needs (Bull, Dubois, Mustanski, Phillips, Prescott, & Ybarra, 2016). The ability for organizations to reflect both rurality and queerness is a theme that runs through successful outcomes found in the literature. A rural LGBTQ organization with the ability to reflect the culture of the surrounding community is a huge boon for queer people residing there.

Community claims to 'rural sameness' is one element in the literature that has been linked with acceptance of queer people and services (Abelson, 2016). This suggests that LGBTQ services need to be given freedom to assert pride in their queer community/identity, in addition to their rural one (Abelson, 2016). Integrating existing services into the community at-large is crucial because those who know an LGBTQ person are more

likely to support queer-affirming policies so connecting LGBTQ people and their families in rural areas is important (Kazyak & Stange, 2016). Pro-LGBTQ policies are a huge benefit to the mental health of this group and the safe by increasing support.

The literature suggests that both public and private arenas are imperative for reducing stigma in the surrounding community at large to negate internalized homophobia by exposing rural communities to queer residents and issues in a communal context through things like speakers, films, and classes (Bourassa et al., 2017). PFLAG, among other services, connects with the community, invites speakers, views films, holds classes, and is integrated with both rural and LGBTQ social networks across the US. Having the ubiquitous presence and pre-established network of a pro-LGBTQ organization, like PFLAG, is important in creating a safe, observable presence for rural queer residents, their supportive families, and members of the community who want to help.

Conclusion. A literature review looking at rural LGBTQ individuals is inherently limited. The literature looking at individual groups—such as transgender people, the elderly, youth, and minorities—is even more limited. For the most part, these articles used the broad term "LGBT." This ostensibly includes transgender individuals, but it does not always refer to the experiences of transgender people, which can be fundamentally different. Racial minorities may also experience discrimination in different ways from white individuals. For the most part, rural areas, including frontiers, are still primarily white (Harley, 2016). According to the Census Bureau, the state of Texas is 79.7% white, 38.8% Hispanic or Latino (who can be of any race), and 12.5% African American (United States Census Bureau, 2015). The needs of non-white residents living in rural areas remains relevant, despite their lack of appearance in much of the literature on rurality.

Concealment of sexual minority status and fear of disclosure can limit political participation in movements that strive for queer equality, so the perpetual fear of stigma creates the conditions that give rise to the fear of stigmatization (Fahs, Frost, & Swank, 2013). This is a cycle of misery that will recreate itself unless safe social integration of queer people in rural areas is a priority. The literature is clear that there is a lack of formal services available in rural areas and those that do exist often re-stigmatize queer people. Community engagement can be low due to fears of retaliation from both the rural community, and the LGBTQ community itself.

The important takeaway is that queer people in rural spaces do not all see happiness and belonging in urban contexts, but they find themselves isolated in the rural areas they call home. Difficulty being LGBTQ in these areas does not appear to be with rurality itself, but with the lack of a community prepared to accept the diversity found among queer people. The places that are accepting in rural areas may be difficult to find and LGBTQ people in rural areas run the risk of exposing themselves if attempting access. There are few gay bars, services specific to the queer community, and the services that are available to everyone can be hostile at worst, and misinformed at a minimum. Rurality, just like sexual minority status, is intricately linked to identity, and adapting existing services accordingly is a good first step.

CII.C Transgender People

The UCLA Williams Institute estimates that the population of adults 18 years of age and older who identify as transgender in Texas is likely more than 125,000 (Herman, 2014). The Institute also estimated that approximately 13,800 13-17 year olds in Texas would identify as trans if asked (Herman, 2014). The National Center for Transgender Equality's 2015 United States Transgender Survey produced the largest compilation of current data about the transgender population in the United States with over 28,000 respondents. Of all transgender people surveyed, approximately 33% identified "transgender woman" or "woman," 29% identified as "transgender man" or "man," 35% as "non-binary," while 3% stated "crossdresser" as their best fit (U.S.

Transgender Survey Texas State Report, 2017). There is significant gender diversity within trans and gender non-conforming identities. This same survey suggests it is likely that transgender people have a similar racial distribution to the United States general population considering white respondents were overrepresented (USTS, 2017). With regards to age, USTS (2017) respondents tended to be younger than the general population.

Protections. At the federal level, all government employees are protected against discrimination based on sexual orientation or gender identity/expression. No state protections exist for transgender (or queer in general) employees in the private sector or in state and local government (Lambda Legal, 2017). Several cities in the state of Texas have included gender identity in their non-discrimination or equal rights ordinances. Houston has provisions to prevent discrimination based on gender identity with regards to city employment and contractors, San Antonio protects against discrimination in housing and public accommodations, as well as for employment by the city or city contractors, while Dallas, Austin, and Fort Worth have these protections for private employment (Lambda Legal, 2017). There is no documentation of these laws being enforced. Without protections in place, transgender residents of Texas have no legal recourse for losing employment, housing, or access to public accommodations due to their identity.

Identity documents. Part of the transition process for many transgender individuals involves a name and gender marker change on identification documents such as driver's license, state ID, passport, or birth certificate. This change represents legal access and protection in spaces like restrooms and changing areas, reducing the amount of harassment trans people receive. The USTS (2017) indicates that only 9% of transgender residents in Texas have all of their identity documents reflecting their preferred name and gender marker, while 77% have no identity documents that reflect who they are. The national average is 11% and 68% respectively (USTS, 2017). It may be more difficult to get name and gender marker changes in Texas. Of those who did not have documents reflecting their preferred name, 42% cited prohibitive cost as the main reason they had not yet changed their documents; however there are many other reasons that transgender people face barriers to document change (USTS, 2017). There is currently no available gender marker or transition process for those who wish to legally transition to a non-binary identity, despite the fact that this status is estimated to constitute a third of the transgender population.

Numerous transgender professionals in Texas have indicated personal frustration with the system. There is precedent for legal gender and name change in Texas, but many judges are hesitant to grant them even though it is required (Bouboushian, 2016). The willingness of the court to grant gender changes often varies by county. More conservative, rural, or suburban counties are far less likely to grant name or gender marker changes to transgender individuals (Bouboushian, 2016). Court orders often require permanent and irreversible changes to a person's body before granting a gender change order (Texas Name Change for Transgender People, 2015). For most transgender people, this means hormone therapy and surgery. Neither is easily accessible. The process is lengthy, expensive and rarely covered by insurance. Such treatments are only available from certain providers, and often leave trans people sterilized (by way of long term hormone therapy or genital reconstruction surgery) before allowing them to formally change gender markers (Wright, 2016). Not all trans people can or want to transition medically. Current regulations are inadequate and put transgender people at risk of harassment.

Trans people who must present IDs that do not match their gender identity experience multiple problems: 32% reported being harassed, assaulted, denied service, or asked to leave an establishment due to the incongruence in one study (Herman, 2014). Identification documents that do not match gender identity or expression can also prevent transgender individuals from participating in any activity requiring identification, such as voting. A 2014 report from the UCLA Williams Institute estimated that almost 6,800 eligible transgender voters did not have identification that matched their gender identity or expression, and this figure is probably outdated, since the estimate was based on a low trans population estimate. The Williams Institute (2014) also stated that

older transgender people, trans people of color, youth, the poor, and those with disabilities experience these restrictions at higher rates, removing a significant amount of agency from these populations.

Income and legal employment. Trans people often experience discrimination in employment, including harassment, termination due to gender identity, restricted opportunities for promotion, and difficulty getting hired (Out & Equal Workplace Advocates, 2017). The USTS (2017) indicates that 17% of trans respondents in Texas were unemployed, and 34% were living in poverty. The national average is 15% and 29% respectively. Among trans people who have been employed in Texas 15% indicated they lost a job due to their gender identity or expression, 27% reported they had been fired, denied a promotion, or were not hired for the same reason. Thirteen percent (13%) indicated that they had been verbally harassed because of their identity at the workplace, 1% had been physically attacked, and 3% had been sexually assaulted. Twenty-two percent (22%) had been otherwise mistreated, reporting experiences such as being told to present their assigned sex to keep a job, being forced to use bathrooms that did not correspond with their identity, or having private information revealed by a supervisor or co-worker. Almost one-third of respondents in Texas experienced some form of mistreatment, ranging from being fired to derogatory comments. Nationally, 2% of trans individuals reported participating in sex work, drug dealing, or other criminalized work; 60% of this group were actively seeking legal employment (USTS, 2017).

Trans people who are employed or have been employed often take measures to avoid harassment and discrimination in the workplace (USTS, 2017). Seventy-seven percent of USTS (2017) respondents indicated they had taken one or more countermeasures against harassment in the workplace. The most common strategies are hiding their identity (53%), not asking for the correct pronouns to be used (47%), delaying transition (26%), or staying in a job they did not like for fear of a worse one (26%). The most common form of mistreatment in the workplace was inappropriate disclosure of private information by a boss or co-worker (16%). One respondent indicated that coworkers gossiped about them and this was a large source of stress, another left a high paying job due to disrespect and took a much less lucrative position solely due to the work environment, and another was fired for using the restroom that matched their gender identity (USTS, 2017). The Human Rights Campaign (2017a) suggests this discrimination limits access to healthcare, removes control over information about one's identity, and keeps transgender-specific protections out of the workplace.

Employee resources and workplace policy. The Human Rights Campaign (HRC) publishes a Corporate Equality Index (CEI, 2017) each year to rate workplaces on LGBTQ support and inclusion. Five indicators comprise the ratings: 1) equal employment policy includes sexual orientation and gender identity in all locations with vendors and contractors maintaining these standards; 2) equivalent benefits for same sex spouses and legal partners, including insurance and bereavement leave as well as trans- inclusive healthcare such as transition-related care, medical leave, no blanket exclusives, and explicit inclusion in policies; 3) LGBTQ competency training, resources, and accountability; 4) a public commitment to LGBTQ causes, including barring corporate philanthropy to anti-LGBTQ organizations; and 5) no major anti-LGBTQ blemishes (CEI, 2017).

The HRC (2017) asserts that the foundational step towards becoming an LGBTQ-supportive workplace is laying out explicit non-discrimination policies for the company (CEI, 2017). Sexual orientation and gender identity are not explicitly covered or regularly included under Title VII protections, which provides legal regulation against discrimination in employment and the workplace (CEI, 2017). Inclusion of gender identity within corporate protections has ballooned since the creation of the CEI; at its inception in 2002, only 5% of participants had gender identity included in worker protections. In the 2017 report, this figure is 96% (CEI, 2017). Corporate insurance policies that are trans inclusive have also rapidly increased from 0% of participants in 2002, 9% in 2010, to 73% in 2017 (CEI, 2017). The CEI (2017) notes that the presence of at least once trans inclusive health coverage policy is necessary for the health of transgender employees. The cost to include them is negligible to employers across industries. Available healthcare policies appear to be a good proxy for supporting trans inclusion and gender diversity acceptance in the workplace.

Being LGBTQ is not always a visible status, so extra effort must be made to give the community space and a voice in the workplace (Beauregard, Bell, Ozbilgin, & Surgevil, 2011). The presence of LGBTQ Employee Resource Groups (ERGs) can be a vital component of changing a workplace's culture. ERGs can provide a link between employees and management, a forum for discussing LGBTQ issues, and a support network for employees who may have difficulty building one. ERGs also can influence corporate accountability, encouraging LGBTQ employee needs to be met. Important factors for ERGs include a place to meet free from harassment, the ability to anonymously file complaints or comments, union representatives for LGBTQ employees, resourced ERGs for LGBTQ employees, inclusion of LGBTQ issues in the development of staff trainings, and bringing in external LGBTQ resources to help improve the organization (Beauregard, et al., 2011). The number of ERGs and similar employee groups has risen from 40% in 2002 to 88% in 2017 (CEI, 2017).

Underground economy. Almost 20% of USTS (2017) respondents indicated they had participated in the underground economy at some point, including sex work and drug sales, and 9% indicated they had done so within the past year. Six percent (6%) had participated at least once in sex work in exchange for food, 8% for a place to sleep, and 19% for money, food, or a place to sleep. Trans women of color, undocumented individuals, and those who had been fired due to their identity were much more likely to have participated in sex work. The report notes that although most sex workers were trans women (50%), others were non-binary people assigned male at birth (7%), trans men (19%), or non-binary people assigned female at birth (23%). Eleven percent of respondents had participated in the drug trade, suggesting that transgender people who experience extreme poverty and lack of resources are more likely to resort to criminal employment (USTS, 2017). Sixty percent of those currently engaged in underground employment indicated that they were looking for legal employment (USTS, 2017).

Criminal justice. Many transgender people have interaction with the criminal justice system. Trans youth, especially transwomen, experience greater rejection in family and school than other queer peers, exposing them to the school-prison pipeline and increasing the likelihood of incarceration (Sevelius, 2012). Even the current focus on bathroom use has the potential to exacerbate the high rates of arrest and incarceration experienced by the transgender community (DiGregorio, 2015). Trans people experience structural disadvantages in numerous domains in the US including greater levels of unstable housing, and they are more exposed and susceptible to interaction with the police, jail, and prison by proxy (Graham 2014). Many trans people become targets for police, especially when non-white, leading to incarceration. Trans people also experience discrimination in the courts because of stigma. One case involved a trans defendant convicted of sexual assault for not disclosing their identity to a partner, which led the court to rule that their sex was not consensual (Shay & Strader, 2012). Trans people are commonly assumed to be confused or deviant, yet their social situation is shaped by stigma positions and structural disadvantages.

