An Intersectional Approach to Queer Health Policy and Practice: Two-Spirit People in Canada

Shari Brotman

Shari Brotman is Assistant Professor at the McGill School of Social Work. She has worked extensively as an educator, researcher, and practitioner in the fields of gerontological social work and anti-oppression social work. Her primary areas of research and writing include access to service among marginalized communities, social justice initiatives in health and social work responses to gay, lesbian, bisexual and Two-Spirit people. Dr. Brotman is currently the coordinator of Project Interaction, the Gay, Lesbian, Bisexual and Two-Spirit Initiative of the McGill School of Social Work.

Bill Ryan

Bill Ryan is a social worker and adult educator who teaches at the School of Social Work of McGill University. He founded an organization called Project 10 in Montreal, which has become one of the largest service organizations for gay, lesbian and bisexual youth in Canada. For the last ten years he has worked individually with hundreds of gay men and lesbians in psychotherapy. Since 1998 he has been working with the World Health Organization in Eastern Europe. He is the author of many papers, articles and chapters on HIV prevention, care, sexuality, and sexual orientation.

ABSTRACT

Brotman and Ryan explore intersectional oppression and discrimination in health care policy as it relates to the queer community. They emphasize that this community is in fact much more diverse than traditionally defined – white, upper class gay men – and that better health services, and access to them, ought to be provided to those who have been marginalized on account of their multiple identities.

Situating Queer Health

The concept of queer[1] health is only beginning to be addressed within institutional and governmental discourses. Up until recently health practitioners and policy-makers rarely considered the health status of queer people as an area of concern, and when doing so, focused almost exclusively on identifying same-sex attraction as pathology[2]. Although professional health associations are beginning to address sexual orientation within guidelines and policy directives[3], most health care institutions and practitioners continue to ignore the health care needs of queer people. What we have today is a health care system in which, at worst, queer people's health is damaged because of oppressive practices, and at best, queer people are simply rendered invisible. Under these conditions, it should be no surprise to us that queer people have an especially mistrustful and apprehensive relationship with health care institutions and professionals. It is also no surprise that, until recently, the voices of queer people in health care decision making, health promotion and disease prevention were largely absent (Ryan, Brotman and Rowe, 2000).

The major exception to this trend has been in the case of research, practice, and policy into the prevention and treatment of HIV/AIDS. To some extent, the emergence of the HIV/AIDS pandemic has paved the way for queer people to be recognized as active partners in health policy and program development (Ryan and Chervin, 2000). Still, this model has had little effect on other health care arenas, as HIV/AIDS bears no relationship to the lived experience of HIV-negative queer men or women (Peers and Demczuk, 1998). In fact the focus of research, activism, and funding on the pandemic has sometimes resulted in the marginalization of other queer health issues[4].

There are many positive developments in recent years, however, that need to be highlighted. A steadily growing interest in the health and health care needs of queer people has emerged over the past ten years in localized, community-based sites, corresponding with advances in queer rights agendas across North America. The entrenchment of sexual orientation as grounds of discrimination in the Canadian Charter of Human Rights and Freedoms has lent legitimacy to the articulation of a rights-based discourse in health care settings. Research and policy focused upon health outcomes and best practices is beginning to emerge thanks to the efforts of queer activists and their allies in health professions to promote the needs of queer people and communities. This has resulted in some institutional recognition of sexual orientation as a category of discrimination and subsequently as a unique social determinant of health in health policy environments.

Queer health activists in Canada have worked to call attention to health disparities among queer people and to substantiate a perspective on global queer health.[5] Many community-based health initiatives have emerged from the grass-roots and, although under-funded, have made inroads in the development of queer health policy and practice. For example, the Canadian Rainbow Health Coalition was launched in 2002 as a pan-Canadian group to advocate for better health services and access across Canada.

While queer health activists and their allies have done much to identify the need for health care policy to address queer-specific discrimination, the movement for global queer health has done little to address diversity within its midst. Focusing on global concepts of exclusion based upon a single identity category, queer health activists have advanced and legitimized a construction of "queer health" reflecting multiple forms of privilege, including such identity categories as white, Christian, young, able-bodied, urban and male. That is, the global health of queer people has largely been articulated and shaped through the lens of a restricted group of relatively privileged queer people. This mirrors the reality within most queer rights-based and community initiatives (Baradaran, 2003).

