RESEARCH THAT MATTERS

HEALTH AND SOCIOECONOMIC WELL-BEING OF LBQ WOMEN in the US

March 2021

Bianca D.M. Wilson
Allegra R. Gordon
Christy Mallory
Soon Kyu Choi
M.V. Lee Badgett

UCLA School of Law Williams Institute

TABLE OF CONTENTS

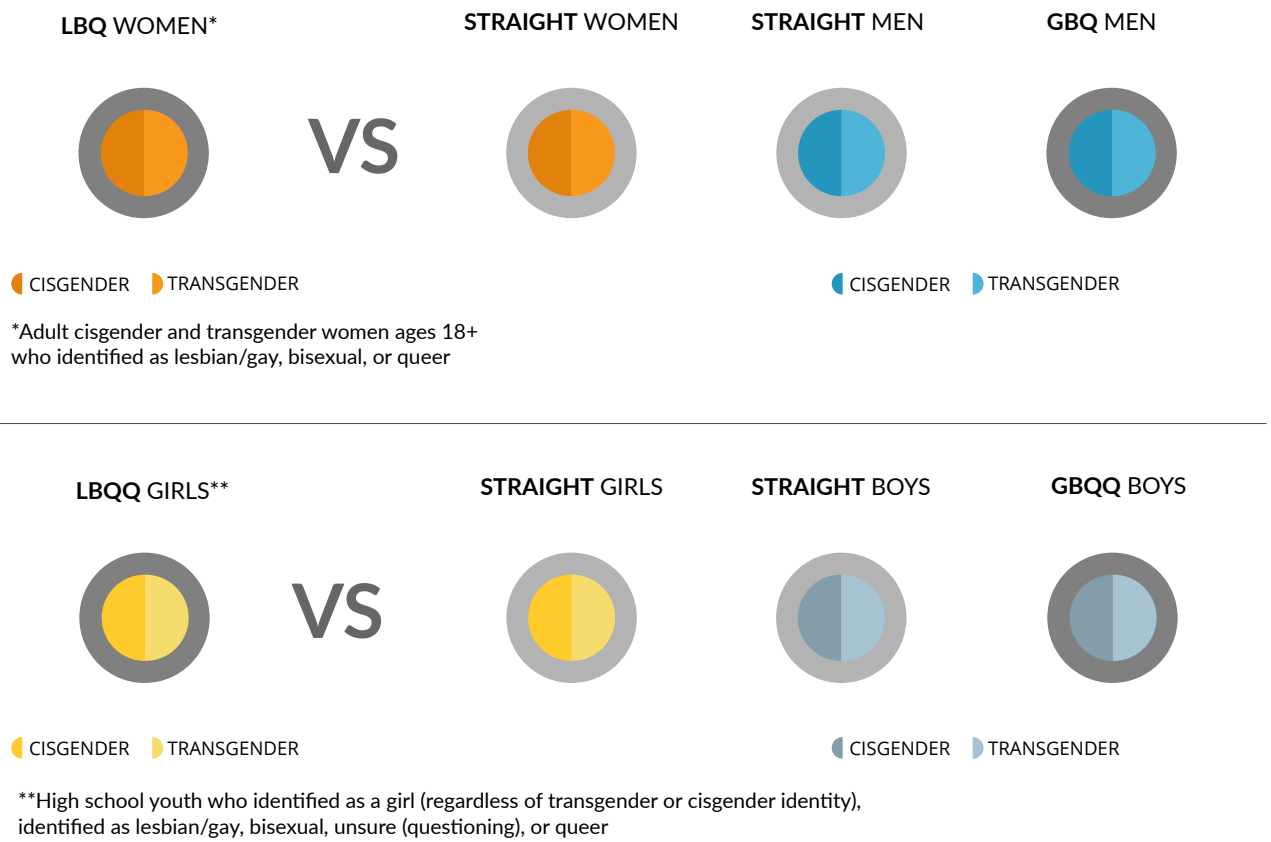
EXECUTIVE SUMMARY

The majority of the LGBTQ community identifies as women and girls.[1] Yet the lives of lesbian, bisexual, and queer (LBQ) women and girls, whether cisgender or transgender, and their unique challenges to well-being and opportunities for resilience are severely underrepresented topics in public discourse in the U.S. The major gaps in research,[2, 3, 4] services,[5, 6, 7, 8] and funding [9, 10] for LBQ women's issues and initiatives have been highlighted in numerous publications. Public awareness of the significant forms of violence and stigma experienced specifically by transgender girls and women, of all sexual orientations, is growing.[11, 12] Recent reports on the impact of the largest pandemic in a century have further put a spotlight on the inequities experienced by women in general in the U.S.[13, 14, 15] This report is intended to serve as a broad overview of what we know about lesbian, bisexual, and queer (LBQ) women's and girls' social, economic, physical, and psychological well-being from a population level and to identify needed next steps in public policy, services, and research.

Our approach to documenting the well-being and concerns of LBQ women is inclusive of transgender women, cisgender women, and women who identify on surveys as both "woman"/"female" and gender nonbinary/genderqueer and as sexual minorities. The focus of the report is on sexual minority status among women. As such, straight transgender and cisgender women are only included in the report as comparison groups to understand the impact of sexual orientation on women's lives. We recognize that this approach prioritizes the social experience of individuals currently identifying as a woman; the overlap in outcome and experiences between women and transgender men and nonbinary people is a goal for a future project. At this moment, our objective is to understand the well-being outcomes for those who sit at the intersection of being an LBQ-identified and woman-identified person in the context of key public policy domains. Where possible, we also assess the relevance of sexual orientation in the status of health and well-being among lesbian, bisexual, queer, and questioning (LBQQ) girls and LGBQQ transgender youth[a]. Our overall analytic approach was to provide data on LBQ women's and girls' well-being, and compare their outcomes to other sexual orientation and gender identity (SOGI) groups that were in more dominant social categories in some way (i.e., men, heterosexual/straight) (See Figure A). This approach reflects our theoretical orientation, which emphasizes the impact of multiple social statuses and forms of stigma in the lives of LBQ women.