Prisons and jails typically accommodate heterosexual, cis-gender groups by dividing their facilities between men and women. Research shows trans inmates may have to choose between the options of solitary confinement or conforming to a normative gender role by having their hair cut and getting assigned to facilities that mirror their assigned sex (Graham, 2014). In addition to discrimination, transwomen report high levels of sexual objectification from inmates and staff (Sevelius, 2012). Harassment of trans inmates is not always along transphobic lines. Black transgender women, once incarcerated, frequently experience abuse from other inmates and staff in the form of gender and sexuality policing, racism, and forced gender conformity euphemized as rehabilitation increasing transwomen's distress, suicidality risk, and worsening chronic stress (Graham 2014). Many transgender individuals have high levels of healthcare utilization, including drug treatment and antiretroviral treatment (Bazerman, Beckwith, Castonguay, Cates, Kurth, Kuo, Liu, Patrick, Peterson, & Trezza, 2017), access to which may be severely impeded access with incarceration. When received, the care that transgender inmates can secure is generally non-affirming, stigmatizing, and discriminatory (Shay & Strader, 2012)

K-12 education and transgender youth. Trans students in K-12 education and public facilities face an uphill battle with few resources or allies, without agency over their own bodies and experiences. Many gender diverse children are aware of their identity from a young age. The USTS (2017) reported that 96% knew their gender was different from the one assigned to them at age 20 or younger, 81% knew at 15 or younger (before high school), and 60% knew before the age of 10. Many of these young people also identified as transgender early on. Eighty-two percent identified with the label transgender by age 20, 53% had identified with this label by age 15, and 25% had identified this way at 10 years old or younger. Thus many children and youth need transgender specific care, support, and protections.

Of USTS (2017) survey respondents in Texas, 73% had experienced some form of harassment in school due to their perceived or actual gender identity or expression. Forty-nine percent had been verbally harassed or threatened, 24% had been physically assaulted, and 17% had been sexually assaulted in K-12 education due to their perceived or actual gender identity and/or expression. Fourteen percent experienced harassment severe enough that they left a K-12 school. Although it is abundantly clear transgender youth are vulnerable in K-12 schools, only four school districts in Texas have protections for students that include gender identity and expression: ISDs in Houston, Dallas, Ft. Worth, and Austin.

Current practice in affirming trans identities (Brill & Pepper, 2008) encourages parents and educators to let children have agency over their gender presentation and identity, including honoring name and pronoun requests. It is also encouraged that children not be steered into their assigned gender but rather allowed to explore and determine the nature of their own identities. Parents and especially teachers are encouraged to understand the difference between biological sex and gender identity, as this is integral to supporting a transgender child in an affirming manner. In K-12 schools, support can manifest as appropriate training for teachers and especially guidance counselors and therapists to understand how to support transgender students. Such supports include the availability of preferred name and gender options in school documents, a requirement of school employees to use requested pronouns and names of students, access to spaces aligning with gender identity, and affirmation of the child's sense of self (Brill & Pepper, 2008).

The presence of a gay-straight alliance (GSA) or similar LGBTQ support-oriented student group has been shown to have positive effects on the experiences of LGBTQ youth in high school (Vanderwalker, 2010). These spaces provide LGBTQ and cisgender heterosexual youth to congregate and create a supportive environment among peers. Legislation in Texas has restricted the nature and ability of students to create GSAs (Vanderwalker, 2010). Students are required by law to receive permission to participate in extracurricular activities, effectively giving parents a way to prevent their child from accessing resources or support. These policies also put children in a position in which they must "out" themselves to parents in order to access needed support structures of their peers. In situations concerning LGBTQ youth, it cannot be assumed that the parent will always act in the best interest of the child due to personal beliefs regarding sexual orientation and gender identity. Parents should be unable to impede access to resources that will help trans youth feel safe.

Financial and administrative support for LGBTQ students, as well as clear, defined policies, can assist trans young people (Vanderwalker, 2010). Having adult advocates for LGBTQ needs on campus and having policy and funds to maintain a safe and healthy environment can lead to long term changes in the status of LGBTQ students (Vanderwalker, 2010). Although some children may go through "phases" of atypical gender behavior, transgender individuals are often aware and able to understand their own identity; providing spaces for children to explore and have agency over themselves is integral to healthy development.

Previous research and practice has discouraged allowing children agency over their gender identities. Instead, children have been encouraged to accept and embrace the gender assigned to them at birth so as not to create "unrealistic expectations" (Brill, 2008). This is ineffective and serves only to alienate transgender individuals. It had previously been thought that what was then termed Gender Identity Disorder caused anxiety and

depression due to incongruity between the idea of self and reality, but professional norms have changed in light of better data. DeMueles, Durwood, Olson, & McLaughlin (2016) recently summarized the findings of several studies of youth who were allowed to socially, but not necessarily medically, transition. These children attained new names, pronouns, and potentially altered gender expression, and subsequently showed no increased signs of depression and only marginal *increases* in anxiety. The evidence of these studies suggests that it is not the identity of the child nor a mental disorder that causes high levels of anxiety and depression in trans individuals, but rather the reaction to them and the lack of support systems surrounding these children (DeMueles, Durwood, Olson, & McLaughlin, 2016). Educators, counsellors, and parents should understand that it is not the identity of the child, but rather the reaction of society to them causing the distress.

College and higher education. For many trans young adults, college and post-GED certification is the first time they have real agency over their lives, bodies, and orientation. For this reason, many young people explore their gender and sexuality when they begin post-high school education. Campus Pride, a national non-profit dedicated to improving LGBTQ affirming services on college campuses, lists several components on which they rate colleges. These include clear non-discrimination policies including gender identity and expression, coverage of transition-related health services in the student and employee insurance packages, gender inclusive housing options, preferred name policies, and trans-inclusive intramural sports policies (Beemyn, 2017). Seven universities in Texas have submitted scorecards tallying services, policies, and programming for LGBTQ students on campus and their scores hover around 1.5 out of a possible five stars (Beemyn, 2017).

Campus Pride defines *gender inclusive housing* as "housing in which students can have a roommate of any gender[.]" (Beemyn, 2017) This differs from co-ed housing in that it is oriented at acceptance and support of gender diverse individuals, rather than just allowing students to room together regardless of legal sex marker. *Preferred name policies* allow students to use a chosen first name in place of legal name on school documents and records. According to CPI, there are 159 campuses nationwide that allow this; 53 campuses allow students to change their gender marker on campus records without medical documents necessary to "prove" identity; six campuses currently allow students to indicate their pronouns on campus records, such as class rosters (Beemyn, 2017). *Trans-Inclusive intramural sports policies* includes any school that allowing transgender students to participate in intramural teams under stated school policy. Under a letter issued during the Obama administration, any school receiving federal funding had an obligation to use the preferred name and pronouns of students as well as to grant them access to gender segregated spaces, teams, and groups congruent with their identity. The letter also made it clear that schools could not segregate transgender students, require them to use certain bathrooms if it was not required of other students with the same gender identity, or bar them from participating in gender segregated activities corresponding with their identity. On February 22nd, 2017, the Trump administration removed the guidelines set forth by the letter. Although this had no effect on the law involved, Title IX of the Education Act Amendments, it retracted federal guidance and guidelines on the issue, giving more discretion to local and state government over the treatment of transgender youth in schools.

Campus Pride is also host to a Shame List, a list of universities nationwide that have applied for Title IX exemptions in order to discriminate against students on the basis of gender identity or sexual orientation (Beemyn, 2017). Texas schools occupy ten places on the list of 121 Shame List schools compared to only seven of 273 schools evaluated at one star (LGBTQ friendly) or better on the Campus Pride Index (Beemyn, 2017). Lending support to the negative nature of higher education experiences among trans individuals in Texas is the USTS (2017) report that 19% of Texas respondents have experienced physical, verbal, or sexual harassment because of their gender identity or perceived gender at colleges and vocational schools.

Healthcare. Transgender and gender diverse individuals have specialized and specific healthcare needs. Healthcare for trans and gender diverse individuals is not comprised solely of transition support services, nor should the focus of transgender health be transition-related services. All providers must be able to sensitively, compassionately, and competently provide care to transgender and gender diverse patients, especially pediatric doctors, therapists, and psychologists. Children are particularly vulnerable to medical mistreatment, and gender

diverse children are far less likely to receive competent gender related care. They also cannot seek it out on their own.

Gender Dysphoria, the prevailing medical definition for gender identity conditions listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM), focuses not on the identity of trans people, but on the distress of the individual. Even this definition has been criticized within the trans and gender diverse community because many trans people do not experience dysphoria, nor is dysphoria necessary to be considered transgender. Dispute on the nature of trans identity, scarcity of providers, and few sources of scientific information based on trans identities, have promoted non-uniform treatment and care standards for trans patients in past decades. The professional research group World Professional Association for Transgender Health (WPATH) has defined the standard of care since it was founded in 1979 in Texas, although its impact has been limited (D'augelli, Grossman, Howell, & Hubbard, 2005).

Insurance and accessibility of care. In Texas, one-fifth of USTS (2017) respondents indicated they experienced an issue with their insurance in the past year, including being denied coverage or treatment due to their identity. Almost one third (30%) indicated having a negative experience at a healthcare provider, such as verbal harassment, sexual or physical assault, refusal of treatment or having to teach a provider about transgender identities in order to receive appropriate care (USTS, 2017). There is currently no state law requiring insurers to cover transgender individuals or transition-related services; these are both incorporated under the Affordable Care Act (USTS, 2017). Those who are insured find that there are few or no providers in the accessible area offering transition-related care. No comprehensive, or even expansive database of providers offering transition-related or transgender-affirming services in Texas exists. Local and national resource pages exist, often listing a few providers across a state or metropolitan area, but many transgender people hear of friendly providers through word of mouth or have to travel long distances to access care (USTS, 2017).

Health impacts of discrimination, violence, and misinformation. Fourteen percent (14%) of respondents in Texas had a professional, such as counselors (religious or otherwise), therapists, doctors, etc., try to stop them from being transgender and 22% did not see a doctor despite needing to do so because they were afraid of mistreatment (USTS, 2017). Although the previously cited statistics in this section are not surveyed in the general population, 41% of USTS (2017) respondents nationwide experienced serious psychological distress in the month preceding completion of the survey, more than eight times that of the general population. Forty percent (40%) have attempted suicide in their lifetime, almost nine times the rate of the general population, and 7% had attempted suicide in the past year- almost 12 times the national rate (USTS, 2017). Those who have experienced a professional try to convince them to not be transgender experienced higher rates of psychological distress (USTS, 2017).

Transgender youth are incredibly vulnerable in all parts of their lives - home, school, and under professional care. Few caretakers, teachers, parents, or clinicians are skilled in supporting transgender youth, which can often result in inappropriate and harmful actions and/or lack of appropriate care. In a study of transgender youth in 2005, it was found that the younger and more gender nonconforming the child is, the more likely that child was to face physical and verbal abuse at the hands of their parents (D'augelli et al., 2005). The sample size of this study was too small to make conclusions about the rate of childhood abuse in gender diverse youth, and in the 12 years since the study the climate around transgender identities has changed dramatically (D'augelli et al., 2005). Although more information is available to parents and practitioners now, few youth receive optimal or even adequate care. Even though the WPATH Standards of Care indicate that best practices to support youth with gender dysphoria is to get timely medical intervention and therapy, only 0.3% of respondents in the USTS (2017) had been treated with puberty suppression medication.

"Reparative" or "conversion" therapy is also permitted in the state of Texas. Conversion therapy focuses on "changing" an individual's sexual orientation or gender identity through, often traumatic, therapies to heterosexual or cisgender identities. The Human Rights Campaign (2012) states that youth who experienced

significant rejection from parents or caregivers were eight times more likely to have attempted suicide, six times more likely to report high levels of depression, and three times more likely to use illegal substances or be HIV positive. All major medical associations have disavowed conversion therapy, stating that homosexuality is not an identity that needs to be cured. Transgender identities, while still tied to the diagnosis of gender dysphoria, are less safe from these methods. Of the associations' statements disavowing conversion therapy quoted by the HRC (2012), only a few identify gender identity, gender nonconformity, or gender presentation as separate identities from sexual orientation, and even fewer identified gender as something that should not be influenced or "corrected" by professionals as opposed to the specific mention of homosexuality. Trans visibility is, again, very important in order for them to receive the care and services they need.

Conclusion. The trans community is under attack from all sides right now and the Texas trans community should be a priority. Existing beneath all issues discussed in this literature review is US culture's passive acceptance of a biological basis for gender. An issue here is that one study found that exposure to the idea of a biological basis for gender can in fact *increase* prejudice toward trans people (Chong & Xu, 2017). Education, an often-cited vanguard for mitigating harmful ideas, has the potential to make prejudice toward trans community members worse. The current climate actively rejects trans people from the mainstream, queer space, and everywhere in between. The transgender community needs visibility and an amplified voice, but their voice needs to not just be heard, but be empowered to direct priorities and resources for organizations that service the queer community. There is an attempt to roll back the rights queer people have gained over the years and the trans community is the first target of these efforts.

CII.D Youth

School. LGBTQ youth experience difficulty deciding to be visible, and whether to disclose or withhold their queer identity. In one study, high school students discussed the ways that they scoped out how their peers felt about the LGBTQ community before making decisions about coming out or expressing aspects of their identity (Lasser & Tharinger, 2003).

While violence against the queer community appears to have seen little change since the 1990s, violence toward LGBTQ youth appears to have worsened (Lindquist, McKay, & Mirsa, 2017). Schools are not always safe places for LGBTQ youth, and they can get more stressful as queer visibility increases, leading to avoidance by those targeted. Negativity comes from both students and faculty (Thurlow, 2005). The 2012 National School Climate Survey stated that "56.9% of queer students reported hearing homophobic remarks from their teachers or other school staff" and "31.8% missed at least one entire day of school in the past month because they felt unsafe or uncomfortable." A study of school districts in Houston suggests that queer students should feel unsafe (Kann, Kinchen, Olsen, McManus & Vivolo-Kantor, 2011). These surveys found queer youth are more likely to be victims of physical fighting, to be threatened or injured with a weapon, bring a weapon to school, skip class *because they feel unsafe*, and experience bullying or victimization (Kann et al., 2011).

Following the publication of the National School Climate Survey, the Gay, Lesbian, and Straight Education Network conducted an in-depth analysis into bullying school districts' policies. This comprehensive analysis found that "less than half (42.6%) [out of 70.3% of districts with anti-bullying policies] enumerated protections for students based upon their actual or perceived sexual orientation," with "districts in the South [being] least likely to enumerate protections for LGBT students in their policies" (Greytak, Kosciw, & Kull, 2015). The lack of policies and reported bullying from students and faculty suggests a clear lack of protections that ultimately causes harm to queer youth.