Several authors have described lesbian women's invisibility in both the women's health movement (which ignored sexual orientation-based oppression) and the gay health movement (which ignored gender-based oppression) (Daley, 1998; Gentry, 1992; Jenness & Broad, 1994). There is also ample evidence of the negative health impact of exclusion faced by older gay men and lesbians who fear accessing health care organizations in either mainstream or queer communities because of the combined realities of homophobia and ageism (Brotman, Ryan and Cormier, 2003). Indeed, there are large gaps in knowledge about the health care issues of queer people who face multiple forms of marginalization and oppression including: lesbian and bisexual women, queers of colour, older, poor, disabled and Aboriginal queers. While it may have been historically relevant to struggle for recognition of queer health as a unique social category, and to expose how homophobia oppressed all queer people regardless of other social locations, doing so entrenched an essentialized ideal of queer health which excluded and oppressed queer people situated at the margins. It is only through the agitation and organization of these queer people that there is growing recognition from within the queer health community of their exclusion. The time has now come for queer health activists to dissect the identity label of "queer," to understand how queer health theory, research and practice misrepresents, and does harm, to queer people who face multiple forms of oppression and ultimately, to make room for diverse queer people at the table.

To do this it is necessary to begin from a perspective which situates difference and diversity within the political context of intersectionality[6]. Addressing difference within queer communities must go beyond reified notions of monolithic "gay" experience in health promotion strategies and problematize identity constructs to include an examination of power, privilege and intersectional identity. By examining the impact of intersectional oppression, we can begin to open up space in which to address the problem of invisibility within the current discourse on queer health, and to develop more inclusive and diverse categories from which to theorize, build capacity and plan action.

To situate this discussion, we will describe the results of a research project completed in 2000 with Two Spirit[7] people in Montreal. This project was undertaken as part of a larger initiative on health care access for gay, lesbian, bisexual and Two-Spirit people in Canada[8]. In total, 5 focus groups (with 61 individuals) were held across Canada[9]. In Montreal, two Two-Spirit focus groups were undertaken with a total number of 12 participants representing both Two-Spirit people themselves, and their Aboriginal allies in health. Individuals came from both reserve-based and urban environments. Conversation focused broadly on the following themes: meanings of health, people's notions of identity and community, and the experience of health care barriers within and outside of Aboriginal communities. We will discuss some of these themes in the current paper.

It is important to identify that neither of the authors of this paper are, ourselves, Two-Spirited. We have attempted, in doing this research project, to take an explicitly reflexive stance[10] as people with multiple privileges granted us by our individual social locations (as a white heterosexual female and white gay male) and status as university researchers. Our history of work as activists and academics on queer issues has supported participatory methods as a means of addressing such issues as power-sharing, promotion of human rights agendas and building alliances with marginalized people and communities. In the current context, all stages of the research process supported the inclusion of Two-Spirit people as consultants and team members[11]. Still we recognize the advantage our privileged space gives us to frame the issues and receive credit for knowledge transfer in academic and public policy circles.

Two-Spirit People's Health: The Impact of Intersectional Oppression

If we accept the premise that health policy largely excludes the voices and realities of queer people generally, and that the smaller body of work on queer health has little reference to multiply marginalized people, then we can begin to understand just how invisible are the health care needs and realities of Two-Spirit people. In fact, Two-Spirit people in Canada have been left out of health research and policy activities in multiple settings; mainstream, queer and Aboriginal. Few people involved in health care at any level have even heard of the term Two-Spirit. Aboriginal communities themselves have little documentation on the lives and experiences of Two-Spirit people and have only recently begun to recognize Two-Spirit people through localized initiatives. This absence of knowledge and understanding contributes to a health environment shaped by ignorance. But it is not ignorance alone that fuels discrimination in health settings. The intersectional oppression that Two-Spirit people face is structural[12] in nature, based upon historical and current discrimination in health care and other settings which inform and have an impact upon health. Colonialism[13], heterosexism, homophobia/transphobia[14], classism and sexism experienced by Two-Spirit people have put them at a unique disadvantage with regard to their health.

Two-Spirit people's health status is informed by multiple layers of oppression, as both Aboriginal and queer. Their health is compromised as a result of historic and current colonial and racist oppression to which all Aboriginal people are subjected (Monture-Angus, 1995; Waldram, 1994; Wright et al., 1997; Wotherspoon, 1994) and which has caused higher rates of substance abuse, addictions, depression and suicide, morbidity and mortality

than experienced by non-Aboriginal populations (Waldram, 1994; Wotherspoon, 1994). Rates of HIV/AIDS in Aboriginal communities are also considerably higher and are connected to the negative impact of social conditions under which most Aboriginal people live in Canada (Wotherspoon, 1994).