[a] The primary focus of this report is the way sexual orientation and gender matters in the outcomes for LBQ girls (cis and trans). However, because of the limitations to how the national youth datasets measure gender identity, we have included data on LGBQQ transgender youth in comparison to heterosexual transgender youth as supplemental information on the role of sexual orientation in trans youth outcomes. These are provided in tables in the main report and appendices.

Figure A. Methods overview



We use multiple datasets to achieve the goal of presenting information on such a wide variety of topics. Almost all datasets used to assess the well-being of LBQ women and LBQQ girls in this report are national population-based (random sample) surveys, except for a few datasets available on specialized topics and subgroups (e.g., foster youth, transgender women). While randomized national surveys are not the only form of rigorous data collection, they provide the highest degree of confidence that the estimates reflect the larger population in the U.S.

FINDINGS

Population Demographics

- About 5% of women are LBQ and 22% of girls are LBQQ (transgender and cisgender women and girls combined), which means there are approximately 6,558,000 LBQ adult women and 2,256,000 LBQQ girls in the U.S.
- LBQ women make up 55% of the LGBTQ adult population; LBQQ girls make up 66% of the LGBTQ youth population.
- Among LBQ women, 2.7% are transgender and 97.3% are cisgender.
- 72% of LBQ women identify as bisexual; among LBQQ girls, 62% identify as bisexual and 25% as questioning.

- Approximately 39% of LBQ women are Latinx, Black, Asian American/Pacific Islander (AAPI), American Indian/Alaskan Native (AI/AN), or other ethnic minority identified. 57% of LBQQ girls are Latinx, Black, AAPI, AI/AN, or other ethnic minority identified.

Stigma, Discrimination, and Victimization

The study of stigma (also referred to as prejudice) has remained a core feature of social science research on the lives of sexual and gender minority people and has served as a foundation of many legal arguments in the interest of LGBT rights. Often conceptualized as flowing from stigma and prejudice, experiences with discrimination and victimization are related but distinct forms of oppression that have remained an important focus of LGBT research and policy discussions. We used data from the Generations/TransPop studies to examine transgender and cisgender LBQ women's experiences with stigma, discrimination, and victimization, and compare them to transgender and cisgender GBQ men. We also use data from the Youth Risk Behavior Surveillance System to identify frequency of experiences of victimization among LBQQ girls compared to heterosexual girls, heterosexual boys, and GBQQ boys.

- LBQ women were more likely than GBQ (gay, bisexual, and queer) men to live in communities they feel are not great places for marginalized groups (racial minorities, LGBT people, and immigrants).
- About 75% of all LBQ women experienced at least one everyday discriminatory event in the past year.
  - Bisexual and queer women were more likely to report everyday discrimination compared with lesbian women.
  - However, lesbians were significantly more likely to report sexual orientation-based discrimination events than bisexual and queer women (57% vs 31%).
- Nearly 46% of LBQ women reported an experience of being physically or sexually assaulted since they were 18 years old, compared with 35% of GBQ men.
- Approximately 24% of LBQQ girls experienced sexual violence in the last year, compared to 15% of both heterosexual girls and GBQQ (gay, bisexual, queer, and questioning) boys.

Socioeconomic Status and Economic Insecurity

Socioeconomic status refers to the social standing or class of an individual or group and reflects a combination of education, income, and occupation. With regard to LBQ women, economic stability has also remained a key area of disparity, either in comparison to heterosexual women or to men in general. Using a combination of the CDC's Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Surveillance (YRBS) Survey, and the Generations/TransPop Studies, we assessed how transgender and cisgender LBQ women and LBQQ girls fared on indicators of economic security prior to the COVID-19 pandemic.

Education

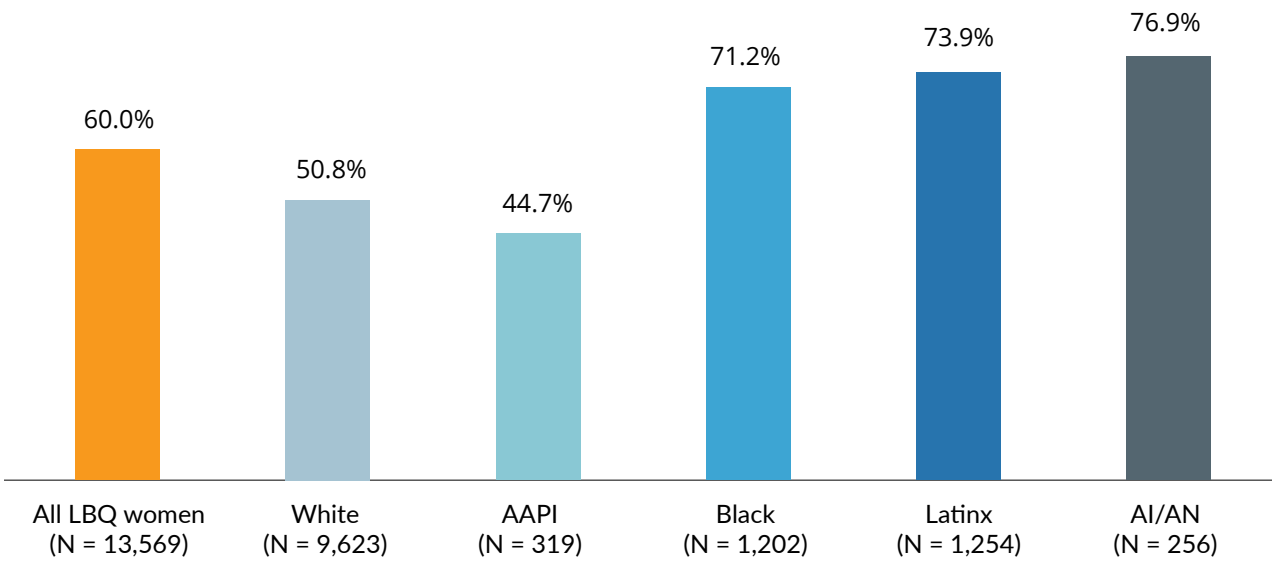
- Among youth, fewer LBQQ girls reported earning A's and B's in high school than straight girls, but more so than GBQQ boys.