Instituting policies with language explicitly protecting the safety of queer youth is crucial to creating a safe environment, but positive interactions with peers can also greatly improve the school environment for queer youth, and their cisgender heterosexual peers that accept them (Bartkiewicz, Boesen, Greytak, Kosciw & Palmer, 2012; Card, Diaz, Russell, & Toomey 2010). Gay-straight alliances or the implementation of small scale interventions led to a marked decrease in bullying at schools (Goodenow, Szalacha, & Westheimer, 2006; Kane, Walls, & Wisneski, 2010; Kann et al., 2011). Social support bolsters the negative mental health associated with being young and queer (Cotter, Evans, & Smokowski, 2014). Online support may help youth connect to social support, but having an in-person social support system resulted in a decrease in victimization occurrences (Craig & McInroy, 2013; Mitchell, Palmer, Reisner, & Ybarra, 2014). These findings are not exclusive to other queer youth, and their cis-heterosexual peers, but also the LGBTQ community at-large. Queer youth who have access to a role model they can communicate with in-person showed decreases in mental distress and suicidal tendencies (Bird, Garofalo, & Kuhns, 2011). This means working on transportation for queer youth who are socially isolated, LGBTQ adolescents in rural areas for instance, is crucial to maintaining a healthy queer community. It is important to make sure queer youth feel safe, secure, and that they belong to a community.

Push-out. The school can be a terrifying and stressful place to be openly or observably queer. Suspension or detention is often the result of public displays of affection among same-gendered peers, even if the affection is only rumored to have occurred (Fields, Hoenig, Russell, & Snapp, 2015). Queer often find themselves marginalized and *pushed out* of institutions tasked with facilitating their safety and mobility (Fields, et al., 2014). Young LGBTQ people instead have their safety and mobility siphoned through repeated exposure to the criminal justice system and legitimate avoidance of mobility-granting institutions, such as family and school, out of fears of safety, discrimination, or rejection (Fields et al., 2014).

Provisions such as anti-bullying laws, or punitive discipline in general, designed to protect marginalized groups like queer youth, can backfire by applying the idea of 'children being children' to aggressors. If the LGBTQ youth retaliates then they can be met with sanctions for violating the punitive anti-bullying and anti-violence structures designed to create a safe space for them (Meiners, 2015; Fields, et al., 2014). Even when not defending themselves, LGBTQ students can still easily become targets of school administration. A lesbian student deciding to come to school more 'butch,' for instance, may have the ability to intimidate her peers into leaving her alone, but school faculty respond with surveillance (Fields et al., 2014). Their poor treatment in school makes LGBTQ youth more likely to be charged with truancy, assault, and disorderly conduct. Some may bring a weapon to school for defense – if they decide to attend at all (Fields et al., 2014). All of these responses can land LGBTQ youth in juvenile detention.

Once inside the juvenile justice system, the poor treatment of LGBTQ youth often continues. Queer youth are overrepresented in juvenile detention facilities and are twice as likely to be detained for non-violent offenses such as sex work, and truancy (Fields et al. 2014). LGBTQ juveniles, like their adult counterparts, face a greater risk of experiencing criminal sanctions for alleged sex offenses such as statutory rape (Shay & Strader, 2012).

School is a place of concern for LGBTQ youth, but the home facilitates experiences with the criminal justice system in the form of high rates of rejection and resulting homelessness (Fields et al., 2014). LGBTQ youth get a bad reputation for 'hustling,' sex work, and engaging in the drug trade, but the offenses that land them in jail are often simply being homeless and on the street (Fields et al., 2014). Homelessness can increase the likelihood of ending up in the juvenile justice system (Fields et al., 2014; Frederick, Karabanow, Kidd, & Quirouette, 2016). When homeless youth get picked up by police, their parents who may not want them get called but often will not respond, with the result that they either spend time in jail. Alternatively, they may be put back into a home that actively rejects them (Fields et al., 2014).

LGBTQ youth who have been pushed out experience several compounding problems. School attendance is mandatory for people on probation, but avoidance of school or engaging in self-defense when attending can

be precisely what placed the student on probation in the first place (Fields et al. 2014). This process of compounding issues gets worse if a student has learning difficulties, is not white, is transgender, or gender non-conforming (Fields et al., 2014).

Health. Being young and queer can be tough. One study showed a "statistically significant elevation in cardio metabolic risk" among LGBTQ individuals who had suffered multiple stressful life events (Hatzenbuehler, McLaughlin, & Slopen, 2014). Stressful experiences encountered while young such as bullying or homelessness are associated with a variety of health issues, and contribute to a higher risk of complications as youth grow into adults. Health problems related to sexually transmitted infections have increased (Andrews, Fisher, Greene, Kuper, & Mustanski, 2015). Preventative care efforts for LGBTQ youth could be bolstered to reduce the impact of stressors on health.

Mental Health. One overview from researchers at the University of Texas at Austin addressed social, well-being, and political factors that influence mental health among LGBTQ youth. The analysis found a lack of "empirically supported approaches for working with LGBTQ youth across a variety of settings, ranging from schools and [community-based organizations] to clinical treatment" (Fish & Russell, 2016). In one study, LGBTQ youth were found to be two to three times more likely to be suicidal, perhaps due to stigma, discrimination, and victimization (Brent, D'Augelli, Friedman, Marshal, McGinley, Murray, & Smith, 2011). Conflict with family religion and LGBTQ identity, internalized homophobia, and religious upbringing can increase suicidal thoughts (Gibbs, 2016), while having a supportive social environment makes youth less suicidal (Hatzenbuehler, 2011). Gibbs suggests that growing up with anti-LGBTQ religious beliefs may resulted in the greatest amount of distress for adolescents (Gibbs, 2016). Youth have reported running away from home, even before they come out, because they fear even more rejection (Bassuk, Keuroghilian, & Shtasel, 2014; Fedders, 2006). Parents that react negatively to a LGBTQ child can force them from the home or cause them to run away (Bassuk, Keuroghilian, & Shtasel, 2014). Because of this lack of support, Gerard suggests that adolescents might feel safer if members outside of their family advocated on their behalf (Gerald, 2016). Some studies have highlighted an association between progressive same-sex marriage policies and a reduction in LGBTQ high school students reporting suicide attempts (Austin, McConnell, Moscoe, Raifmane, 2017).

Homelessness. Another problem that LGBTQ youth experience disproportionately is homelessness. A study conducted by the Williams Institute (2012) at UCLA estimated that "LGBT youth make up no more than 10% of [the] population segment, yet total 40% of homeless youth," with "nearly seven in 10 (68%) of respondents" citing family rejection as the primary reason for being homeless. A study about the needs and experiences of LGBTQ youth who are homeless found that they had been "homeless longer and [had] more mental and physical health problems than non-LGBTQ youth" (Choi, Gates, Shelton, & Wilson, 2015). One analysis reports that "high percentages of LGBT homeless youth...reported they dropped out of high school, largely in grades 11 and 12" (Bidell, 2014). San Antonio has one of the few homeless LGBTQ youth shelters in the country because of their unusually high suicide rate, but only admits 18-25 year olds, leaving those who have been pushed out of school to fall further behind (Wright, 2015). LGBTQ youth can experience discrimination in non-LGBTQ-oriented programs from staff who often feel unprepared to work with them (Berberet, 2006). Planning programs well in advance with particular care for the experiences of LGBTQ youth is suggested for any effort that targets them, or any organization claiming to open its doors (Berberet, 2006).

CII.E Seniors

LGBTQ seniors, whether they have lived openly or not, have experienced many difficulties in their lifetimes. (Giunta & Rowan, 2016). Older LGBTQ adults may have experienced regular police raids of LGBTQ

establishments and the HIV/AIDS epidemic, and have been viewed by the mainstream throughout their lives as sinners, deviants, pedophiles, criminals, perverts, sexually promiscuous, and drug abusers deserving of violence. The population of LGBTQ seniors is expected to double by 2030 (Krinsky & Porter, 2014). LGBTQ older adults experience higher levels of substance abuse, depression, social isolation, and suicide than heterosexual seniors (Hash & Rogers, 2013). LGBTQ seniors who are low SES, immigrants, gender non-conforming, transgender, bisexual, and non-white have experienced discrimination from both society at-large and from more privileged parts of the LGBTQ community itself (Ator, Ellis, Kerr & Milford, 2016).

LGBTQ people who are married have the greatest advantages in physical/mental health, social integration, are more likely to be out, and have greater socioeconomic resources (Bryan, Goldsen, Jen, Kim, & Muraco, 2017). LGBTQ seniors, however, have been unable to legally marry until recently. Non-Hispanic white LGBTQ seniors and transgender women are most likely to be partnered followed by lesbians, bisexual men, and bisexual women (Croghan, Moone, & Olson, 2014; Bryan et al., 2017). One study found half of gay adult men living alone and another found gay seniors are the most likely to be single. (Croghan, Moone, & Olson, 2014; Bryan et al., 2017). Another reported that gay men have a more difficult experience of aging than lesbians, in part due to societal pressures around masculinity and heteronormativity (Hash & Rogers, 2013).

Marriage access has been extremely important to the well-being of the queer community, but not without its drawbacks. An unforeseen issue caused by marriage equality is the assimilation of LGBTQ Americans into the independent, heteronormative fabric of US society. Marriage equality has helped produce lower concentrations of LGBTQ people in their own spaces, more difficulty sustaining social networks, further isolation, and loneliness (Ator et al., 2016). LGBTQ services tend to remain in these urban, formerly LGBTQ spaces furthering the difficulty older adults outside of those areas experience in accessing them, especially if they lack transportation (Ator et al., 2016; Fenkl, 2012). Many services to LGBTQ seniors are advertised in publications only found in businesses within LGBTQ areas (Ator et al., 2016), so available culturally welcoming resources may not be known (Goldsen, 2016).

The resources that do exist tend to be concentrated in metropolitan areas, whether they be LGBTQ or not (Ator, Ellis, Kerr, & Milford, 2016). Long-term and end-of-life services, for instance, are lacking for LGBTQ seniors and most often found in cities (Fenkl, 2012). A large amount of senior care is also faith-based posing particular challenges for many LGBTQ older adults as they age (Goldsen, 2016), since some denominations and faiths are not welcoming to LGBTQ individuals.

LGBTQ older adults experience the same psychosocial anxieties they have had throughout their lives in non-affirming spaces. Some debate whether to return to the closet or not when they move into a care facility to avoid the discrimination and poor treatment they have come to expect in the mainstream (Hash & Rogers 2013). Services for LGBTQ older adults often do not have the competence to ease this transition. Few service providers have had more than one hour of training on LGBTQ issues in the previous five years, and such training is often not offered at industry events (Croghan, Moone, & Olson, 2014).

LGBTQ seniors face health disparities because they are less likely to disclose orientation/identity, experience a lifetime of chronic stress associated with being stigmatized, and are less likely to seek medical care for fear of discrimination and the cost of services (Giunta & Rowan, 2016). Delaying medical treatment risks worsening conditions while increasing the cost to treat it, creating even larger disparities for queer seniors in health and economic resources (Giunta & Rowan, 2016). Delaying and avoiding care is common to LGBTQ people and this trend does not stop as they age (Hash & Rogers 2013). Not only does this impact healthcare utilization, but it motivates LGBTQ adults to remain invisible. Isolation results in a greater likelihood that LGBTQ seniors will be neglected by staff in hospitals, medical offices, nursing homes, senior centers, and social services (Hash & Rogers, 2013).

If queer seniors even have access to care, they can be reluctant to secure it out of fears of service denial and poor quality. These experiences are documented in interview data and in self-report measures from Canada, the US, and Australia (Croghan, Moone, & Olson, 2014). LGBTQ seniors simply do not believe they will receive quality care in aging services if their identity is known to the provider (Croghan, Moone, & Olson, 2014). Even when staff and other residents share beliefs with LGBTQ seniors, they may discriminate if it is disclosed (Croghan, Moone, & Olson, 2014).

Ageism and LGBTQ phobia. Marginalization of queer people compounds as they age because older adults are stigmatized (Acey, Goldsen, Guess, Jen, & Kim, 2016). Seniors in the US are marginalized through individualized processes like stereotypes and avoidance of contact in addition to structural disadvantages like discrimination in housing, social services, and employment (Achenbaum, 2015). American society values youth. LGBTQ seniors must contend with ageism in addition to the host of issues that come along with being an LGBTQ person in Texas - sexism, homophobia, femininity policing, racism, classism, xenophobia, and discrimination because of gender expression. One study suggests LGBTQ seniors feel 'twice hidden' because of their age and LGBTQ community membership (Hash & Rogers, 2013). LGBTQ seniors, however, experience layers of marginalization, of which age is a component (Sokolec, 2015). They are resilient, but they did not have much choice.

The LGBTQ community is also youth-centric. LGBTQ life and resources can center around young members, isolating seniors from a supportive community (Ator et al., 2016; Fenkl, 2012). Another way ageism leaves LGBTQ seniors invisible is by neglecting to inquire about sexual orientation and gender identity when gathering information about the senior population (Goldsen, 2017). These questions commonly appear in surveys targeting youth and middle-aged people (Goldsen, 2017). Ageism also negatively impacts youth by driving a wedge between young people and real-life role models (Ator et al., 2016; Goltz, 2014). Connecting LGBTQ older adults, not just with other seniors, but to the larger LGBTQ community is important. Having seniors speak on college campuses has been used to connect LGBTQ young adults with older peers in addition to highlighting LGBTQ aging issues in mainstream space (Bourassa, Galarza, Lane & Shupp, 2017).

There is a lived history of discrimination from both society at-large and from *within* the LGBTQ community for older adults who are nonwhite, gender non-conforming, transgender, bisexual, poor, and non-citizens (Hash & Rogers, 2013; Robinson & Ross, 2013; Goldsen, Jen, & Kim, 2017; Woody, 2014). More layers of marginalization will mean worse outcomes because the mainstream *and* the LGBTQ community can perpetrate discrimination. Seniors in these categories may feel more isolated, have worse physical and mental health, may be even more reluctant to seek care, and fear seeking community in queer people (Hash & Rogers, 2013). Bisexual older adults, for instance, will have experienced denial of their sexual minority status by society at-large and by the LGTQ community for their whole lives (Hash & Rogers, 2013).