Queer communities also face oppression in the form of heterosexism and homophobia/transphobia which has resulted in increased health risks, some of which are similar to those identified in Aboriginal contexts, such as higher rates of addiction, depression and suicidal ideation (Andersen, 1996; Hartstein, 1996; Hershberger, Pilkington & d'Augelli, 1996; Ramafedi, 1999). These experiences of oppression, which contribute to greater negative health outcomes, are complex and interweaving and result in specific forms of exclusion and marginalization. For example, there is some documentation that the interactions between racism/colonialism and homophobia/transphobia put Two-Spirit people at greater risk of HIV infection (Ryan & Chervin, 2000). Although there is no epidemiological research specific to Two-Spirit people from which to draw to confirm the impact of multiple oppression on health, our qualitative research has demonstrated that Two-Spirit people confront many health problems (Brotman, Ryan, Jalbert and Rowe, 2002a).

These experiences of oppression, which contribute to greater negative health outcomes, are complex and interweaving and result in specific forms of exclusion and marginalization.

We can look to the role of identity formation in health status and outcomes as a means of highlighting this reality. Intersectionality theory can help to frame this discussion from the perspectives of Two-Spirit people. The process of self-definition and self creation for people whose identities are doubly bound is fraught with conflict and challenge. This complex issue is referred to as intersectionality and identity (Crenshaw, 1995). Often labouring to reconcile both identities, Two-Spirit people can become caught between two worlds, forever defined as "other" by those communities in which they seek to define themselves. In attempting to maintain loyalties to many often politically, morally or philosophically opposed communities, these people may become hybridized subjects (Bhabha, 1994) which brings with it risks to the development of a healthy and integrated sense of self (Brotman and Kraniou, 1998).

The issue of "coming-out" is particularly salient in the current context. Queer health research has pointed time and again to the importance of coming out as gay, lesbian or bisexual to the positive health and well-being of queer people[15]. But the accepted model of coming out has been critiqued by queers of colour as being largely derived from the experiences of queers of privilege; namely, white, upper class, gay men (Smith, 1997). Many contemporary queer people are not comfortable naming themselves as "gay," "lesbian," or "bisexual," and feel rather as if they had been grouped into these categories by the power of the English language alone. In Aboriginal communities, for example, there is research which points to the ways in which historic forms of colonial oppression actually informed homophobia within Aboriginal communities (Brown, 1997; Jacobs, Thomas and Lang, 1997; Roscoe, 1987; Tafoya, 1997; Wright, Lopez & Zumwalt, 1997). Colonization and Christianity regarded Aboriginal cultural beliefs, and undoubtedly, Aboriginal gay men, lesbians, bisexuals and transgendered people, as abnormal. Therefore, Christianity has made possible the growth of heterosexism and homophobia/transphobia that are used as a justification for the exclusion and rejection of Aboriginal queers in modern day Aboriginal communities (Jacobs and Brown, 1997; Meyer, 1998; Williams, 1984). Thus, accepting to call oneself gay or lesbian and thus merging oneself into the larger queer body politic means accepting a construction that is colonialist and oppressive in nature. Connecting coming out to good health may also label those who choose not to "come out" for reasons related to rejection of essentialized identity constructs, as experiencing unhealthy self-concept. This places Two-Spirit people in the uneasy position of having to accept an exclusionary label which goes against their sense of identity or risk being seen as exhibiting internalized homophobia.

Aboriginal queers are in a unique position of having another choice. For them, the term "Two-Spirit" (Two-Spirit People of the First Nations, 1998[16]) enables a process of positive self-affirmation and connection to a pre-colonial time of Aboriginal solidarity which runs counter to hegemonic constructions of gay identity. Unlike many other communities of colour, Two-Spirit people can look to a unique history in which they were honoured. Claiming this identity can, therefore, help reposition Two-Spirit people as central to their community's history and tradition as both queer and Aboriginal (Walters, 1997).

Unfortunately, claiming Two-Spirit identity is not achieved by all Aboriginal queer people for a variety of reasons including lack of awareness of this history and tradition in pre-colonial times and because being "out" results in homophobic/transphobic oppression within communities. While claiming a Two-Spirit identity represents a positive self-affirmation, it does not change the fact that risk of discrimination within and without Aboriginal communities is very real. Meyer (1998) observed that coming out is often difficult because of the "internalized concept of sin" stemming from Christian evangelization and its acceptance by Aboriginal family and community. Indeed, coming out is also sometimes perceived as a process of rejection of Aboriginal identity because "gay identity" is associated with Western culture and ideology. As a result, Two-Spirit people struggle to achieve safety through a variety of means, not least of which is choosing to leave their community. This strategy of coping and survival does have consequences. Although an urban centre can offer anonymity and the potential to connect with a

larger queer community, it may result in the loss of identity and cultural connection and to exposure to additional forms of racism and colonialism not experienced within or buffered by living on reserve (Meyer, 1998).