- Among adults, more LBQ women (28.2%) completed college compared to straight men, but at a similar rate compared to straight women.
    - However, among LBQ women, women of color and bisexual women had lower rates of college or high school completion compared with White and lesbian women.

Income and Poverty

- Only 25% of LBQ women have household incomes over $75,000 compared with 33% of heterosexual women, 40% of heterosexual men, and 32% of GBQ men.
- 48% of LBQ women are living in a lower-income household (with an income less than 200% of the federal poverty line), compared with 42% of straight women, 38% of GBQ men, and 34% of straight men.
    - Among LBQ women who are parents, the lower-income rates are even higher. (See Figure B.)

Figure B. Percent of LBQ women with children under 18 living in a low-income household by race



- In their lifetime, approximately 33% of LBQ women have experienced a major financial crisis, declared bankruptcy, or were more than once unable to pay their bills on time in the year before the survey. In contrast, far fewer GBQ men (23%) and heterosexual men (15%) reported the same experiences.
- Fewer LBQ women (46%) were employed than heterosexual women (52%) and either heterosexual (64%) or GBQ (55%) men.

Housing and Homelessness

- More LBQ women (4%) had experienced recent homelessness and unstable housing

compared to straight women (2%), but this finding is likely driven by the high rate of homelessness among LBQ transgender women (23%).

- Fewer LBQ women (60%) than heterosexual women (69%) and men (70%) reported owning their home.

Health

The health inequities faced by LBQ girls and women are fundamentally affected by the social and policy environment. In the past two decades, research on the physical and mental health of LGBTQ populations has grown exponentially. Yet attention to the specific health experiences of diverse populations of sexual minority women—and implications for public health practitioners, policymakers, and community advocates—is lacking. In this section, we use data from BRFSS/YRBS and the Generations/TransPop studies to highlight key indicators of population physical and mental health for transgender and cisgender LBQQ adolescent girls and LBQ adult women.

Mental and Behavioral Health Among Youth

- 44% of LBQQ girls reported having considered suicide in the last year, compared to 18% of straight girls, 13% of straight boys, and 32% of GBQQ boys.
    - The percent of LBQQ girls who considered suicide did not differ significantly by race, but all groups reported relatively high levels: AI/AN (56%), another race/ethnicity (49%), White (45.0%), Latinx (44%), Black (39%), and AAPI girls (37%).
    - Bisexual girls had higher odds of feeling sad or hopeless compared with lesbian and questioning girls.
    - Lesbian and bisexual girls were equally likely to report having attempted suicide in the past year.
- LBQQ girls were nearly three times more likely than heterosexual girls to use cigarettes.
- LBQQ girls were more likely than heterosexual girls and boys and GBQQ boys to report current alcohol and marijuana use.

Mental and Behavioral Health

- More LBQ women (46%) had been diagnosed with depression compared to straight women (23%), straight men (13%), and GBQ men (31%).
    - Over half of AI/AN and White LBQ women reported having been diagnosed with depression in their lifetime.
- LBQ women are more likely to smoke cigarettes and binge drink compared with heterosexual men and women, but less likely than men in general to use smokeless tobacco products.

Physical Health

- Nearly 29% of LBQ women described their health as fair or poor, compared to 19% of straight women.
    - A higher proportion of LBQ women of color described their health as fair or poor compared with White LBQ women.
    - Bisexual women were more likely to report fair or poor health compared to lesbians.
- More LBQ women (35%) reported up to 14 days a month of limited mobility due to physical health (i.e., mild disability), compared to straight women, straight men, and GBQ men (28%, 25%, and 30%, respectively).
- More LBQ women (32%) reported a BMI over 30 compared to straight women (29%) and GBQ men (27%).
- More LBQ women than all other groups reported having been diagnosed with asthma, arthritis, or cancer, but significantly fewer reported high blood pressure compared with heterosexual and GBQ men.
- More LBQ women reported a diagnosis of heart disease, high blood pressure, and diabetes compared to straight women.
- Overall, LBQ women reported few cases of being HIV positive, though 7% of LBQ trans women reported being HIV positive.

Health Care Access

- 14% of LBQ women were uninsured compared with 10% of heterosexual women.
- Women of color were generally more likely to be uninsured compared with White women.
    - Lesbian and bisexual women had similar rates of being uninsured.
- 29% of LBQ women were without a regular health care provider, a similar percentage to GBQ men, but higher than the percentage of heterosexual men and women.
- Over half of LBQ women fear being negatively judged by their health care provider, and many feared anti-LGBT bias might impact their care.
- LBQ women were more likely (90%) to never visit LGBT centers for health care compared to GBQ men (77%).

Reproductive Health

- 27% of LBQ women had a child under 18 in their household.
    - 32% of LBQ women of color had minor children in their home.
- 18% of LBQ women reported wanting children but were not able to have them.
- Data on the experiences, needs, and hopes of trans women related to family formation are severely lacking in reproductive-focused datasets.

- Among LBQ cisgender women who had children, there were several ways their families came to be, including 80% through a current or previous sexual relationship, 23% through step-parenthood, 10% through alternative insemination using a sperm donor, and 5% through adoption.
- Cisgender LBQ women of childbearing age (18–49 years) used abortion services at similar rates to heterosexual cisgender women.
- Black and Latinx LBQQ girls had the highest prevalence of having accessed HIV testing (19% and 14%, respectively). Black LBQQ girls and those of another race/ethnicity had the highest prevalence of having accessed STI testing (18% and 16%, respectively).
- About 33% of LBQ women and 25% of GBQ men have never been tested for HIV.
- Fewer LBQ cis women (43%) than straight cis women (71%) age 40+ years had ever had a mammogram.
- About 22% of LBQ cis women reported having a child for whom they have no legal recognition as their parent.