The *threat* of discrimination acts on multiple layers including orientation, gender expression, race/ethnicity, citizenship, socioeconomic status, sex, and age (Giunta & Rowan, 2016). The literature suggests that LGBTQ adults are aging well, despite multiple layers of prejudice and structural discrimination, but disparities in health, economic resources, experiences of discrimination, and social isolation remain (Goldsen, 2014). LGBTQ seniors can feel disconnected from the contemporary LGBTQ community, feel vulnerable in their neighborhood, experience ageism and homophobia simultaneously, and are dealing with a lifetime of pain, trauma, criminalization, fear, and stigma (Hash & Rogers, 2013). Nonwhite seniors also can find resistance to their identity in the mainstream, indifference toward them in the LGBTQ community because of their age, can experience rejection in their community of color, and racism by the mainstream *and* the LGBTQ community. Alienation is an issue for LGBTQ seniors, but can be worse for people of color who have more communities to feel alienated from (Woody, 2014).

Around 20% of the estimated two million LGBTQ seniors are people of color and people of color are most likely to identify as LGBTQ (Acey et al., 2016; Gates, 2012). Psychological distress results from racism,

social isolation, and heterosexist discrimination so queer seniors of color experience it at greater intensities and for longer durations (Acey et al., 2016). Feelings of insignificance are found to be especially acute in LGBTQ people of color (Woody, 2014). LGBTQ people who are racial and ethnic minorities are more likely to be single creating further disadvantage in the realms of health, social integration, and economic resources (Bryan et al., 2017). They live with higher rates of chronic disease, impairment, mental health problems, obesity, and HIV even though two thirds self-report good health (Acey et al., 2016). Mobility issues associated with chronic stigma can compound through the persistent threat of discrimination influencing social engagement, and ultimately taking a toll on health (Giunta & Rowan, 2016).

Aging issues. Heteronormative markers of successful aging, like marriage, children, traditional college, and independence, have been difficult for LGBTQ people to attain. Inability to hit these markers influences internalized homophobia which is associated with lower self-esteem, mental health, and identity formation (Fabbre, 2015). The issues *within* the LGBTQ community also persist with age. Bisexual people can feel alienated unless they adhere to a gay or lesbian identity, trans people as minority members get cut out of the conversation due to differing needs and concerns between them and others, non-white community members can experience racism, etc. (Hash & Rogers, 2013). Adversity is part of the aging process.

A history of violence and discrimination can cause life-long mental and physical health problems (Hash & Rogers, 2013). Understanding what LGBTQ seniors have experienced is important. The LGBTQ rights movement rapidly progressed in their lifetime through the construction of the 'homosexual' in social consciousness as well as its attachment to mental illness, denial of assembly by police, gay liberation and feminist movements, the HIV/AIDS epidemic, increasing visibility of trans, bisexual, and queer community members, the shift towards civil rights and LGBTQ issues in mainstream political space, the sudden shift reversing these gains, and a lifetime of marginalization from both mainstream society and within the rapidly changing LGBTQ community itself (Bradford, Driskell,& Wagenen, 2013). LGBTQ older adults have experienced a lot of marginalization in their lifetime.

Coping with adversity is a primary characteristic of the aging experience. LGBTQ seniors are found to be resilient due to a lifetime of experience (Bradford, Driskell,& Wagenen, 2013). Three-fourths of Baby Boomer respondents held the belief that living as a sexual or gender minority has prepared them to better cope with aging in one study (Goldsen, 2014). Experiences that imbue LGBTQ older adults with resiliency have real physical and mental health consequences throughout life however (Goldsen, 2014). Understanding adversity functions in queer aging is important because there is a direct association between marginalization and poor health (Bryan, Emlet, Goldsen, Kim, & Shiu, 2017).

The highest levels of resilience among LGBTQ seniors were found in those who were out and had higher identity affirmation (Bryan et al., 2017). Some areas of research suggest open identification as LGBTQ can come coupled with greater self-esteem and life satisfaction (Bradford, Driskell,& Wagenen, 2013). The older the LGBTQ adult is, the more likely they are to have internalized sexual stigma, but the lifetime amount of victimization is actually lower for older age groups because they were and are less likely to disclose (Goldsen, 2014).

Resilience comes at a cost. Issues impacting LGBTQ seniors as they age include lack of protections from harassment, absent family medical leave, and medical decision-making for an ill partner (Anastas, 2013). LGBTQ seniors rely on elderly services more than heterosexual seniors do because of a history of disadvantage (Krinsky & Porter, 2014). LGBTQ older adults were structurally barred from securing the most common form of caregiving – a child or spouse (Krinsky & Porter, 2014; Dessel & Rodenborg, 2017). Issues like denial of transferrable spousal benefits through social security and the Veterans Administration increases the likelihood that LGBTQ seniors will live alone (Krinsky & Porter, 2014). Isolation can intensify for minority subgroups within the LGBTQ community. They experience aging differently because of structural disadvantage along

the lines of race, gender, class, citizenship, sexual orientation, and gender expression (Bradford, Driskell,& Wagenen, 2013). All of this leads to worse health.

LGBTQ seniors can resist and avoid utilizing healthcare (Ator et al. 2016; Goldsen, Kim, & Shiu, 2017). Access is important for those who are aging. LGBTQ seniors aging with HIV tend to experience early onset of comorbid illnesses including depression and are more likely to utilize care if they have access to case management services (Cahill, Ing, Karpiak, London & Seidel, 2014). LGBTQ baby boomers are thinking about gender transitions as trans acceptance and visibility increases in shared space (Fabbre, 2015). Transgender older adults experience reluctance to access physical and mental health care for the same reasons that LGBQs do, but the added barrier for trans seniors is the small amount of health care providers with enough knowledge to provide adequate care (Has & Rogers, 2013). This does not scratch the surface of the discrimination and stigma experienced by transgender people in healthcare (Hash & Rogers, 2013; Cahill, 2016). Even if they can find competent care, the cost of transgender health in old age can be a lot for an individual to afford (Hash & Rogers 2013). Medicalized surveillance and a loss of autonomy are common to the aging process (Woddy, 2014). Protecting LGBTQ seniors is crucial to ensure they do not become controlled by the very institutions that stigmatized them (Kia, 2015).

Senior Housing. A survey of nursing home directors in 2010 found 75% of respondents had less than one hour of LGBTQ cultural competency training on homophobia, heterosexism, and awareness in the previous five years (Krinsky & Porter, 2014). Agencies on Aging in the US (2014) found a lack of outreach to queer seniors, lack of relevant services for them, and a lack of staff trained on LGBTQ aging issues (Croghan, Moone, & Olson, 2014). Sixty percent of respondents in this study believed there was no need to engage queer issues and three-fourths assumed LGBTQ seniors would simply be welcomed at any facility without issue (Croghan, Moone, & Olson, 2014). Abuses of LGBTQ people in nursing homes range from denial of power of attorney to restricting visitors (Croghan, Moone, & Olson, 2014). LGBTQ seniors need safe spaces to enjoy the rest of their lives. Some theorists suggest a healthy LGBTQ aging experience is the one that acknowledges the futility of trying to exist within a mainstream, heteronormative context, like a nursing home (Fabbre, 2015).

Community belonging is one of the most common protective factors associated with better mental and physical health. Seniors can find difficulty getting competent service, so affordable, senior LGBTQ housing is a must when looking at ways to take care of them (Ator et al., 2016). Where one lives, their independence, and community integration are important for all seniors and should be a focus of assistance for LGBTQ older adults (Sokolec, 2015). LGBTQ people are often socially isolated and senior living communities work to decrease social isolation (Woody, 2016). Spaces designed intentionally for socialization, full time on-site case management services, and collaboration with local LGBTQ senior centers if they exist are suggested for senior living in order to create a family environment (Larson, 2016; Woody, 2016).

Fears of physical and financial dependence are common to LGBTQ seniors and one of the best ways to address dependence is with community building (Woody, 2014). Access is always a crucial factor so affordability of residing within a community needs to be a priority. LGBTQ senior housing is mostly accessible to those who have a lot of economic resources right now (Fenkl, 2012). The Montrose Center in Houston, Texas is an example of a community tackling issues related to queer aging through its Seniors Preparing for Rainbow Years (SPRY) program (Ator et al., 2016). This is a partnership with a federally qualified health center connected to the LGBTQ community, Legacy Community Health, to acquire grant funding in order to serve the needs of the city's LGBTQ seniors (Ator et al., 2016). They first emphasize community integration through weekly support groups and occasional social gatherings while case management and one-on-one therapy exist on the periphery of the social integration efforts, but are not mandatory (Ator et al., 2016). Connecting seniors to the LGBTQ community has a base of evidence combatting the poor mental and physical health that exists after a lifetime of discrimination and continued fears that it will happen. The Montrose Center makes integration a priority. The result was a decrease in feelings of isolation even for clients who opted out of individual therapy (Ator et al., 2016). LGBTQ seniors in this program rely less on clinical interventions and

more on monthly social events calendars that include peer support groups, congregate meals, and individual therapy (Ator et al., 2016). They also focus on using seniors as peer outreach workers to provide screening for depression/suicide/substance-abuse, supportive interventions, and to assist with community integration by accessing LGBTQ social and civic groups (Ator et al., 2016).

The role of informal networks. The chances that an LGBTQ person will live alone *increases* with age while the size of their social network *decreases* (Bryan, Goldsen, Kim, & Muraco 2017; Croghan, Moone, & Olson, 2014). Living alone and being socially isolated is found most often in transgender men followed by cisgender, gay men (Croghan, Moone, & Olson, 2014). One study found around a third of LGBTQ people 65 and older had children, but this number drops as their age decreases (Croghan, Moone, & Olson, 2014). Informal networks are important to all aging adults for securing support when needed.

One study focuses on the process seniors go through to secure support. They first rely on family, either spouses or children, both of which LGBTQ older adults have been barred from through marriage and adoption denial. They then turn to distant relatives if close family is not available. LGBTQ seniors can have issues with relatives, or may avoid them if they are closeted. A history of discrimination strains their ability to access the second common source of support. LGBTQ seniors often must rely on neighbors and friends. If these cannot be secured then they are exposed to potentially stigmatizing, often discriminatory formal community-based supports (Karpiak, Larson, Ing, & Seidel, 2014). Fear of nursing homes is common for aging adults.

One of the primary indicators that an older person will stay in their home or community is having a caregiver (Croghan, Moone, & Olson, 2014). Marriage denial and anti-queer adoption policies disenfranchised LGBTQ seniors by infringing on their ability to build care into their individual contexts while heterosexual people's ability to build it was subsidized (Croghan, Moone, & Olson, 2014). Eighty-five percent of family caregiving has been found to be done by wives, adult daughters, and daughters-in-law (Croghan, Moone, & Olson, 2014). Family is the most common source of care and LGBTQ seniors have often been rejected by family (Croghan, Moone, & Olson, 2014). Family caregiving is also a money saver so marriage and adoption denial has hurt the resources of both seniors and the LGBTQ community by proxy (Croghan, Moone, & Olson, 2014). One study reported that 64% of LGBTQ seniors reported only having a 'chosen family' to rely on (Croghan, Moone, & Olson, 2014).

LGBTQ seniors are less likely to find support from common sources like relatives, parents, and siblings because their networks often do not include them (Bryan et al. 2017). They tend to receive it from close friends and partners (Hash & Rogers, 2013). Only 10% of US caregivers are non-kin, but this rate is much higher for LGBTQ seniors (Croghan, Moone, & Olson, 2014). People with better health can build strong support into their network because they have greater social resources to help with integration (Bryan et al., 2017; Fenkl, 2012).

Access to support is one of the clear variables associated with good senior health and life satisfaction, especially for people of color (Acey et al., 2016). These supports are imperative as more than 40% of Hispanic and black LGBTQ seniors in one study lived at or below 200% of the federal poverty line as opposed to 30% for non-Hispanic whites (Acey et al., 2016). LGBTQ seniors of color further benefit from social network building because word of mouth most often connects LGBTQ older adults to culturally competent services (Woody, 2014). Strong networks are associated with greater social resources and these groups may benefit most from the mental and economic buffers (Acey et al., 2016).

Social network building is also important because LGBTQ seniors utilize their informal networks more than heterosexual seniors do (Goldsen, 2014). LGBTQ seniors seek advice, get help with personal matters, errands, emergencies, and receive emotional support from close friends more often (Goldsen, 2014). Social support increases the odds of coming out, reducing internalized homophobia while increasing healthcare utilization (Croghan, Moone, & Olson, 2014). The support of friends fights poor mental health and predicts decreased

anxiety, depression, and internalized homophobia (Hash & Rogers, 2013). High-risk alcohol consumption, for instance, is more common to LGBTQ people, but it reduces with social support (Bryan, Goldsen, & Kim, 2017).

The vast majority of respondents in one study who report having close friends also report having someone that will take care of them (Croghan, Moone, & Olson, 2014). LGBTQ seniors often lack adequate informal social-care networks to meet their needs (Brennan-Ing, et al., 2014). Even if they did, their networks would be filled with caregiving friends and neighbors. This does not just strain LGBTQ seniors, but also burdens the community and its allies (Brennan-Ing, 2014).

About two in five LGBTQ people have no partner or spouse leaving the bulk of caregiving to LGBTQ friends and neighbors (Croghan, Moone, & Olson, 2014). LGBTQ seniors can be twice as likely to be serving as caregivers than the general population, and they are rarely related to the person being cared for (Croghan, Moone, & Olson, 2014). Caregivers can be offered resources through various avenues, but avenues are often restricted to *legal* family (Croghan, Moone, & Olson, 2014). Marriage and adoption denial also impacts LGBTQ caregivers because seniors have had difficulty building care within their networks (Croghan, Moone, & Olson, 2014). Caregivers have constraints placed on their economic mobility, retirement security, social relations, work, physical/mental health, and time (Croghan, Moone, & Olson, 2014). They also report high levels of chronic stress; common to LGBTQ people regardless of social position (Croghan, Moone, & Olson, 2014). Stress experienced by caregivers reduces health and is linked to nursing home attendance for the person receiving care (Croghan, Moone, & Olson, 2014). Supporting the informal networks utilized by LGBTQ seniors is important for their health and the health of their caregivers (Croghan, Moone, & Olson, 2014).