Queer communities themselves hold discriminatory beliefs about Aboriginal people. One such example is in the case of the stereotyping of the "ethnic" family/community. Western queer political agendas have tended to mythologize "ethnic" communities as being more homophobic/transphobic than mainstream communities. The theory is that the "ethnic family/community's" attachment to traditional or religious values and doctrine renders them a more frequent site of queer people's oppression (Van der Meide, 2001). This form of racist stereotyping has served to mask the political and supportive role of the family/community within communities of colour as "a source of resistance to racism" (Anthias & Yuval-Davis, 1992: 124), and ultimately has resulted in the alienation of queer people of colour and Two-Spirit people from mainstream queer communities which are seen as being irrelevant and/or racist towards their particular experience.

What results is an experience of bifurcation (Brotman and Kraniou, 1998) in which Two-Spirit people end up being forced to choose between defending family and community in response to racist and colonialist attitudes in queer communities or defending their sexuality or gender identity in response to homphobic/transphobic attitudes in Aboriginal communities. This bifurcation of identity and allegiance significantly undermines two-Spirit people's potential to self affirm. Two-Spirit people also risk losing support from those who can help to counter either the experience of racism/colonialism or homophobia/transphobia felt within mainstream, Aboriginal or queer environments. As a result, Two-Spirit people are wary to seek out help from local communities with whom they share a component of their identities, and when doing so, often have to make choices as to which component of their identity matters most to an interaction. The health consequences of living in and between spaces and communities, of facing discrimination on multiple fronts and on experiencing isolation have been outlined previously. They include significant mental health problems such as addictions and substance abuse, depression and suicidal ideation. Because of the combined effects of oppression in health care settings, Two-Spirit people also hesitate to access mainstream or community-based resources and often only do so when in crisis (Brotman, Ryan, Jalbert and Rowe, 2002b). Two-Spirit people we spoke with confirmed that this crisis-oriented interaction with health care delivery systems in urban centres, made it highly unlikely that health care workers would ever have the opportunity to uncover or explore the roots of homophobia/transphobia in Two-Spirit people's decision to leave their community or in addressing racism and colonialism within contemporary queer culture.

Conclusion: Intersectionality and Health Policy - Transforming Relations

This paper only begins to touch upon the usefulness of an intersectional approach in understanding the impact of oppression on the health of marginalized populations. In highlighting the lived experience of Two-Spirit people, we hoped to call attention to the ways in which people who, because of their social location, experience powerlessness in multiple arenas, not least of which are the communities with whom they identify. Intersectional theory can provide a framework from which to explore and expose the ways in which structural forms of oppression, experienced simultaneously, can contribute to a bifurcated sense of identity and fractured experience of community which ultimately complicates people's capacity to self-affirm and to find safe, inclusive and healthy spaces. We focused on the themes of identity and access in the lives of Two-Spirit people in order to demonstrate the ways in which health status is significantly undermined by essentializing and discriminatory approaches in both mainstream and community-based sectors.

We cannot underestimate the value of documenting the experiences of multiply marginalized people from their own standpoint. In the case of Two-Spirit people, this would enable us to learn about their struggles to reconcile competing senses of space, to self-affirm, to gain recognition and respect for their whole selves and to achieve good health. Documenting Two-Spirit people's strengths and resilience can help to support their inclusion in health systems through increased understanding of their unique identities, struggles, and experiences. This understanding can contribute to the incorporation of their self-identified priorities into disease prevention and health promotion strategies. It also serves to publicly document and support community capacity and suggest new partnership models in order to bring about improved health.

We want to end by making some general conclusions about the necessity to transform health policy in order to incorporate an intersectional approach to the design and delivery of health services. Particular attention must be placed on the development of services for queer people which centrally locates queer people's multiple identities and the impact of being multiply situated upon the capacity of queer people to positively self-affirm, both within their own communities as well in mainstream society. Intersectional approaches to policy and program development facilitate a process in which power relations are explicitly named and, as a result, altered. The promotion of capacity-building is essential to this process. This can be achieved through a variety of means including supporting localized health initiatives under community control, improving training and educational opportunities, and facilitating interactions between sectors and networks. These initiatives not only require adequate funding but a commitment to the repositioning of players to include diversely situated people and their allies around the decision-making table, as equal partners. Only then can the system be transformed to reflect the values of emancipation, solidarity and human rights.

Notes

[1] A new and fluid identity label, queer incorporates ambiguity into definitions of gender identity and sexual orientation. It is a re-appropriation of a traditional "put-down" and explores new combinations of identities and pluralistic forms of sexual expression. At the same time, the term queer is meant to gather resistance to all forms of heterosexist oppression. An umbrella term, queer incorporates terms such as gay, lesbian, bisexual and transgender.