System Involvement

The term we use to refer to people's interactions with the child welfare and/or criminalization systems is "system-involved." System involvement has long been identified as an area in which racial, gender, and socioeconomic disparities exist, particularly for youth. Our previous research has shown the overrepresentation of LGBT youth and adults in these systems, noting the high rates among LGBT youth and adults who are also racial minority women. Here we highlight findings from these prior studies that describe the system involvement of cisgender LBQ women and cisgender and transgender girls. To do this, we use a combination of datasets: Generations/TransPop studies, Los Angeles Foster Youth Study, National Youth in Custody Survey, and National Inmates Survey. Unfortunately, the youth and adult incarceration data and adult foster care history data were not available for transgender women.

- 39% of cis girls in juvenile detention are LBQQ.
    - The majority of LBQQ cis girls (64%) who were incarcerated are girls of color, particularly Black and Latinx.
- LBQ cis women make up 33% of women in prison; again, the majority (61%) are women of color.
- Almost 8% of transgender and cisgender LBQ women of color compared with 3% of White LBQ women report experiencing serious trouble with the police or the law.
- In a survey of youth, LBQQ cis and trans girls were found to represent 9% of the foster youth population, which indicated slight overrepresentation at the time the survey was conducted.
- About 4% of cisgender adult LBQ women (ages 18–41) reported having lived in foster homes as a child; lesbians (9%) were slightly more likely than bisexual (1%) and queer (7%) women to report a history of foster care.
    - Among LBQ women and GBQ men who had child welfare experiences, nearly 40% reported that they moved to different placements because of how people treated them due to their minority sexual orientation or gender identity.

Resilience

Resilience refers to surviving and thriving despite ongoing challenges, and the concept has particular relevance for understanding how LGBTQ people negotiate oppression and minority stress. This next section examines indicators of and resources for resilience through different support systems, using questions asked in the Generations/TransPop surveys. Unfortunately, resilience is not a focus of national health data and therefore we do not have any resilience findings for LBQQ girls.

- About 68% of LBQ transgender women felt connected to the transgender community, which was more than we found among GBQ transgender men.
    - 66% of cisgender LBQ women felt connected to the LGBT community, which was about the same number of GBQ cis men.
    - Bisexual cis women (59%) were less likely to feel connected to LGB communities compared with cis lesbians (81%).
- Fewer LBQ women (60%) felt social support compared with heterosexual women (76%).
- Fewer LBQ women (30%) felt moderate levels of social well-being compared with 37% of GBQ men, 42% of heterosexual women, and 50% of heterosexual men.
- In terms of political engagement, LBQ cis women were much more likely to participate in political or civic activities focused on a mix of issues (around LGBT, race, women's issues, etc.) compared with cis GBQ men, who primarily focused on LGBT issues.
- A notable indicator of resilience across the outcomes covered in this report is that we identified no disparities specific to Asian- American and Pacific Islander LBQ women compared to other racial groups. However, research also shows that there is diversity in health and well-being among AAPI people. As such, future research should examine the distinct experiences among AAPI LBQ women of various ethnicities.

POLICY IMPLICATIONS

Our findings highlight the need for an intersectional approach to policymaking that considers the needs of individuals based on their multiple marginalized characteristics, including race, sex, sexual orientation, and gender identity. Comprehensive, nationwide non-discrimination protections such as the Equality Act would ensure that LBQ women and girls are legally protected from discrimination based on their sexual orientation and gender identity, as well as their race and sex, in multiple settings including schools and public accommodations. Other policies that support survivors of violence, such as the Violence Against Women Act, could benefit LBQ women, who are more likely to experience certain types of violence and often lack access to equal resources. The findings also indicate a need for policies that seek to achieve equity in wages, reduce unemployment, and increase access to housing for women, people of color, and LGBTQ people. In addition, LBQ women and girls continue to face barriers in accessing health care and policies aimed at reducing or eliminating these barriers—such as policies that reduce administrative barriers to enrolling in Medicaid and expand insurance coverage for certain types of care would likely have a disproportionate impact on LBQ women and girls. Finally, criminal legal system reforms aimed at reducing or ending over-incarceration and over-policing generally, and in particular for LGBTQ people and people of color, would benefit LBQ women and girls who face higher rates of incarceration and victimization while in custody.

SUMMARY

Our research highlighted the significance of sexual orientation in the lives of women in the U.S. Across the many issues we covered, it is clear that there are multiple areas of vulnerability in every policy domain for LBQ women and girls. Some of these areas of vulnerability are particularly heightened for sexual minority women (e.g., poverty, depression; criminalization); others are shared with either heterosexual women (e.g., physical and sexual assault) or sexual minority men (e.g., bullying, lack of healthcare access and insurance). Despite covering a broad range of topics relevant to the lives of LBQ women and girls, there are many topics we did not address here. Further research is needed to understand how the various disparities identified here are associated with one another (e.g., the relationship between race, sexual orientation, and weight-based stigma and health outcomes). National data on topics like interpersonal violence, sex work, and the role of gender expression and nonbinary identities among LBQ women are also needed. Many existing data sources still do not include adequate measures of sexual orientation and gender identity. SOGI data collection must be expanded on national and state surveys to get a fuller picture of the social, health, and economic outcomes of LBQ women. Further, it is critical to support ongoing efforts to engage in community-based research that aims to fill the gaps left by state-sponsored surveys[b].