Conclusion. *Caring and Aging with Pride* found that LGBTQ seniors, especially those of color, want services like senior housing, transportation, legal assistance, social events, and support groups (Acey et al., 2016). Socialization options can be more important to some LGBTQ seniors than competent counseling services (Brennan-Ing, 2014). Cultural events and volunteer work have been used to increase life satisfaction for LGBTQ older adults living in senior housing (Larson, 2016). Social support, the size of the social network, a positive identity, and engagement in physical and leisure activities are associated with better physical and mental health (Goldsen, 2014). These are all suggested features for LGBTQ senior living.

Exclusion can be common for LGBTQ people of color, especially seniors, and their needs should direct community priorities since all LGBTQ community members benefit from relevant services and socialization options. Spiritual resources are found to be greater among nonwhite LGBTQ adults (Goldsen, Jen, & Kim, 2017). Including spirituality in programming is suggested to create a welcoming environment for LGBTQ seniors of color that counters the poor mental health outcomes associated with greater lifetime experiences of discrimination (Acey et al., 2016). Programming that includes diverse cultural holidays, exploration of cultural histories, and inclusive messages/images fosters a welcoming environment that speaks directly to LGBTQ seniors of color (Acey et al., 2016).

Socialization cannot happen without a formal commitment to safe spaces. Any organization serving LGBTQ seniors should formalize a commitment to working through community problems of racism, sexism, and trans/bi/homophobia with board representation, positions as managers/program directors/coordinators, and specific language written into the mission statement, organization purpose, and staffing materials (Acey et al., 2016). This does the work of formally recognizing that LGBTQ seniors of color experience real and significant barriers like racism, poverty, and worse quality health and aging services not faced and rarely acknowledged by queer white people and mainstream aging communities.

LGBTQ seniors can be resistant to aging services like care managers, adult daycare, assisted living, or nursing facilities both because of a history of discrimination, and because they encounter staff that are oblivious to LGBTQ issues (Hash & Rogers, 2013). Mainstream society, and service providers for U.S. seniors commonly

overestimate levels of LGBTQ inclusion in various policy domains which is a significant issue considering various policy domains in fact impede LGBTQ seniors from securing quality care (Krinsky & Porter, 2014). Aging services are not competent if they believe LGBTQ seniors generally experience inclusion.

Among social workers, men and those who hold politically conservative beliefs are found to have the least support for pro-LGBTQ policy (Dessel & Rodenborg, 2017). Age competent and affirming practices are suggested for health care professionals working with LGBTQ older adults because issues of aging combine with LGBTQ issues (Hash & Rogers, 2013). Professionals are urged to understand the time period in which older LGBTQ clients lived, and to acknowledge the difficulties posed by aging while LGBTQ (Hash & Rogers, 2013; Desse & Rodenborg, 2017).

A social entrepreneurship approach, highlighted by Kidd & McKenzie (2014) has been successful to help organizations understand relevant community issues. The approach includes involving leaders and staff in community investment, organizational flexibility, using a leveraged approach to get better returns on health equity, to share a passion to tackle community problems, and to build social capital *within* marginalized communities. Social entrepreneurship hinges on action through interconnectedness to common goals and rapid implementation of solutions in order to drive resources toward the communities being served (Kidd & McKenzie, 2014).

One study of a cultural competency training program, Open Door, in Massachusetts found positive change by using evidence-based methods such as increasing elder care providers' knowledge of current laws and disparities surrounding queer seniors, bringing awareness to resources tailored to them, changing flawed personal beliefs like being oversensitive to the disclosure of sexual minority status, empowering service providers to confront homophobic and transphobic remarks, and bolstering understanding of how LGBTQ-specific programing is beneficial to LGBTQ seniors (Krinsky & Porter, 2014; Dessel & Rodenborg, 2017; Hash & Rogers, 2013). One key finding in this study is a *drop* in confidence of service provider's ability to serve the needs of transgender older adults after training, but this finding may be a result of exposing the provider to the extreme difficulties faced by the transgender community as they age (Giunta & Rowan, 2016). There is no standardized way to measure the effectiveness of cultural competency training so increases in knowledge, attitudes, or skills cannot be compared to any baseline competence (Giunta & Rowan, 2016).

APPENDIX D:
BIBLIOGRAPHY

2015 U.S. Transgender Survey Texas State Report. (2017, January). Retrieved from http://www.transequality.org/sites/default/files/docs/usts/TX%20State%20Report%20FINAL%20-%202.9.17.pdf

Abelson, M.J. (2016) 'You aren't from around here': Race, masculinity, and rural transgender men. *Gender, Place & Culture, 23*(11), 1535-1546.

Acey, K., Goldsen, F., Guess, A., Jen, S., & Kim, H. (2016). A collaboration for health and wellness: GRIOT circle and caring and aging with pride. *Journal of the American Society on Aging*, 40(2), 49-55.

Achenbaum, A. (2015). A history of ageism since 1969. *Journal of American Society on Aging*, 39(3), 10-16.

Acquaviva, K. D., & Krinsky, L. (2015). Bridging politics, policy, and practice: Transforming health care in Massachusetts through the creation of a statewide commission on LGBT aging. *Geriatric Nursing*, *36*(6), 482-483.

Akerlund, M., & Cheung, M. (2000). Teaching beyond the deficit model: Gay and lesbian issues among African Americans, Latinos, and Asian Americans. *Journal of Social Work Education*, *36*(2), 279-292.

Anastas, J. (2013). Policy, Practice and people: Current issues affecting clinical practice. *Clinical Social Work Journal,* 41, 302-307.

Anderson, K.A., Giunta, N., Grudowski, E.S. & Rowan, N.L. (2013) Aging well and gay in rural America: A case study. *Journal of Gerontological Social Work*, *56*(3), 185-200.

Andrews, R., Fisher, K.A., Greene, G. J., Kuper, L., & Mustanski, B. (2015). "Is this normal? Is this not normal? There is no set example": Sexual health intervention preferences of LGBT youth in romantic relationships. *Sexual Research and Social Policy,* 12(1), 1-14.

Ator, M., Ellis, C., Kerr, C., & Milford, J. (2016). Innovative approaches address aging and mental health needs in LGBTQ communities. *Journal of the American Society on Aging*, 40(2), 56-62.

Austin, S.B., McConnell, M., Moscoe, E., & Raifmane, J. (2017). Difference-in-differences analysis of the association between state same-sex marriage policies and adolescent suicide attempts. *JAMA Pediatrics*, 171(4), 350-356.

Badgett, M.V. L. (2014a). The economic case for supporting LGBT rights. *The Atlantic.*

Badgett, M. V.L. (2014b). The economic cost of stigma and the exclusion of LGBT people: A case study of India. *World Bank Group.* https://openknowledge.worldbank.org/handle/10986/21515.

Badgett, M. V. L., Durso, L. E., Mallory, C., & Kastanis, A. (2013a). The business impact of LGBT-supportive workplace policies.

Badgett, M. V. L., Durso, L. E., & Schneebaum, A. (2013b). New patterns of poverty in the lesbian, gay, and bisexual community.

Badgett, M. V. L., Nezhad, S., Waaldijk, C., & Meulen, R. Y. (2014). The relationship between LGBT inclusion and economic development: An analysis of emerging economies.

Baker, K., Cray, A., & Durso, L. (2013). LGBT communities and the Affordable Care Act: findings from a national survey. *Washington, DC: Center for American Progress*.

Ball, M., Barker, E., & Dwyer, A. (2015). Policing LGBTIQ in rural spaces: emerging issues and future concerns. *Rural Society,* 24(3), 227-243.

Balsam, K. F., Beadnell, B., Molina, Y., Simoni, J., & Walters, K. (2011). Measuring multiple minority stress: The LGBT people of color microaggressions scale. *Cultural Diversity & Ethnic Minority Psychology*, 17(2), 163-174.

Barringer, M. N., & Gay, D. A. (2017). Happily Religious: The surprising sources of happiness among lesbian, gay, bisexual, and transgender adults. *Sociological Inquiry*, *87*(1), 75-96.

Bartkiewicz, M. J., Boesen, M. J., Greytak, E. A., Kosciw, J. G., & Palmer, N. A. (2012). The 2011 *National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools*. New York: GLSEN.

Bassuk, E. L., Keuroghilian, A. S., & Shtasel, D. (2014). Out on the street: A public health and policy agenda for lesbian, gay, bisexual, and transgender youth who are homeless. *American Journal of Orthopsychiatry*, 84(1), 66-72.

Bazerman, L., Beckwith, C., Castonguay, B., Cates, A., Kurth, A., Kuo, I., Liu, T., Patrick, R., Peterson, J., & Trezza, C. (2017). Gender differences in HIV care among criminal justice-involved persons: baseline data from the CARE+ corrections study. *Plos One*, 1-15.

Beauregard, T. A., Bell, M. P., Özbilgin, M. F., & Sürgevil, O. (2011, January 26). Voice, silence, and diversity in 21st century organizations: Strategies for inclusion of gay, lesbian, bisexual, and transgender employees. Retrieved May 01, 2017, from http://onlinelibrary.wiley.com/doi/10.1002/hrm.20401/abstract.

Beck, M. J., Rausch, M. A., Lane, E. M., & Wood, S. M. (2016). College, career, and lifestyle development with students who are LGBTQ: Strategies for school counselors. *Journal of LGBT Issues in Counseling*, *10*(4), 197-210.

Beemyn, G. (2017, February 22). Campus pride trans policy clearinghouse. Retrieved May 01, 2017, from https://www.campuspride.org/tpc/.

Bennett, K., Ricks, J. M., & Howell, B. M. (2014). "It's just a way of fitting in:" Tobacco use and the lived experience of lesbian, gay, and bisexual Appalachians. *Journal of health care for the poor and underserved*, *25*(4), 1646.

Benson, K. & Johnson, S. (2014). "It's always the mother's fault": Secondary stigma of mothering a transgender child. *Journal of GLBT Family Studies*, 10, 124-144.

Berberet, H. (2006.) Putting the pieces together for queer youth: A model of integrated assessment of need and program planning. *Child Welfare*, 85(2), 361-384.

Biblarz, T. J., & Savci, E. (2010). Lesbian, gay, bisexual, and transgender families. *Journal of Marriage and Family*, *72*(3), 480-497.

Bidell, M.P. (2014). Is there an emotional cost of completing high school? Ecological factors and psychological distress among LGBT homeless youth. *Journal of Homosexuality* 61(3):366-381.

Bird, J., Garofalo, R., & Kuhns, L. (2011). The impact of role models on health outcomes for lesbian, gay, bisexual, and transgender youth. *Journal of Adolescent Health*, 50(4), 353-357.

Birkett, M., Espelage, D. L., & Koenig, B. (2009). LGB and questioning students in schools: The moderating effects of homophobic bullying and school climate on negative outcomes. *Journal of Youth and Adolescence, 38*(7), 989-1000.

Bockting, W., Horvath, K.J., Iantaffi, A., & Swinburne-Romine, R.(2014) A comparison of mental health, substance use, and sexual risk behaviors between rural and non-rural transgender persons. *Journal of Homosexuality, 61*(8), 1117-1130.

Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the US transgender population. *American journal of public health*, *103*(5), 943-951.

Boone, D., Cohn, T., & Whiting, E. (2012). Exploring protective factors among college-aged bisexual students in rural areas: An exploratory study. *Journal of Bisexuality*, 12, 507-518.

Bos, H. M., Gartrell, N. K., Peyser, H., & Van Balen, F. (2008). The USA national longitudinal lesbian family study (NLLFS): Homophobia, psychological adjustment, and protective factors. *Journal of Lesbian Studies*, *12*(4), 455-471.

Bouboushian, J. (2016, August 09). Texas court disallows official gender change. Retrieved May 01, 2017, from http://www.courthousenews.com/texas-court-disallows-official-gender-change/

Bourassa, D , Galarza, J., Lane, C., & Shupp, M. (2017) Serving our (in)visible elders: The impact of a LGBTQ+ aging presentation on a rural college campus. *Journal of Gay & Lesbian Social Services*, *29*(1), 25-40.

Bradford, J., Driskell, J., & Wagenen, A. (2012). 'I'm still raring to go': Successful aging among lesbian, gay, bisexual, and transgender older adults. *Journal of Aging Studies*, 27, 1-14.

Brennan-Ing, M. (2014). Social care networks and older LGBT adults: Challenges for the future. *Journal of Homosexuality*, 61(1), 21-52.

Brent, D. A., D'Augelli, A. R., Dietz, L. J. D., Friedman, M.S., Marshal, M. P., Mcginley, J., Murray, P. J., Smith, H. A., Stall, R., & Thomas, B. C. (2011). Suicidality and depression disparities between sexual minority and heterosexual y00outh: A Meta-Analytic Review. *Journal of Adolescent Health*, 49(2), 115-123.

Brill, S. A., & Pepper, R. (2008). *The transgender child: A Handbook for families and professionals*. San Francisco, CA: Cleis Press.

Brooks, S. (2016). Staying in the hood: Black lesbian and transgender women and identity management in north Philadelphia. *Journal of Homosexuality, 63*(12), 1573-1593.

Brown, A. (2017). *5 key findings about LGBT Americans.* Pew Research Center. Retrieved from http://www.pewresearch.org/fact-tank/2017/06/13/5-key-findings-about-lgbt-americans/?utm_content=buffer8d9cc&utm_medium=social&utm_source=twitter.com&utm_campaign=buffer.

Browne, K., Bakshi, L., & Lim, J. (2011). 'It's something you just have to ignore': Understanding and addressing contemporary lesbian, gay, bisexual and trans safety beyond hate crime paradigms. *Journal of Social Policy*, *40*(4), 739-756.

Bryan, A., Emlet, C., Goldsen, K., Kim, H.J., & Shiu, C. (2017). The cascading effects of marginalization and pathways of resilience in attaining good health among LGBT older adults. *Gerontologist*, 57(1), 72-83.

Bryan, A., Goldsen, K., Kim, H.J., & Muraco, A. (2017). Social network types and mental health among LGBT older adults. *Gerontologist*, 57(1), 84-94.

Bryan, A., Goldsen, K., Jen, S., Kim, H.J., & Muraco, A. (2017). Who says I do: The changing context of marriage and health and quality of life for LGBT older adults. *Gerontologist*, 57(1), 50-62.

Bryan, A., Goldsen, K., & Kim, H.J. (2017). Factors associated with high-risk alcohol consumption among LGB older adults: The roles of gender, social support, perceived stress, discrimination, and stigma. *Gerontologist*, 57(1), 95-104.