[2] Queer people have historically been socially defined within medical terms as mentally ill, thus rendering the health care system one of the primary arenas through which control over their lives was exerted. Since homosexuality was, up until recently, labeled a psychiatric disorder, it was up to medical professionals to "cure" queer people of their same-sex attractions. Many people today can still remember being institutionalized, undergoing therapies or treatments designed to cure them of their "unnatural and unhealthy" preoccupations and/or facing social stigma and isolation initiated by and in medical systems (Brotman, Ryan, Jalbert and Rowe, 2002a)

[3] For further information, please check the web-sites of the American Psychological Association or the Canadian Association of Social Workers as examples of professional bodies that have incorporated statements on sexual orientation into guidelines and policy.

[4] There was a gay and lesbian health movement in North America in the 1970s, which was nurtured by the birth of gay and lesbian community organizations. However, the advent of AIDS interrupted this movement as activists deployed their energy and resources in the fight against this disease. The gay and lesbian health movement did not die with the appearance of AIDS, but it quieted down, became less visible and resource-poor (Mancoske and Lindhorst, 1995).

[5] The current paper defines health from a broad perspective that incorporates the physical, psychological, emotional, social and spiritual components that contribute to health and well-being. The World Health Organization definition of health is most closely aligned with the ideology of health as understood in the current context. Identifying health as a broad and holistic construct is particularly important when considering the lives and experiences of queer people. The experience of being in a homophobic/transphobic society necessitates a broad view of health in which issues such as coming out, locating community and managing oppression are contextualized and understood as mental health issues. Utilizing this perspective facilitates the integration of an analysis of the health impacts of oppression and marginalization upon the lives of queer people and the necessity of a holistic perspective when articulating recommendations for change (Brotman, Ryan, Jalbert and Rowe, 2002a).

[6] Intersectionality theory is derived from the broader body of writing on "critical race theory" (Crenshaw 1995; Delgado, 1995) although anti-racist feminist literature of the same period also refers to this concept (Bannerji, 1995; Bishop, 1994; Stasiulis, 1990). These theories emerged over the past fifteen years in an attempt to expose and examine "the historical centrality and complicity of law in upholding white supremacy and concomitant hierarchies of gender, class and sexual orientation" (West, 1995: xi) in the United States (Crenshaw, 1989; Delgado, 1995), and Canadian (Duclos, 1993; Khana, 2000), legal systems. Formed for the most part, by legal theorists of colour, critical race theory addresses the law's treatment of indigenous peoples and people of colour and the role the law has played in shaping and maintaining social domination and subordination (West, 1995: xi). Intersectionality is based on the premise that intersections of oppressions cannot be captured wholly by looking at the separate identity dimensions of experiences (Anthias & Yuval-Davis, 1992; Caldwell, 1995; Crenshaw, 1995; Davis, 1996; Grillo, 1995; Grillo & Wildmann, 1995; Mama, 1992). An intersectional approach has also been applied to sexual orientation as an identity category in recent years (Eaton, 1995; Gunning, 1995; Van der Meide, 2002). This critique has developed from within a radical framework, focusing on the liberatory struggles and resistance strategies of persons of colour as well as state and legal mechanisms of oppression (Friere, 2001). Critical race theorists have paid a great deal of attention to contemporary manifestations of these historic processes, commenting on the role of both neo-liberal and postmodern discourses in law, the state and society. The liberatory project of critical race theory is ultimately useful to many other theoretical and practice disciplines, particularly those considering contemporary problems in health care.

[7] Much evidence indicates that Aboriginal people, prior to colonization and contact with European cultures, believed in the existence of three genders: the male, the female and the male-female gender, or what we now call the Two-Spirit person. The term Two-Spirit, though relatively new, was derived from interpretations of Aboriginal languages used to describe people who had received a gift from the Creator, that gift being the privilege of housing both male and female spirits. The concept of Two-Spirit related to today's designation of gays, lesbians, bisexual and transgender persons of Native origins. Two-Spirit people traditionally held esteemed positions in their communities. The arrival of the Europeans was marked by the imposition of foreign views and values on Native spirituality, family life and traditions. The missionary churches' views on sexuality, for example, created many new taboos. Many traditions, including that of the Two-Spirit were eradicated or at least driven underground from many (but not all) tribes of North America (Meyer, Goodleaf and Labelle, 2000).