An important point to make about the findings from this study across so many topics in this moment is that all the data were collected before the COVID-19 pandemic. Given the known mental and physical health and economic impacts of the COVID-19 pandemic, all of these findings must be understood in the context of vulnerability for the impact of the pandemic and essentially considered a baseline for what we see moving forward. Gender-focused research over the next five years should specifically look at not just women's well-being as a function of the pandemic, but also the role of sexual orientation in those outcomes.

[b] For example, there is a new effort by a diverse array of scholars and activists to gather data from a large community sample of sexual minority women in the US. The Survey will be in the field in 2021. www.LGBTQwomensurvey.org

INTRODUCTION

The lives of sexual minority women, including unique challenges to well-being and specific opportunities for resilience, is a severely underrepresented topic in public discourse in the U.S. Twenty years ago, a groundbreaking report on the health of lesbian-identified women summarized research across multiple areas of physical and mental health topics.[16] Since then, many scholars and advocates have noted that there are still many gaps in research,[17, 18, 19,] services,[20, 21, 22, 23] and funding[24, 25] for sexual minority women's issues. Without an understanding of the state of sexual minority women's health and well-being, policymakers and community activists invested in improving the lives of all women and all LGBT people do not know whether or how to approach that work in specific ways for those who sit at the intersection of these groups. This report is intended to serve as a comprehensive overview of what we know about sexual minority women's health and well-being from a population level and to identify needed next steps in public policy, services, and research.

LBQ WOMEN: DEFINITIONS

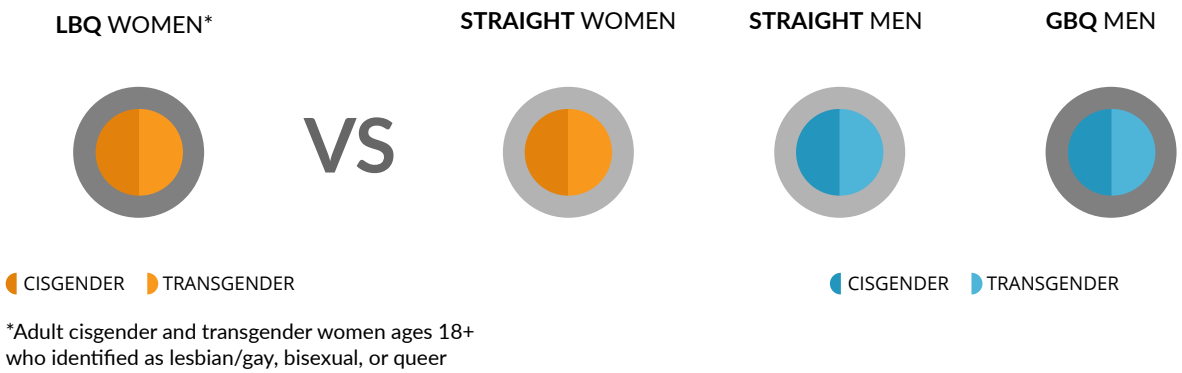
The term "sexual minority" has grown in use in the past two decades, particularly within the health fields, to refer to the diverse population of people who express identities, attractions, and/or behaviors that sit outside of a heteronormative framework.[26] In this report, we use the term "sexual minority women" to refer to women who currently identify as something other than heterosexual as well as those who are not exclusively in sexual and romantic relationships with or exclusively attracted to men. This report largely focuses on a subset of sexual minority women: those who identify as lesbian or gay (herein referred to as lesbian), bisexual, or a term other than these two that we place collectively under the category "queer" (LBQ). Among youth, the focus is also on girls identified as LBQ in addition to youth who indicate they are unsure or questioning their sexual identity (LBQQ). Given this focus on sexual minority women and girls exclusively through the lens of identity, future work is needed that examines the experiences and policy needs of other sexual minority women's and girls' subgroups (e.g., women/girls who do not identify as LBQ and report non-heterosexual attractions and sexual behaviors).

Our approach to documenting the well-being and concerns of LBQ women is inclusive of transgender women, cisgender women, and women who identify as both "woman"/"female" and "gender nonbinary or genderqueer" on surveys. All heterosexual women (cis and trans) are included only as a comparison group. We recognize that this approach prioritizes the social experience of individuals currently identifying as a woman and not the potential differences based on sex assigned at birth or the experience of gender-affirming transitioning. Further, this report includes people who identified as men only in comparison groups, regardless of their sex assigned at birth (i.e., transgender or cisgender men). There may be overlap between the experiences and well-being outcomes of LBQ women and those who once identified as or were assumed to be girls/women; however, understanding these areas of overlap and difference is a goal for a future project. In this moment, our objective is to understand the well-being outcomes for those who sit at the intersection of being an LBQ-identified and woman/girl-identified person in the context of key public policy domains.

We use the term "LBQ women" throughout this report, although at times those included in this group may vary depending on the data source. The report relies on data from multiple surveys, each of which varies slightly in how it measures sexual orientation identity (See Methods Note). Nonetheless,

a common feature across them is all the surveys limited sexual minority identity response options to "gay/lesbian" or "bisexual." An exception is the one adult survey used for this report that allowed a participant to select "lesbian" or "bisexual" and then another identity label (e.g., "queer"). Further, the youth surveys used for this report included an option indicating a "questioning" stage of identity (i.e., "unsure" or "not sure yet"). For the sections on youth, "LBQQ" refers to girls who identify as lesbian, bisexual, or questioning and LGBQQ refers to trans youth who selected gay/lesbian, bisexual, or questioning—a group included in this report because they include lesbian and bisexual transgender girls and the survey from which the youth data come from do not allow us to identify trans girls separate from trans boys and trans nonbinary youth.