Buchmueller, T., & Carpenter, C. S. (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.

Bull, S., Dubois, Z., Mustanski, B., Phillips, G., Prescott, T., & Ybarra, M. (2016). Reaching adolescent gay, bisexual, and queer men online: development and refinement of a national recruitment strategy. *Journal of Medical Internet Research*, 18(8), 1-13.

Cahill, S. (2016). LGBT experiences with health care. *Health Affairs*, 36(4), 773-774.

Cahill, S., Ing, M., Karpiak, S., London, A., & Seidel, L. (2014). Service utilization among older adults with HIV: The joint association of sexual identity and gender. *Journal of Homosexuality*, 61(1), 166-196.

Cahill, S., Valadéz, R., & Ibarrola, S. (2013). Community-based HIV prevention interventions that combat anti-gay stigma for men who have sex with men and for transgender women. *Journal of public health policy*, *34*(1), 69-81.

Carabez, R., Pellegrini, M., Mankovitz, A., Eliason, M., Ciano, M., & Scott, M. (2015). "Never in all my years": Nurses' education about LGBT health. *Journal of Professional Nursing*, *31*(4), 323-329.

Card, N. A., Diaz R. M., Russell B., Russell, S. T., Toomey, R. B., & Toomey, R., C. (2010). Gender-nonconforming lesbian, gay, bisexual, and transgender youth: School victimization and young adult psychosocial adjustment. *Developmental Psychology*, 46 (6), 1580–1589.

Center for American Progress, Human Rights Campaign, & Movement Advancement Project. (2013). *A broken bargain: Discrimination, fewer benefits, and more taxes for LGBT workers*. Retrieved from http://libproxy.utdallas.edu/login?url=http://search.proquest.com/docview/1463054466?accountid=7120.

Center for American Progress & Movement Advancement Project. (2015). *Paying an unfair price: The financial penalty for LGBT people of color in America.* Washington, D.C.

Chapman, M. V. & Evans, C. B. (2014). Bullied youth: the impact of bullying through lesbian, gay, and bisexual name calling. *American journal of orthopsychiatry*, *84*(6), 644.

Choi, S. K., Gates, G., Shelton, J., & Wilson, B.D. (2015). *Serving Our Youth 2015: The needs and experiences of lesbian, gay, bisexual, transgender, and question youth experiencing homelessness.* True Colors Fund & The Williams Institute. Los Angeles: CA.

Choi, S. K., & Meyer, I. H. (2016). *LGBT aging: A review of research findings, needs, and policy implications.* (pp. 1-54). Los Angeles: The Williams Institute. Retrieved August 8th, 2017, from https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Aging-A-Review.pdf.

Chong, B. & Xu, J. (2017). The effects of gender neuroessentialism on transprejudice: An experimental study. *Sex Roles*, 1-11.

Cohn, T., Glass, J., & Stroup, J. (2014). The adjustment to U.S. rural college campuses for bisexual students in comparison to gay and lesbian students: An Exploratory Study. *Journal of Bisexuality*, 14, 94-109.

Connolly, C. & Leedy, G. & (2007). Out in the cowboy state, *Journal of Gay & Lesbian Social Services*, *19*(1), 17-34.

Cotter, K. L., Evans, C.B.R., & Smokowski, P. R. (2014). Cumulative bullying victimization: An investigation of the dose-response relationship between victimization and the associated mental health outcomes, social supports, and school experiences of rural adolescents. *Children and Youth Services Review*, 44, 256-264.

Craig, S. & McInroy, L. (2013). You can form a part of yourself online: The influence of new media on identity development and coming out for LGBTQ. *Journal of Gay & Lesbian Mental Health*, 18, 95-109.

Croghan, C., Moone, R., & Olson, A. (2014). Friends, family, and caregiving among midlife and older lesbian, gay, bisexual, and transgender adults. *Journal of Homosexuality*, 61(1), 79-102.

Culton, L. & Oswold, R. F. (2003). Under the rainbow: Rural gay life and its relevance for family providers. *Family Relations*, 52, 72-81.

Dabelko-Schoeny, H. & King, S.(2009). "Quite frankly, I have doubts about remaining": Aging-in-place and health care success for rural midlife and older lesbian, gay, and bisexual individuals. *Journal of LGBT Health Research*, *5*(1/2), 10-21.

D'augelli, A. R., Grossman, A. H., Howell, T. J., & Hubbard, S. (2005). Parent reactions to transgender youth's gender nonconforming expression and identity. *Journal of Gay & Lesbian Social Services, 18*(1), 3-16.

DeMaria, C., Israel, T., Joplin, A., Ley, D., Smiley, V., Trott, E. M., & Willging, C. E. (2016). Coaching mental health peer advocates for rural LGBTQ people. *Journal of Gay & Lesbian Mental Health*, *20*(3), 214-236.

DeMueles, M., Durwood, L., Olson, K. R., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in theiriIdentities. *Pediatrics*.

Dessel, A. & Rodenborg, N. (2017). Social workers and LGBT policies: Attitude predictors and cultural competence course outcomes. *Sexual Research and Social Policy*, 14, 17-31.

DiGregorio, N. (2015). Same-sex marriage policies and lesbian family life. *Sexuality Research and Social Policy*, (13), 58-72.

Dilley, J. A., Simmons, K. W., Boysun, M. J., Pizacani, B. A., & Stark, M. J. (2010). Demonstrating the importance and feasibility of including sexual orientation in public health surveys: health disparities in the Pacific Northwest. *American journal of public health*, *100*(3), 460-467.

Douglas, J. H., & Steinberger, M. D. (2015). The sexual orientation wage gap for racial minorities. *Industrial Relations, 54*(1), 59-108.

Drew, Q. & Strickler, E. (2015). Starting and sustaining LGBTQ antiviolence programs in a southern state. *Partner Abuse*, 6(1), 78-106.

Drott, A., Evans, S., & Oswalt, S. B. (2016). Beyond alphabet soup: helping college health professionals understand sexual fluidity. *Journal of American College Health*, *64*(6), 502-508.

Drumheller, K., & McQuay, B. (2010). Living in the buckle: Promoting LGBT outreach services in conservative urban/rural centers. *Communication Studies*, *61*(1), 70-86.

Duncan, D. T., Hatzenbuehler, M. L., & Johnson, R. M. (2014). Neighborhood-level LGBT hate crimes and current illicit drug use among sexual minority youth. *Drug and alcohol dependence*, *135*, 65-70.

Durso, L. E. & Gates, G. J. (2012). *Serving our youth: Findings from a national survey of services providers working with lesbian, gay, bisexual and transgender youth who are homeless or at risk of becoming homeless*. UCLA: The Williams Institute. Retrieved from: http://escholarship.org/uc/item/80x75033

Elias, T., Jaisle, A., & Morton-Padovano, C. (2017). Ethnic identity as a predictor of microaggressions toward blacks, whites, and Hispanic LGBs by blacks, whites, and Hispanics. *Journal of homosexuality*, *64*(1), 1-31.

Erzen, T. (2006). *Straight to Jesus: Sexual and Christian conversions in the ex-gay movement*. University of California Press.

Estell, D. B., Marshall, A., Yarber, W. L., Sherwood-Laughlin, C. M., & Gray, M. L. (2015). Coping and survival skills: The role school personnel play regarding support for bullied sexual minority-oriented youth. *Journal of school health*, *85*(5), 334-340.

Etengoff, C. (2017). Petitioning for Social Change: Letters to Religious Leaders From Gay Men and Their Family Allies. *Journal of homosexuality*, *64*(2), 166-194.

Etengoff, C., & Daiute, C. (2015). Clinicians' perspective of the relational processes for family and individual development during the mediation of religious and sexual identity disclosure. *Journal of homosexuality*, *62*(3), 394-426.

Fabbre, V. (2015). Gender transitions in later life: A queer perspective on successful aging. *Gerontologist*, 55(1), 144-153.

Fahs, B., Frost, D., & Swank, E. (2013). Region, social identities, and disclosure practices as predictors of heterosexist discrimination against sexual minorities in the United States. *Sociological Inquiry*, 83(2), 238-258.

Fahs, B., Frost, D. M., & Swank, E. (2012). Rural location and exposure to minority stress among sexual minorities in the United States. *Psychology & Sexuality*, *3*(3), 226-243.

Farmer, G. W., Blosnich, J. R., Jabson, J. M., & Matthews, D. D. (2016). Gay acres: sexual orientation differences in health indicators among rural and nonrural individuals. *The Journal of Rural Health*, *32*(3), 321-331.

Fedders, B. (2006). Coming out for kids: recognizing, respecting, and representing. *Nevada Law Journal,* 6:774, 774-804.

Federal Student Aid. (2017, June 29). *Dependency status.* Retrieved May 2, 2017, from https://studentaid.ed.gov/sa/fafsa/filling-out/dependency#dependent-or-independent.

Fenkl, E (2012). Aging gay men: A review of the literature. *Journal of LGBT Issues in Counseling*, 6(3), 162-182.

Fields, A., Hoenig, J., Russell, S., & Snapp, S. (2015). Messy, butch, and queer: LGBTQ youth and the school-to-prison pipeline. *Journal of Adolescent Research*, 30(1), 57-82.

Fish, J. & Russell, S. (2016). Mental health in lesbian, gay, bisexual, and transgender (LGBT) youth. *Annual Review of Clinical Psychology,* 12, 465-487.

Fisher, C. M., Irwin, J. A., & Coleman, J. D. (2014). LGBT health in the midlands: A rural/urban comparison of basic health indicators. *Journal of Homosexuality*, *61*(8), 1062-1090.

Flores, A., Herman, J., & Gary Gates, T. B. (2016). How many adults identify as transgender in the United States? University of California, Los Angeles, UCLA School of Law. Los Angeles, C.A.: The Williams Institute. Retrieved August 8th, 2017, from https://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf.

Frederick, T., Karabanow, J., Kidd, S., & Quirouette, M. (2016). Conflict with the law: Regulation & homeless youth trajectories toward stability. *Canadian Journal of Law and Society*, 31(3), 383-404.

Gallardo, M. E., Haldeman, D. C., Helbok, C. M., & Schank, J. A. (2010). Challenges and benefits of ethical small-community practice. *Professional Psychology: Research and Practice*, *41*(6), 502.

Galletly, C., Herrmann, M., Hollander, G., & Turrell, S. (2012). Lesbian, gay, bisexual, and transgender communities' readiness for intimate partner violence prevention. *Journal of Gay & Lesbian Social Service, 24(3), 289-301.*

Gallup . (February 2013). *LGBT percentage highest in D.C., Lowest in North Dakota*. Washington, D.C.: Gallup Politics. Retrieved October 8, 2016, from http://www.gallup.com/poll/160517/lgbt-percentage-highest-lowest-north-dakota.aspx.

Garrison, T. (2009, April). OMG: Straights are taking over gay Cedar Springs. Retrieved April 29, 2017, from https://www.dmagazine.com/publications/d-magazine/2009/april/is-oak-lawn-going-hetero/
Gates, G.J. (2013). *LGBT Parenting in the United States.* The Williams Institute. Los Angeles, CA: UCLA School of Law.

Gates, G. J. (2012). *Special Report: 3.4% of U.S. Adults identify as LGBT*. Retrieved from http://www.gallup.com/poll/158066/special-report-adults-identify-lgbt.aspx.

Gates, G. J. (2013, February 27) *LGBT parenting in the United States*. Retrieved April 29, 2017, from https://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/lgbt-parenting-in-the-united-states/.

Gates, G. J. (2017, August). LGBT data collection amid social and demographic shifts of the US LGBT community. *American Journal of Public Health*, 1220-1222.

Gates, G. J. (January 11th, 2017). *In U.S., More adults identifying as LGBT.* Social Issues. Washington, D.C.: Gallup, Inc. Retrieved August 7th, 2017, from http://www.gallup.com/poll/201731/lgbt.

Gates, G.J., & Cooke, A.M. (2010). *Census snapshot: Texas, 2010.* Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/Census2010Snapshot_Texas_v2.pdf.

Gates, G.J., & Cooke, A.M. (2012, April 18). United States census snapshot: 2010. Retrieved April 29, 2017, from http://escholarship.org/uc/item/4j23r1rx.

Gibbs, J. (2016). Religious conflict, sexual identity, and suicidal behaviors among LGBT young adults. *Arch Suicide Research*, 19(4), 472-488.

Gibbs, J. J., & Goldbach, J. (2015). Religious conflict, sexual identity, and suicidal behaviors among LGBT young adults. *Archives of suicide research*, *19*(4), 472-488.

Giuliano, T. A. & Gomillion, S. C. (2011). The influence of media role models on gay, lesbian, and bisexual identity. *Journal of homosexuality*, *58*(3), 330-354.

Giunta, N. & Rowan, N. (2016). Lessons on social and health disparities from older lesbians with alcoholism and the role of interventions to promote culturally competent services. *Journal of Human Behavior in the Social Environment*, 26(2), 210-216.

GLSEN. (2016). GLSEN condemns court decision preventing U.S. Department of Education from enforcing Title IX to protect transgender and gender nonconforming students. Retrieved April 28, 2017, from https://www.glsen.org/article/glsen-condemns-court-decision-preventing-us-department-education-enforcing-title-ix-protect.

Goldsen, K. (2016). Aging out in the queer community: Silence to sanctuary to activism in faith communities. *Journal of the American Society on Aging*, 40(2), 30-33.

Goldsen, K. (2017). Dismantling the silence: LGBTQ aging emerging from the margins. *Gerontologist*, 57(1), 121-128.

Goldsen, K. (2015). Promoting health equity among LGBT mid-life and older adults. *Journal of the American Society on Aging*, 38(4), 86-92.

Goldsen, K., Jen, S., & Kin, H.J. (2017). Race/Ethnicity and health-related quality of life among LGBT older adults. *Gerontologist*, 57(1), 30-39.

Goldsen, K., Kim, H., & Shiu, C. (2017). Health care engagement among LGBT older adults: The role of depression diagnosis and symptomatology. *Gerontologist*, 57(1), 105-114.

Goltz, D. (2014). "We're not in oz anymore": Shifting generational perspectives and tensions of gay community, identity, and future. *Journal of Homosexuality*, 61(11), 1503-1528.