[8] The project was undertaken under the auspices of The McGill Centre for Applied Family Studies (McGill School of Social Work, Montreal) with the support of Égale (Equality for Gays and Lesbians Everywhere, Ottawa) in partnership with Health Canada. This paper contains some excerpts from our publication: Brotman, S., Ryan, B., Jalbert, Y. & Rowe, B. (2002). Reclaiming space-regaining health: Health care access and Two-Spirit people in Canada. Journal of Gay and Lesbian Social Services 14(1), 67-87.

[9] Morgan, D. (1997). Focus groups as qualitative research. Thousand Oaks, CA: Sage.

[10] Taking a reflexive stance requires researchers to position and name themselves, including acknowledging the privileged position they occupy outside the world in which they are studying as academics tied to institutions of power. It also requires researchers to identify how this and other privileged or marginalized positions they occupy inform the process of research and analysis (Eakin et al., 1996:162). Reflexive researchers committed to the development of anti-oppressive projects and processes must explicitly claim their ideological positions and work towards power-sharing in design and methods.

[11] Particular thanks to Natalie Lloyd

[12] Structural intersectionality refers to the burdens faced by multiply marginalized people which are the consequence of multiple forms of oppression such as gender and class oppression, compounded by structural racially discriminatory practices (Crenshaw, 1995: 358). These include housing, employment, and health care as examples. Crenshaw points to the fact that, intersectional subordination does not necessarily result from the intentional practices of systems and institutions but "is frequently the consequence of the imposition of one burden interacting with predisposing vulnerabilities to create yet another dimension of disempowerment" (Crenshaw, 1995: 359).

[13] Colonialism, in the current context, is the process through which Aboriginal people were subjected to occupation by European settlers to North America beginning in the 16th Century. Policies of eradication and assimilation marked contact between Aboriginal peoples and newly formed occupying governments whose prime interests were in freeing up land for settlement by European arrivals and gaining control over local resources. The Churches, through their missionary agents, were central to the plan of assimilation and eradication through conversion of Aboriginal people to Christianity. Forced resettlement of Aboriginal peoples to reserves and residential schooling of children resulted in the loss of language, tradition and culture, the breakdown of family and community, the eradication of subsistence ways of life and self-determination and death. Aboriginal people were faced with great poverty and disease, inadequate housing and substandard living conditions which continue to this day (Brotman, Ryan, Jalbert & Rowe, 2002b).

[14] The term "homophobia" was coined in 1973 by George Weinberg. For him, homophobia is the irrational fear, hatred and intolerance of homosexuals. Transphobia can be defined in a similar vein as the irrational fear, hatred and intolerance of transgendered people. For Simkin (1993), heterosexism is the presumption that heterosexuality is the norm and that any other form of sexual expression is deviant.

[15] Coming out theory postulates that the act of coming out, to oneself, one's family, one's community and society as a whole is a process of self acceptance and letting go of shame and dramatically improves the likelihood of developing positive self esteem and by extension, good health (Brotman, Ryan, Jalbert and Rowe, 2002a). Many studies on queer health, from the perspectives of both gay men and lesbians have concluded this to varying degrees.

[16] To find out more about the status of Two-Spirit people in Canada: Deschamps, G. *We Are Part of a Tradition: the 2-Spirited People of the First Nations.*

Bibliography

Anderson, S. C. "Substance abuse and dependency in gay men and lesbians." *Health Care for Lesbians and Gay Men: Confronting homophobia and heterosexism.* Ed. K. Jean Peterson. New York: Harrington Park Press, 1996. 59-76.

Anthias, F. & N. Yuval-Davis. *Racialized boundaries: Race, nation, gender, colour and class and the anti-racist struggle.* London: Routledge, 1992.

Baradaran, A. *Canadian caucus for Two-Spirited and queers of colour.* Ottawa: EGALE Canada, 2003. www.egale.ca

Bannerji, H. *Thinking through: Essays on feminism, marxism and anti-racism.* Toronto: Women's Press, 1995.

Bhabha, H. *The location of culture.* London: Routledge, 1994.

Bishop, A. *Becoming an ally: Breaking the cycle of oppression.* Halifax: Fernwood Publishing, 1994.

Brotman, S. & S. Kraniou. "Ethnic and lesbian: Understanding identity through the life-history approach." *Affilia* 14(4) (1999): 417-438.

Brotman, S., B. Ryan & R. Cormier. "The health and social service needs of gay and lesbian elders and their families in Canada." *The Gerontologist* 43(2) (2003): 192-202.

Brotman, S., B. Ryan, Y. Jalbert & B. Rowe. "The impact of coming out on health and health care access: The Experiences of gay, lesbian, bisexual and Two-Spirit people." *Journal of Health and Social Policy* 15(1) (2002a): 1-29.