Figure 1. Methods overview

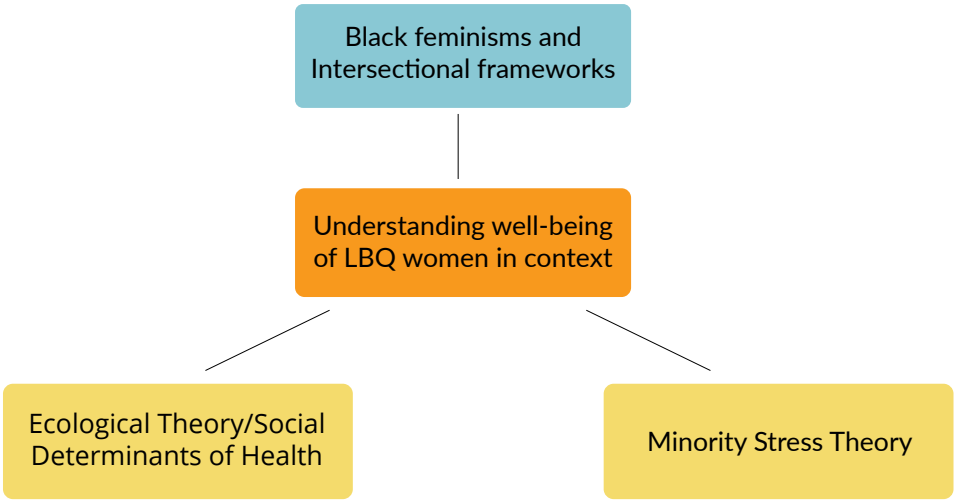


GUIDING FRAMEWORKS

Our selection of topics was guided by several existing theoretical and applied research frameworks. The overall focus of the report is on LBQ women's well-being. To that end, we use an expansive definition of "well-being" similar to that used by the recent National Academy of Sciences on LGBT people. Their definition includes multiple dimensions along which communities should be thriving: mental health, physical health, economic health, and social and cultural experiences.[27] Further, our approach is heavily informed by multiple theoretical frameworks that emphasize the roles of structural, institutional, and cultural factors in producing inequities across the population. These key frameworks include ecological theory[28, 29] and related public health frameworks emphasizing a

social determinants of health perspective,[30, 31] in which individual outcomes and behaviors are best understood in the context of their immediate as well as social and cultural surroundings.[32] We rely on minority stress theory as a framework that has documented pathways by which anti-LGBT bias impact LGBT people's mental health.[33, 34] Finally, we are guided by the collection of writings and frameworks (intersectionality[35, 36, 37] triple jeopardy,[38] etc.) that have identified multiple forms of oppression (anti-LGBT bias, racism, sexism, and other forms) as the root of material and health inequities and disparities among Black women and extend this work to sexual minority women of color.[39, 40]

Figure 2. Guiding theoretical frameworks informing analysis of sexual minority women's well-being



In sum, we apply an expansive conceptualization of well-being in combination with an understanding that individual and group level outcomes must be understood in social context and that experiences with oppression are a key feature of that context in the lives of LBQ women. However, we acknowledge that such a perspective could lead to a report on an exhaustive list of topics and documenting all possible outcomes among sexual minority women is not the aim of this report. As such, the parameters of the report are guided also by a public policy focus—meaning the goal is to provide information relevant to pressing ongoing public policy debates that may impact LBQ women in the United States.

REPORT OVERVIEW

Drawing from the frameworks described above, this report seeks to document LBQ women's economic, social, and health outcomes in the context of indicators of stigma and discrimination. We address six major domains: (1) Population estimates and demographic characteristics, (2) Discrimination and victimization, (3) Economic insecurity, (4) Health, (5) Criminalization and child welfare system-involvement, and (6) Resilience. In each section, we focus on providing estimates of the percentage of the population that might be impacted by key areas of public policy debates per topic. We do not provide in-depth statistical analysis to explain the mechanisms for differences between groups. For each outcome, if data are available, we assess how LBQ women compare with

other more dominant groups at the intersection of sexual orientation and gender: heterosexual women, heterosexual men, and gay, bisexual, and queer (GBQ) men. Additionally, we present data on variability among sexual minority women regarding age, racial/ethnic, and sexual identity groups.

We use multiple datasets to achieve the goal of presenting information on such a wide variety of topics. Almost all datasets used to assess the well-being of sexual minority women are national population-based (random sample) surveys, except for a few datasets available on specialized topics and subgroups (e.g., youth, transgender women). While randomized surveys are not the only form of rigorous data collection, they provide the highest degree of confidence that the estimates reflect the larger population. Details on the methodology and analysis strategies can be found in the Methods Note of this report. Statistical values described in the text are rounded to nearest whole number and more precise values are presented in the tables.

LBQ WOMEN AND GIRLS POPULATION

We estimate that there are a total 6,558,000 LBQ adult women and 2,256,000 LBQQ girls in the U.S. (Table 1). The number of adult LBQ women indicates that this group makes about 55% of the total LGBTQ population. The finding reflects what we see in other studies: the growing proportion that women and girls make up of the larger LGBT population and the significant proportion that younger people account for in the total.[41] Our estimates for adults include both cisgender and transgender women who identify as lesbian/gay or bisexual, and for youth include those who identify as a girl (regardless of transgender status) and as lesbian/gay or bisexual or are unsure about their sexual orientation identity (as an indicator of questioning status).[c] In the interest of providing information on youth who explicitly identify as transgender, we include estimates throughout the report where possible on sexual minority trans youth, which theoretically includes trans girls, trans boys, and trans nonbinary youth who identify as lesbian/gay, bisexual, or unsure. The inclusion of "Q" for questioning status leads us to add a "Q" to the "LBQ" or "LGBQ" labels for youth. LGBQQ trans youth comprise 73.5% of the trans youth population. Table 2 shows proportions of key demographic and social identity characteristics among sexual minority women and girls as well as transgender youth.