Gonzales, G., & Blewett, L. A. (2014). National and state-specific health insurance disparities for adults in same-sex relationships. *American journal of public health, 104*(2), e95-e104.

Goodenow, C., Szalacha, L., & Westheimer, K. (2006). School support groups, other school factors, and the safety of sexual minority adolescents. *Psychology in the Schools*, 43, 573–589.

Gorman-Murray, A. (2008). Queering the family home: narratives from gay, lesbian and bisexual youth coming out in supportive family homes in Australia. *Gender, Place and Culture*, *15*(1), 31-44.

Graham, L. (2014). Navigating community institutions: Black transgender women's experiences in schools, the criminal justice system, and churches. *Sexual Research & Social Policy*, (11), 274-287.

Grant, J. M., Motter, L. A., Tanis, J., Harrison, J., Herman, J. L., & Keisling, M. (2011). *Injustice of every turn: A report of the national transgender discrimination survey*. Washington, D.C.: National Center for Transgender Equality and National Gay and Lesbian Task Force.

Greytak, E.A, Kosciw, J. G., & Kull, R. M. (2015). *From statehouse to schoolhouse: Anti-bullying policy efforts in U.S. states and school districts.* GLSEN. New York: NY.

Gruenewald, J. (2012). Are anti-LGBT homicides in the United States unique? *Journal of interpersonal violence*, *27*(18), 3601-3623.

Gruenewald, J., & Kelley, K. (2014). Exploring anti-LGBT homicide by mode of victim selection. *Criminal Justice and Behavior*, *41*(9), 1130-1152.

Haas, A.P., Eliason, M., Mays, V., Mathy, R. M., Cochran, S.D., D'Augelli, A.R., Silverman, M.M., Fisher, P.W., Hughes, T., Rosario, M., Russell, S.T., Malley, E., Reed, J., Litts, D.A., Haller, E., Sell, R.L., Remafedi, G., Bradford, J., Beautrais, A.L., Brown, G.K., Diamond, G.M., Freidman, M.S., Garofalo, R., Turner, M.S., Hollibaugh, A., Clayton, P.J. (2011). Suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal of Homosexuality*, 59(1), 10-51.

Hamel, L., Firth, J., Hoff, T., Kates, J., Levine, S., & Dawson, L. (2014). HIV/AIDS in the lives of gay and bisexual men in the United States. Menlo Park, CA: Henry J. Kaiser Family Foundation.

Harley, D.A. (2016) LBGT Elders in rural settings, small towns and frontier regions. In D.A. Harley and P.G. Teaser (eds.), *Handbook of LGBT Elders* (pp. 493-511). Switzerland: Springer International Publishing.

Harrison, B. F., & Michelson, M. R. (2015). God and marriage: The impact of religious identity priming on attitudes toward same-sex marriage. *Social Science Quarterly*, *96*(5), 1411-1423.

Hash, K. & Rogers, A. (2013). Clinical practice with older LGBT clients: Overcoming lifelong stigma through strength and resilience. *Clinical Social Work Journal*, 41, 249-257.

Hatzenbuehler, M.L. (2011). The social environment and suicide attempts in lesbian, gay, and bisexual youth. *Pediatrics*, 127(5), 896-903.

Hatzenbuehler, M. L., McLaughlin, K.A., & Slopen. (2014). Stressful life events, sexual orientation, and cardiometabolic risk among young adults in the United States. *Health Psychology*, 33(10), 1185-1194.

Hein, L. C., & Scharer, K. M. (2013). Who cares if it is a hate crime? Lesbian, gay, bisexual, and transgender hate crimes—mental health implications and interventions. *Perspectives in psychiatric care*, *49*(2), 84-93.

Herbst, J. H., Jacobs, E. D., Finlayson, T. J., McKleroy, V. S., Neumann, M. S., Crepaz, N., & HIV/AIDS Prevention Research Synthesis Team. (2008). Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. *AIDS and Behavior*, *12*(1), 1-17.

Herdt, G., & Kertzner, R. (2006). I do, but I can't: The impact of marriage denial on the mental health and sexual citizenship of lesbians and gay men in the United States. *Sexuality Research and Social Policy Journal of NSRC*, *3*(1), 33-49.

Herman, J. L. (2014, September). The potential impact of voter identification laws on transgender voters. Retrieved May 01, 2017, from https://williamsinstitute.law.ucla.edu/research /transgender-issues/the-potential-impact-of-voter-identification-laws-on-transgender-voters/.

Higa, D., Hoppe, M. J., Lindhorst, T., Mincer, S., Beadnell, B., Morrison, D. M., Wells, E. A., Todd, A., & Mountz, S. (2014). Negative and positive factors associated with the well-being of lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) youth. *Youth Sociology, 46*(5), 663-687.

Hill, G. J. & Wienke, C. C. (2013). Does place of residence matter? Rural–urban differences and the wellbeing of gay men and lesbians. *Journal of Homosexuality*, *60*(9), 1256-1279.

Himmelstein, Kathryn E. and Bruckner, Hannah. (2011, January). Criminal-justice and school sanctions against nonheterosexual youth: A national longitudinal study. *Pediatrics*, 127(1), pp. 49-57. Retrieved from http://pediatrics.aappublications.org/content/pediatrics/early/2010/12/06/peds.2009-2306.full.pdf.

Horn, S., Kosciw, J., Russell, S. T., & Saewyc, E. (2010). Safe schools policy for LGBTQ students. Social policy report. Volume 24, Number 4. *Society for Research in Child Development.*

Hornsey, M. J. (2006). Why do people engage in collective action? Revisiting the role of perceived effectiveness. *Journal of Applied Social Psychology*, 36(7), 1701-1722.

Human Rights Campaign. (2017a). Cities & counties with non-discrimination ordinances that include gender. Retrieved April 28, 2017, from http://www.hrc.org/resources/cities-and-counties-with-non-discrimination-ordinances-that-include-gender.

Human Rights Campaign. (2017b). *Corporate equality index*. Retrieved April 28, 2017, from: http://assets.hrc.org//files/assets/resources/CEI-2017-Final.pdf?_ga=2.135860211.3505049.1500566438-1901526012.1500566438.

Human Rights Campaign. (2012). *Discrimination against transgender workers*. Retrieved May 01, 2017, from http://www.hrc.org/resources/discrimination-against-transgender-workers.

Ingram, L.A., Smallwood, S.W., Spencer, S.M., Thrasher, J.F., & Thompson-Robinson, M.V. (2017). Different Dimensions: Internalized Homonegativity Among African American Men Who Have Sex With Men in the Deep South. *Journal of Homosexuality, 64*(1), 45-60.

Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, D.C.: National Academies Press.

Jansen, S. (2011, August 16). RIP gay Montrose? Community members say yes, no and maybe so. Retrieved April 29, 2017, from http://www.houstonpress.com/news/rip-gay-montrose-community-members-say-yes-no-and-maybe-so-671569.

Jeffries IV, W. L., Okeke, J. O., Gelaude, D. J., Torrone, E. A., Gasiorowicz, M., Oster, A. M., ... & Bertolli, J. (2014). An exploration of religion and spirituality among young, HIV-infected gay and bisexual men in the USA. Culture, health & sexuality, 16(9), 1070-1083.

John-Baptiste, A. (2014). *Intersecting identities of individuals in the workplace: A phenomenological study of the lived experiences.* Fielding's School of Human & Organizational Development.

Jones, G. S. (May 6th, 2015). Texas religious freedom and discrimination research findings. *Portland: Gallatin Public Affairs*. Retrieved October 8th, 2015, from http://www.txwins.org/wp-content/uploads/2015/05/TX_Polling_Data_Memo_05.6.2015.pdf.

Jones, K. E. (2010). *"I only date guys that who look like me": A study of race and sexuality in Chicago's LGBT community*. Roosevelt University.

Jow, L. (2015, May 7th). *429,000 LGBT workers in Texas lack statewide protections against ongoing employment discrimination*. Retrieved August 8th, 2017, from The Williams Institute: https://williamsinstitute.law.ucla.edu/press/press-releases/429000-lgbt-workers-in-texas-lack-statewide-protections-against-ongoing-employment-discrimination/.

Kane, S. B., Walls, N. E., & Wisneski, H. (2010). Gay-straight alliances and school experiences of sexual minority youth. *Youth & Society*, 41(3), 307-332.

Kann, L., Kinchen, S., Olsen, E. O., McManus, T., & Vivolo-Kantor, A. (2014). School violence and bullying among sexual minority high school students, 2009-2011. *Journal of Adolescent Health*, 55(3), 432-438.

Kaplan, D. M. (2014). Career anchors and paths: The case of gay, lesbian, & bisexual workers. *Human Resource Management Review*, *24*(2), 119-130.

Karpiak, S., Larson, B., Ing, M., & Seidel, L. (2014). Social care networks and older LGBT adults: challenges for the future. *Journal of Homosexuality*, 61(1), 21-52.

Kates, J., Ranji, U., Beamesderfer, A., Dawson, L. (2016, November). Health and access to care and coverage of lesbian, gay, bisexual, and transgender (LGBT) individuals in the U.S. Retrieved from http://www.kff.org/disparities-policy/issue-brief/health-and-access-to-care-and-coverage-for-lesbian-gay-bisexual-and-transgender-individuals-in-the-u-s/.

Kazyak, E. (2011). Disrupting cultural selves: Construction of gay and lesbian identities in rural locales." *Qualitative Sociology*, 34, 561-581.

Kazyak, E. & Stange, M. (2016). Examining the nuance in public opinion of pro LGB policies in a "red state." *Sexuality Research and Social Policy*, 13, 142-157.

Kia, H. (2015). Hypervisibility: toward a conceptualization of LGBTQ aging. *Sexuality Research and Social Policy*, 13(46), 46-57.

Koken, J. A., Bimbi, D. S., & Parsons, J. T. (2009). Experiences of familial acceptance-rejection among transwomen of color. *Journal of Family Psychology, 23*(6), 853-860.

Kosciw, J.G., Kull, R.M., & Palmer, N.A.(2015). Reflecting resiliency: openness about sexual orientation and/or gender identity and its relationship to well-being and educational outcomes for LGBT students. *American Journal of Community Psychology, 55*, 167-178.

Krinsky, L. & Porter, K. (2014). Do LGBT aging trainings effectuate positive change in mainstream elder service providers? *Journal of Homosexuality*, 61(1), 197-216.

Lambda Legal. (2017, March 07). Know your rights: Texas. Retrieved May 01, 2017, from http://www.lambdalegal.org/states-regions/texas.

Larson, B. (2016). Intentionally designed for success: Chicago's first LGBT-friendly senior housing. *Journal of the American Society on Aging*, 40(2), 106-107.

Lasser, J. & Tharinger, D. (2003). Visibility management in school and beyond: a qualitative study of gay, lesbian, bisexual youth. *Journal of Adolescence,* 26, 233-244.

Lee, M., & Quam, J. K. (2013). Comparing supports for LGBT aging in rural versus urban areas. *Journal Of Gerontological Social Work*, *56*(2), 112-126.

LGBT Aging Center. (2010). Improving the lives of LGBT older adults: Full report. (2010, March). Retrieved April 29, 2017, from http://www.lgbtagingcenter.org/resources/resource.cfm?r=16.

Lindquist, C., McKay, T., & Misra, S. (2017). *Violence and LGBTQ+ communities: What do we know, and what do we need to know?* Center for Justice Safety and Resilience, NC.

Linley, J. L., & Nguyen, D. J. (2015). LGBTQ experiences in curricular contexts: New directions for student services, 2015(152), 41-53.

Linley, J. L., Nguyen, D., Brazelton, G. B., Becker, B., Renn, K., & Woodford, M. (2016). Faculty as sources of support for LGBTQ college students. College Teaching, 64(2), 55-63.

Lytle, M. C., De Luca, S. M., Blosnich, J. R., & Brownson, C. (2015). Associations of racial/ethnic identities and religious affiliation with suicidal ideation among lesbian, gay, bisexual, and questioning individuals. Journal of affective disorders, 178, 39-45.

Mallory, C., & Sears, B. (2015, April 28). 429,000 LGBT workers in Texas lack statewide protections against ongoing employment discrimination. Retrieved April 29, 2017,

fromhttps://williamsinstitute.law.ucla.edu/press/press-releases/429000-lgbt-workers-in-texas-lack-statewide-protections-against-ongoing-employment-discrimination.

Marks, L. (2012). Same-sex parenting and children's outcomes: A closer examination of the American psychological association's brief on lesbian and gay parenting. Social *Science Research, 41*, 735-751.

Martin, J. I., Messinger, L., Kull, R., Holmes, J., Bermudez, F., & Sommer, S. (2009). Council on social work education. Lambda Legal study of LGBT issues in social work.

Martos, A. j., Wilson, P. A., & Meyer, L. (2017, July 10). *Lesbian, gay, bisexual, and transgender (LGBT) health services in the United States: Origins, evolution, and contemporary landscape*. PLoS ONE, 1-18. Retrieved August 7th, 2017, from https://doi.org/10.1371/journal.pone.0180544

Masci, D., & Lipka, M. (2015). Where Christian churches, other religions stand on gay marriage. Pew Research Center.

McGovern, A. E. (2012). When schools refuse to say gay: The constitutionality of anti-LGBTQ no-promo-homo public school policies in the United States. *Cornell JL & Pub. Pol'y*, *22*, 465.

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

Meiners, E. (2015). Trouble with the *child* in the carceral state. *Social Justice*, 41(3), 120-144.

Meyer, D. (2010). Evaluating the severity of hate-motivated violence: Intersectional differences among LGBT hate crime victims. *Sociology*, *44*(5), 980-995.

Mitchell, K. J., Palmer, N. A., Reisner, S. L., & Ybarra, M. L. (2014). Online social support as a buffer against online and offline peer and sexual victimization among U.S. LGBT and non-LGBT youth. *Child Abuse & Neglect*, 39, 123-136.

Mize, T. D. (2016). Sexual orientation in the labor market. *American Sociological Review*, *81*(6), 1132-1160.

Mohr, J. J. & Fassinger, R. E. (2003). Self-acceptance and Self-disclosure of sexual orientation in lesbian, gay, and bisexual adults: An attachment perspective. *Journal of Counseling Psychology, 50*(4), 482-495.