Brotman, S., B. Ryan, Y. Jalbert & B. Rowe. "Reclaiming space-regaining health: Health care access and Two-Spirit people in Canada." *Journal of Gay and Lesbian Social Services* 14(1) (2002b): 67-87.

Brown, L. B. "Women and men, not-men and not-women, lesbians and gays : gender style alternatives." *Journal of Gay & Lesbian Social Services* 6(2) (1997): 5-20.

Caldwell, P. "A Hair piece: Perspectives on the intersection of race and gender." *Critical race theory: The cutting edge.* Ed. R. Delgado. Philadelphia: Temple University Press, 1995.

Crenshaw, K. "Mapping the margins: Intersectionality, identity politics, and violence against women of colour." *Critical race theory: The key writings that formed the movement.* Eds. K. Crenshaw, N. Gotanda, G. Peller & K. Thomas. New York: WW Norton and Co., 1995.

Crenshaw, K. "Demarginalizing the intersections of race and sex: A Black feminist critique of anti-discrimination doctrine, feminist theory and antiracist politics." University of Chicago Legal Forum, 139, at 153, 1989.

Daley, A. "Lesbian invisibility in health care services – Heterosexual hegemony and strategies for change." *Canadian Social Work Review.* Vol. 15, No. 1 (1998): 57-71.

Davis, A. "Gender, class and multiculturalism: Rethinking 'race' politics." *Mapping multi-culturalism.* Eds. A. Gordon & C. Newfield. Minneapolis: University of Minnesota Press, 1996.

Delgado, R. "Race, sex, class and their intersections." *Critical race theory: The cutting edge.* Ed. R. Delgado. Philadelphia: Temple University Press, 1995.

Deschamps, G. *We are part of a tradition.* Toronto: The 2-Spirited people of the First Nations, 1998.

Duclos, N. "Disappearing women: Racial minority women in human rights cases," *Canadian Journal of Women and the Law* 25(6) (1993).

Eakin, J., A. Robertson, B. Poland, D. Coburn & R. Edwards. "A critical social science perspective on health promotion research." *Health Promotion International* 11 (1996): 157-165.

Eaton, M. "Homosexual unmodified: Speculations on law's discourse: Race, and the construction of sexual identity." *Legal interventions: Lesbians, gay men, and the politics of law.* Eds. Didi Herman & Carl Stychin. Philadelphia, PA: Temple University Press, 1995.

Friere, P. *Pedagogy of the oppressed.* 30th anniversary edition. New York: Continuum, 2001.

Gentry, S. E. "Caring for lesbians in a homophobic society." *Health Care for Women International.* Vol. 13 (1992): 173-180.

Grillo, T. "Anti-Essentialism and intersectionality: Tools to dismantle the master's house." *Berkeley Women's Law Journal* 10 (1995): 16-30.

Grillo, T. & S. Wildman. "Obscuring the importance of race: The implication of making comparisons between racism and sexism (or Other-isms)." *Critical race theory: The cutting edge.* Ed. R. Delgado. Philadelphia: Temple University Press, 1995.

Gunning, I. "Stories from home: Tales from the intersection of race, gender and sexual orientation." 5S.Cal. Rev. *L. & Women's Studies* 143, at 147 (1995).

Hartstein, N. B. "Suicide risk in lesbian, gay, and bisexual youth." *Textbook of Homosexuality and Mental Health.* Eds. Robert P. Cabaj and Terry S. Stein. Washington, DC: American Psychiatric Press, 1996. 819-837.

Hershberger, S.L., N.W. Pilkington & A.R. D'Augelli. Categorization of lesbian, gay and bisexual suicide attempters, *Gay and lesbian mental health – A sourcebook for practitioners.* Ed. Christopher J. Alexander. New York: Harrington Park Press, 1996. 39-59.

Jacobs, M.A. & L.B. Brown. "American Indian lesbians and gays: an exploratory study." *Journal of Gay & Lesbian Social Services* 6(2) (1997): 29-41.

Jacobs, S.E., W. Thomas & S. Lang. *Two-Spirit people: Native American gender identity, sexuality and spirituality.* Chicago: University of Illinois Press, 1997.

Jenness, V. & K. Broad. "Antiviolence activism and the (in)visibility of gender in the gay/lesbian and women's movements." *Gender & Society* Vol. 8, No. 3 (1994): 402-423.

Khana, M. *Multiplying meaning in law and social work discourse: A Case for intersectionality.* Unpublished Master's Thesis. Montreal, QC: McGill School of Social Work, 2000.

Mama, A. "Black women and the British state: race, class and gender analysis for the 1990s." *Racism & Antiracism: Inequalities, Opportunities & Policies.* Eds. P. Braham, A. Rattansi & R. Skellington. London: Sage, 1992.