Table 1. Population estimates of lesbian, bisexual, and queer women and girls in the US

	LBQ WOMEN	LBQQ GIRLS	LBQQ TRANS YOUTH
Percentage among women/girls	5.1%	21.9%	--
Percentage of total population	2.6%	10.8%	2.3%
Population estimate	6,558,000	2,256,000	481,000

Source: BRFSS, 2017–2019 (adults); YRBS, 2019 (youth)
Note: Population size estimate is rounded to the nearest 1,000. LBQ = lesbian, bisexual, queer; LBQQ = lesbian, bisexual, queer, questioning; LGBQQ= lesbian, gay, bisexual, queer, questioning; The estimates for LBQQ girls and LGBQQ trans youth are not mutually exclusive.

[c] The ideal approach would have been to explicitly include binary identified trans girls and cis girls in one estimate of LBQQ girls; however, this was not possible with the way transgender status was measured by the 2019 CDC youth survey used for the report—it asks about whether a youth identifies as transgender but not whether they identify as a transgender girl or boy or as nonbinary, and the standard "sex" question does not allow us to adequately assess assigned sex at birth. This means that our grouping of sexual minority girls is inclusive of cisgender girls and any trans youth who selected "girl" in response to the sex question, regardless of whether they intended that response to mean their sex assigned at birth or gender identity.

Table 2. Demographic characteristics among LBQ women, LBQQ girls, and LGBQQ trans youth in the US

	LBQ WOMEN (N = 13,569)	LBQQ GIRLS (N = 18,446)	LGBQQ TRANS YOUTH (N = 2,610)
Age (mean)	35.4	15.9	15.8
AGE GROUP			
Under 50	79.9%	--	--
50+	20.1%	--	--
GENDER IDENTITY			
Transgender	2.7%	--	--
Cisgender	97.3%	--	--
RACE/ETHNICITY			
White	61.2%	42.9%	52.2%
Black	14.1%	15.1%	10.6%
Asian/Pacific Islander (AAPI)	4.3%	5.4%	5.7%
American Indian/Alaskan Native (AI/AN)	1.4%	1.4%	0.7%
Latinx	15.3%	30.1%	25.4%
Other	3.7%	5.1%	5.5%
SEXUAL IDENTITY			
Lesbian/Gay	28.3%	13.4%	28.9%
Bisexual	71.7%	62.0%	46.5%
Questioning (not sure)	--	24.6%	24.6%

Source: BRFSS, 2017-2019 (adults); YRBS, 2019 (youth)

TRANSGENDER WOMEN AND SEXUAL IDENTITY

Throughout this report, the findings on each domain of well-being include sexual minority women and girls who are both transgender and cisgender. Comparisons between heterosexual and sexual minority women are commonplace in the research literature, leading to a general understanding that sexual orientation matters as a key factor in women's lives.[42] However, these comparisons rarely include trans women. Further, very little research has looked at the experiences of sexual minority transgender women in comparison with heterosexual-identified transgender women.[43] In addition to general demographic information on race, age, and partnership status, there are transgender-specific demographics and experiences that are not asked in general population surveys but are nonetheless relevant for understanding the health and well-being outcomes of trans sexual minority women. We used the 2015 U.S. Transgender Survey to provide additional information on the demographics and characteristics of trans women by sexual orientation in order to present a more nuanced context for the analyses in each well-being domain.

In sum, data from this large-scale community sample show several key areas of differences in the characteristics of transgender women depending on their sexual orientation. Transgender women who identify with a sexual minority identity (e.g., lesbian, bisexual, queer) are more likely to be younger, White, and have a college education compared with those who identify as heterosexual or straight. Further, LBQ transgender women are more likely to feel that people assume they are

trans, which appears to correspond to their being less likely to be living full time in their current gender identity (i.e., as a woman), have completed a legal name change, and have undergone some form of medicalized gender-affirming therapy, and are more likely to use the term transgender to describe themselves. However, trans sexual minority women were no more or less likely to use the pronouns "she/her" to refer to themselves. These distinctions between trans women of different sexual identities may help to anchor discussions about the subsequent findings related to health and economic outcomes in the context of potential vulnerability for victimization and discrimination.

Table 3. Demographics of a community sample of LBQ and straight transgender women in the US

	LBQ TRANS WOMEN (N = 6,774)	STRAIGHT TRANS WOMEN (N = 1,308)
Age (mean)	36.2	**40.3**
MARITAL STATUS		
Currently married	20.5%	16.7%
RACE/ETHNICITY		
Black	8.0%	26.7%
Latinx	14.6%	22.4%
AAPI	4.5%	5.2%
AI/AN	1.0%	0.7%
POC (combined)	28.1%	**55.0%**
White	72.0%	**45.0%**
EDUCATION		
College educated or higher	38.2%	34.4%
GENDER IDENTITY		
Woman	36.6%	**42.6%**
Trans woman	63.4%	**57.4%**
SOCIALIZE WITH OTHER TRANS PEOPLE		
Online only	16.3%	15.7%
In person/other	74.1%	**67.4%**
Don't socialize with trans people	9.6%	**16.9%**
OUTNESS		
Currently live full time in a gender different from ASAB	66.4%	**78.3%**
Comfortable using term "transgender" to describe you	76.2%	**66.3%**
Ever tried/completed legal name change to match GI	45.7%	**59.3%**
She/her pronoun use	83.0%	81.8%
Age started living full time as a woman (mean)	32.2	**29.0**
EXPRESSION		
People can tell I'm trans even if I don't tell them		
Always	4.3%	**2.4%**
Never	14.9%	**19.8%**

	LBQ TRANS WOMEN (N = 6,774)	STRAIGHT TRANS WOMEN (N = 1,308)
GENDER-AFFIRMING CARE		
Any hormone/surgery (incl. electrolysis + voice therapy)	76.7%	**84.8%**

Source: USTS, 2015

Note: Bold numbers indicate statistically significant differences between that comparison group and LBQ trans women.