Moon, D. (2014). Beyond the dichotomy sex religious views of homosexuality. *Journal of Homosexuality, 61*(9), 1215-1241.

Movement Advanced Project. (2012). State policy profile - Texas. *Equality Maps*. Denver, CO, United States. Retrieved October 8th, 2016, from http://www.lgbtmap.org/equality_maps/profile_state/44.

National Center for Transgender Equality. (2016, May 13). *Map: State health insurance rules*. Retrieved April 29, 2017, from http://www.transequality.org/issues/resources/map-state-health-insurance-rules.

Newport, F. (2001). American attitudes toward homosexuality continue to become more tolerant. *Gallup*. Retrieved from http://www.gallup.com/poll/4432/american-attitudes-toward-homosexuality-continue-become-more-tolerant.aspx.

Orel, N. A. (2014, October). Investigating the needs and concerns of lesbian, gay, bisexual, and transgender older adults: The use of qualitative and quantitative methodology. *Journal of Homosexuality*, 61(1), 53-78. Retrieved August 7, 2017, from http://www.tandfonline.com/doi/abs/10.1080/00918369.2013.835236.

Out & Equal Workplace Advocates. (2017). *2017 workplace equality fact sheet*. Retrieved From http://outandequal.org/2017-workplace-equality-fact-sheet/.

Paluk, E. & Tankard, M. (2017). The effect of a Supreme Court decision regarding gay marriage on social norms and personal attitudes. *Psychological Science*, 1-11.

Pew Research Center. (2013). *A Survey of LGBT Americans: Attitudes, experiences and values in changing times*. Pew Social Trends, Washington, D.C. Retrieved October 8th, 2016, from http://www.pewsocialtrends.org/files/2013/06/SDT_LGBT-Americans_06-2013.pdf.

Philadelphia Commission on Human Relations. (2016). *Addressing racism and discrimination in Philadelphia's LGBTQ Community.* Philadelphia, PA.

Perry, B., & Alvi, S. (2012). 'We are all vulnerable' The in-terrorism effects of hate crimes. International Review of Victimology, 18(1), 57-71.

Peters, J.W., Becker J. & Hirschfeld Davis J. (2017). Trump rescinds rules on bathrooms for transgender students. New York Times. Retrieved from https://www.nytimes.com/2017/02/22/us/politics/devos-sessions-transgender-students-rights.html?_r=0.

Reeves, B. & Quinn, A. (2009). The use of the Internet to promote social justice with LGBT Individuals. *Counterpoints, 358*, 139-148. Retrieved from http://www.jstor.org/stable/42980369.

Rhodes, C. D., & Stewart, C. O. (2016). Debating LGBT workplace protections in the Bible Belt: Social identities in legislative and media discourse. *Journal of homosexuality*, *63*(7), 904-924.

Robinson, M. & Ross, L. (2013). Gender and sexual minorities: Intersecting inequalities and health. *Ethnicity and Inequalities in Health and Social Care*, 6(4), 91-96.

Rockenbach, A. N., Lo, M. A., & Mayhew, M. J. (2017). How LGBT college students perceive and engage the campus religious and spiritual climate. *Journal of homosexuality, 64(*4), 488-508.

Roe, S. (2017). "Family support would have been like amazing:" LGBTQ youth experiences with parental and family support. *The Family Journal*, *25*(1), 55-62.

Rosario, M., Li, F., Wypij, D., Roberts, A. L., Corliss, H. L., Charlton, B. M., . . . Austin, S. B. (2016, March 9th). Disparities by sexual orientation in frequent engagement in cancer-related risk behaviors: A 12-year follow-up. *American Journal of Public Health*, 106(4), pp. 698-706.

Rothman, E. F., Exner, D., & Baughman, A. L. (2011). The prevalence of sexual assault against people who identify as gay, lesbian, or bisexual in the United States: A systematic review. Trauma, Violence, & Abuse, 12(2), 55-66.

Ryan, C. (2010). Engaging families to support lesbian, gay, bisexual, and transgender youth: The family acceptance project. *Prevention Researcher*, *17*(4), 11-13.

Saad, L. (2012). U.S. Acceptance of gay/lesbian relations is the new normal. *Gallup*. Retrieved from http://www.gallup.com/poll/154634/Acceptance-Gay-Lesbian-Relations-New-Normal.aspx?g_source=homosexuality&g_medium=search&g_campaign=tiles.

Schwartz, K. (2009). *Social environmental factors that influence comfort with sexual orientation: Differences between young adult sexual -minority males and females*. Chestnut Hill College.

Sevelius, J. (2013). Gender Affirmation: A framework for conceptualizing risk behavior among transgender women of color. *Sex Roles,* (68), 675-689.

Sears, B., & Mallory, C. (2014). Employment discrimination against LGBT people: Existence and impact. Gender Identity and Sexual Orientation Discrimination in the Workplace: A Practical Guide.

Seil, K. S., Desai, M. M., & Smith, M. V. (2014, September 10th). Sexual orientation, adult connectedness, substance use, and mental health outcomes among adolescents: Findings from the 2009 New York City Youth Risk Behavior Survey. *American Journal of Public Health*, 104(10), pp. 1950-1956.

Severson, N., Muñoz-Laboy, M., & Kaufman, R. (2014). 'At times, I feel like I'm sinning': the paradoxical role of non-lesbian, gay, bisexual and transgender-affirming religion in the lives of behaviourally-bisexual Latino men. Culture, health & sexuality, 16(2), 136-148.

Sharp, K. (2017, June 16). The deadly consequences of Texas' anti-LGBT adoption bill. Retrieved June 18, 2017, from http://www.huffingtonpost.com/entry/the-deadly-consequences-of-texas-hb-3859_us_5942d4b4e4b0d188d027fca6.

Shaver J., Stephenson R., & Whitehead J. (2016) Outness, stigma, and primary health care utilization among rural LGBT populations. *PLoS ONE, 11*(1), 1-17.

Shay, G. & Strader, K. (2017). Queer (in)justice: Mapping new gay (scholarly) agendas. *Journal of Criminal Law and Criminology*, 102(1), 171-193.

Shetty, G., Sanchez, J. A., Lancaster, J. M., Wilson, L. E., Quinn, G. P., & Schabath, M. B. (2016). Oncology healthcare providers' knowledge, attitudes, and practice behaviors regarding LGBT health. Patient education and counseling, 99(10), 1676-1684.

Shilo, G., & Savaya, R. (2011). Effects of family and friend support on LGB youths' mental health and sexual orientation milestones. *Family Relations*, *60*(3), 318-330.

Singh, A. A., Meng, S., & Hansen, A. (2013). "It's already hard enough being a student": Developing affirming college environments for trans youth. *Journal of LGBT Youth, 10*(3), 208-223.

Smallwood, S.W., Spencer, S.M., Ingram, L.A., Thrasher, J.F., & Thompson-Robinson, M.V. (2017). Different dimensions: Internalized homonegativity among African American men who have sex with men in the Deep South. *Journal of Homosexuality, 64*(1), 45-60.

Sokolec, J. (2015). The meaning of "place" to older adults. *Clinical Social Work Journal*, 44, 160-169.

Stotzer, R. L. (2008). Gender identity and hate crimes: Violence against transgender people in Los Angeles County. *Sexuality Research and Social Policy*, *5*(1), 43-52.

Swank, E., Frost, D. M., & Fahs, B. (2012). Rural location and exposure to minority stress among sexual minorities in the United States. Psychology & Sexuality, 3(3), 226-243.

Tasker, F. & Golombok, S. (1995). Adults raised as children in lesbian families. *American Journal of Orthopsychiatry, 65*(2), 203-215.

Texas Department of State Health and Human Services. Texas HIV medication program. (2017, April 5). Retrieved from https://www.dshs.texas.gov/hivstd/meds/.

Texas Department of State Health and Human Services. Texas Population, 2016 (Projections). (2014, December 17). Retrieved from https://www.dshs.texas.gov/chs/popdat/ST2016p.shtm.

Texas Family Code. (1995). The parent-child relationship and the suit affecting the parent-child relationship. Retrieved from http://www.statutes.legis.state.tx.us/Docs/FA/htm/FA.153.htm.

Texas Health and Safety Code. (1991). Retrieved from http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.85.htm.

Texas Medical Association. (2016). Health insurance coverage. Retrieved April 29, 2017, from https://www.texmed.org/Template.aspx?id=42282.

The LGBT Aging Project . (2016, August 25). LGBT seniors are being pushed back into the closet. *The Atlantic*. Boston, MA. Retrieved 8th 2016, October, from http://www.theatlantic.com/health/archive/2016/08/lgbt-seniors/497324/.

The University of Texas at Austin. (2015). *University of Texas at Austin/Texas Tribune poll: Texans divided on gay marriage.* Texas Politics Project . Austin: The University of Texas at Austin. Retrieved October 8th, 2015, from https://www.texastribune.org/2015/06/24/uttt-poll-texans-divided-gay-marriage/?utm_source=texastribune.org&utm_medium=rss&utm_campaign=Tribune%20Feed:%20Main%20Feed.

Thurlow, C. (2005). Naming the ‘‘outsider within’’: Homophobic pejoratives and the verbal abuse of lesbian, gay and bisexual high-school pupils. *Journal of Adolescence*, 24, 25-38.

Toomey, R. B., Ryan, C., Diaz, R. M., & Russell, S. T. (2011). High school gay–straight alliances (GSAs) and young adult well-being: An examination of GSA presence, participation, and perceived effectiveness. Applied Developmental Science, 15(4), 175-185.

Trans Road Map. (2015, May 31). *Texas Name Change for Transgender People.* Retrieved from http://www.tsroadmap.com/reality/name/texas.html.

Trout, M. (2015). Federalizing hate: Constitutional and practical limitations to the Matthew Shepard and James Byrd, Jr. Hate Crimes Prevention Act of 2009. *Am. Crim. L. Rev.*, *52*, 131.

TX HB 3859. (2017). Retrieved June 18, 2017, from http://www.capitol.state.tx.us/BillLookup/History.aspx?LegSess=85R&Bill=HB3859.

Ura, A., Walters, E., & McCullough, J. (2016, June 09). Comparing nondiscrimination protections in Texas cities. Retrieved April 29, 2017, from https://www.texastribune.org/2016/06/09/comparing-nondiscrimination-ordinances-texas/.

USAGov (2017).*Top questions about Social Security.* Retrieved April 29, 2017, from https://www.usa.gov/about-social-security.

U. S. Census Bureau (2010a). *2010 Census urban and rural classification and urban area criteria* [Urban Rural by State 2010]. Retrieved from https://www.census.gov/geo/reference/ua/urban-rural-2010.html.

U. S. Census Bureau (2010b). *QuickFacts: Texas.* Retrieved March 29, 2017, from https://www.census.gov/quickfacts/TX.

U. S. Census Bureau. (2010). *American Community Survey*. Washington, D.C.: U.S. Government Printing Office.

United States Department of Agriculture. (2017, June 8th). *State fact sheets: Texas data.* (USDA, Editor) Retrieved August 8th, 2017, from Economic Research Service: https://data.ers.usda.gov/reports.aspx?StateFIPS=48&StateName=Texas&ID=17854.

Wade, L. (2016). *People of color are far more likely to be victims of anti-LGBT crimes*. Retrieved from https://psmag.com/news/people-of-color-are-far-more-likely-to-be-victims-of-anti-lgbt-crimes.

Walls, N. E., Kane, S. B. and Wisneski, H. (2010). Gay-straight alliances and school experiences of sexual minority youth. *Youth & Society, 41*(3), 307-332.

The Williams Institute. (2016). Same-sex couple and LGBT demographic data interactive. Los Angeles, CA: The Williams Institute, UCLA School of Law.

Williams Institute. (2016). *LGBT people in Texas*. UCLA School of Law. Los Angeles, CA: The Regents of the University of California. Retrieved October 8, 2016, from http://williamsinstitute.law.ucla.edu/wp-content/uploads/Texas-fact-sheet.pdf.

Wilson, M. M. (2014). Hate crime victimization, 2004–2012 statistical tables. Washington: Bureau of Justice Statistics.

Windmeyer, S., Humphrey, K., & Barker, D. (2013). An institutional responsibility: Tracking retention & academic success of out LGBT students. Campus Pride Blog. April, 8.

Wood, A. W., & Conley, A. H. (2014). Loss of religious or spiritual identities among the LGBT population. *Counseling and Values, 59*(1), 95-111.

Woody, I. (2014). Aging out: A qualitative exploration of ageism and heterosexism among aging African American lesbians and gay men. *Journal of Homosexuality*, *61*(1), 145-165.

Woody, I. (2016). Mary's house: An LGBTQ/SGL-friendly, alternative environment for older adults. *Journal of the American Society on Aging*, 40(2), 108-109.

Worthen, M. G. (2014). The interactive impacts of high school gay-straight alliances (GSAs) on college student attitudes toward LGBT individuals: An investigation of high school characteristics. *Journal of Homosexuality*, *61*(2), 217-250.

Worthen, M. G., Lingiardi, V., & Caristo, C. (2016). The roles of politics, feminism, and religion in attitudes toward LGBT individuals: A cross-cultural study of college students in the USA, Italy, and Spain. *Sexuality Research and Social Policy,* 1-18.

Wright, J. (2015). *One of nation's few homeless shelters for LGB youth opens doors in San Antonio, Texas.* Towelroad. Retrieved from http://www.towleroad.com/2015/03/one-of-nations-few-lgbtq-youth-homeless-shelters-opens-its-doors-in-san-antonio/.

Wright, J. (2016a*). Appeals court: Trans man can't be listed as male on driver's license*. Retrieved April 28, 2017, from https://www.texasobserver.org/texas-appeals-court-says-trans-man-cant-be-listed-as-male-on-drivers-license/.

Wright, J. (2016b). *Even in cities with nondiscrimination ordinances, LGBT Texans aren't really protected.* Retrieved April 28, 2017, from https://www.texasobserver.org/about-those-nondiscrimination-ordinances/.

Yoder, J. B., & Mattheis, A. (2016). Queer in STEM: Workplace experiences reported in a national survey of LGBTQA individuals in science, technology, engineering, and mathematics careers. *Journal of homosexuality*, *63*(1), 1-27.