Mancoske, R. & T. Lindhorst. "The Ecological context of HIV/AIDS counseling: Issues for lesbians and gays and their significant others." *Journal of Gay and Lesbian Social Services.* Vol. 2, No. _ (1995): 25-40.

Meyer, F. *The Two-Spirit papers: the impact of heterosexism and homophobia on Inuit and First Nations peoples' lives.* Unpublished Master's Thesis. Montreal, QC: McGill School of Social Work, 1998.

Meyer, F., S. Goodleaf & D. Labelle. Two-Spirit people. [Project Interaction Web Site]. www.mcgill.ca/interact/

Monture-Angus, P. *Thunder in my soul: A Mohawk woman speaks.* Halifax: Fernwood, 1995.

Morgan, D. *Focus groups as qualitative research.* Thousand Oaks: Sage, 1997.

Peers, L., Demczuk, I. « Lorsque le respect ne suffit pas : Intervenir auprès des lesbiennes » *Reconnaître – Les lesbiennes face à la discrimination.* Ed. Demczuk. Montreal : Les Éditions du Remue-ménage, 1998. 77-116.

Remafedi, G. "Sexual orientation and youth suicide." *JAMA.* Vol. 282, No. 13 (1999): 1291-1292.

Roscoe, W. "Bibliography of berdache and alternative gender roles among North American Indians." *Journal of Homosexuality* 14(3/4) (1987): 81-171.

Ryan, B., S. Brotman & B. Rowe. *Access to care: Exploring the health and well-being of gay, lesbian, bisexual and Two-Spirit people in Canada.* Montreal: McGill Centre for Applied Family Studies, 2000.

Ryan, B. & M. Chervin. "Framing Gay Men's Health In A Population Health Discourse: A Discussion Paper." A Discussion Paper Written For Health Canada. Ottawa: Health Canada, 2001.

Simkin, R. "Unique health care concerns of lesbians." *The Canadian Journal of Obstetric/Gynecology Women's Health Care* 5(5) (1993): 516-522.

Smith, A. "Cultural diversity and the coming-out process: Implications for clinical practice." Ed. Beverly Greene. Thousands Oaks, CA: Sage, 1997.

---. "Ethnic and cultural diversity among lesbians and gay men." *Psychological Perspectives on Gay and Lesbian Issues.* Vol. 3 (279-)

Stasiulis, D. "Theorizing connections: Gender, race, ethnicity and class." *Race and ethnic relations in Canada.* Ed. P. Li. Toronto: Oxford University Press, 1990.

Tafoya, T. N. "Ethnic and Cultural Diversity Among Lesbians and Gay Men." *Native gay and lesbian issues: the Two-Spirited.* Ed. B. Greene. Thousand Oaks: Sage Publication, 1997.

Van der Meide, W. "The Intersection of sexual orientation, race, religion, ethnicity, and heritage language: The State of research" (a literature Review and research Backgrounder). Prepared for the Canadian Heritage Multiculturalism Program at 10, Intersections of Diversity Seminar, 2002.

Van der Meide, W. "The Intersection of sexual orientation and race: Considering the experiences of lesbian, gay, bisexual, transgendered (LGBT) people of colour and Two-Spirited people." Ottawa: EGALE, 2001.

Waldram, J. "Cultural and socio-economic factors in the delivery of health care services to Aboriginal people." *Racial minorities, medicine and health.* Eds. B.S. Bolaria, B.S. & R. Bolaria. Halifax: Fernwood, 1994.

Walters, K. L. "Urban lesbian and gay American Indian identity: implications for mental health service delivery." *Journal of Gay & Lesbian Social Services* 6(2) (1997): 43-65.

Weinberg, G. *Society and the healthy homosexual.* Garden City: Anchor, 1973.

West, C. Forword. Critical race theory: *The Key writings that formed the movement.* Eds. K. Crenshaw, N. Gotanda, G. Peller & K. Thomas, K. New York: The New Press, 1995.

Williams, W. L. *The Spirit and the Flesh – Sexual diversity in American Indian Culture.* Boston: Beacon Press, 1984.

Wotherspoon, T. "Colonization, Self-determination and the health of Canada's First Nations peoples." Racial minorities, medicine and health. Eds. B.S. Bolaria & R. Bolaria. Halifax: Fernwood, 1994.

Wright, J.A., M.A. Lopez & L.L. Zumwalt. "That's what they say: the implications of American Indian gay and lesbian literature for social service workers." *Two Spirited people – American Indian lesbian women and gay men.* Ed. L.B. Brown. New York: Harrington Park Press, 1997.