STIGMA, DISCRIMINATION, AND VICTIMIZATION

STIGMA

The study of stigma (also referred to as prejudice) has remained a core feature of social science research on the lives of sexual and gender minority people and has served as a foundation of many legal arguments in the interest of LGBT rights.[44, 45, 46, 47, 48] Stigma refers to both negative and/or stereotypical societal attitudes about a group as well as the internalization (or directing towards oneself) of these negative attitudes.[49, 50, 51] In this section we present findings on LBQ women's experiences with various forms of stigma. To do this, we rely primarily on a LGBT-specific population-based survey (Generations/TransPop). Many of these questions are so specific to LGBT experiences that we do not include a comparison group of heterosexual people. However, where possible, we compared findings with those pertaining to sexual minority men. A strength of the Generations/TransPop dataset is that it allowed participants to select other sexual minority identities in addition to lesbian or bisexual, which we combine into a "queer" category representing other sexual identities defined by sexual attractions to and relationships with only women or to multiple genders (e.g., queer, pansexual).

Community Stigma

As an indicator of perceived prejudice within community settings, we assessed whether LGBT women felt that the city or area where they resided was a bad place to live for different minority groups. More LBQ women than straight women and men reported living in neighborhoods they felt were a bad place for racial/ethnic minorities, transgender people, and immigrants. Slightly more LBQ women than GBQ men reported living in neighborhoods they felt were a bad place for racial/ethnic minorities, LGB people, and immigrants (Table 4).

Table 4. Perceived prejudice within community settings among LBQ women compared to other SOGI groups

	LBQ CIS WOMEN (N = 803)	LBQ TRANS WOMEN (N = 68)	ALL LBQ WOMEN (N = 871)	STRAIGHT WOMEN (N = 276)	STRAIGHT MEN (N = 277)	GBQ MEN (N = 754)
CITY OR AREA WHERE YOU LIVE IS NOT A GOOD PLACE FOR…						
Racial/ethnic minorities	37.7%	29.5%	37.1%	**20.6%**	**14.1%**	**27.6%**
Gay, lesbian, or bisexual people	33.2%	28.6%	32.9%	24.3%	**21.2%**	**25.7%**
Transgender people	49.4%	34.2%	48.3%	**33.5%**	**29.3%**	**40.2%**
Immigrants from other countries	38.7%	31.9%	38.2%	**19.3%**	**16.3%**	**31.1%**

Source: Generations Study and TransPop Study data

Note: Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

Lesbians and bisexual/queer women did not differ in how they viewed the city or area where they lived for different minority groups. White LBQ women and women of color also felt similarly about the city or areas where they lived. More LBQ women under the age of 50 (40%) believed that their city or area was a bad place to live for racial/ethnic minorities and LGB people (34%) compared with those over the age of 50 (See Appendix A for Stigma tables).

Interpersonal and Internalized Stigma

As indicators of interpersonal (how non-marginalized groups feel about marginalized groups) and internalized (how someone feels about their own marginalized identity) stigma, we assessed whether LBQ women have negative expectations of people's responses to their LBQ and transgender status and how they felt about their identities. In the available datasets for this topic, LGBQ transgender and cisgender women and men were asked different types of questions; therefore, we report the findings separately.

Transgender Stigma

Using the Gender Non-Disclosure Scale, a five-item scale that includes questions such as "I modify my way of speaking" and "I avoid exposing my body, such as wearing a bathing suit or nudity in lockers room," we assessed the extent to which transgender adults avoid disclosing their identity.[52] The scale responses range from "Strongly agree" to "Strongly disagree" with an average score between 1 and 5, with 5 meaning someone makes a stronger effort to hide their gender identity. About 31% of LBQ transgender women expressed moderate levels of avoiding disclosure of their gender identity, meaning they scored an average of 4 or above. We also examined the extent to which transgender-identified people internalized stigma that others have toward transgender people. Using the Internalized Transphobia Scale, a six-item scale that includes measures such as "I resent my transgender identity" and "Being transgender makes me feel like a freak," we found that nearly 9% of LBQ transgender women scored an average of 4 and above on a 1–5 scale.[53] LBQ and GBQ transgender women and men similarly avoided disclosing their transgender identity and experienced internalized transphobia (Table 5).

Table 5. Gender identity stigma among LGBQ trans women and men

	LBQ TRANS WOMEN (N = 68)	GBQ TRANS MEN (N = 50)
REPORTED A MODERATE LEVEL OF…		
Avoiding disclosure of gender identity (i.e., I don't talk about certain experiences from my past or I change parts of what I will tell people)	30.7%	30.9%
Internalized transphobia (i.e., I resent my transgender identity)	8.6%	10.3%

Source: TransPop Study data

Thirty-four percent of White LBQ transgender women reported moderate levels of avoiding disclosure of their gender identity. Seven percent of LBQ women of color who are transgender felt the same. Yet. about 26% of women of color and 7% of White transgender-identified LBQ women reported experiencing a moderate level of internalized transphobia. With regard to age, 37% under the age of 50 and 11% age

50 and above avoided disclosure of their gender identity. About 10% of younger women and 3% of older women experienced moderate levels of internalized transphobia (See Appendix A for Stigma tables).

LGB Stigma

In this next section, we examine stigma around LGB identity among LBQ women who are not transgender. Using the Felt Stigma Scale, which includes three items—"Most adults where I live think less of a person who is LGB"; "Most employers where I live will hire openly LGB adults if they are qualified for their job"; "Most adults where I live would not want someone who is openly LGB to take care of their children"— we find that 13% of LBQ cisgender women and 12% of GBQ cisgender men felt moderate levels of stigma related to their LGB identity (Table 6).[54] From a scale of 1–5, they scored an average of 4 and above. We used the Internalized Homophobia Scale, a five-item scale, to measure the extent to which someone has internalized stigma associated with LGB identity. Items include comments such as "I have tried to stop being attracted to adults who are the same sex as me" and "I wish I weren't LGB."[55] Less than 1% of LBQ cisgender women expressed experiencing internalized homophobia, and although 1.3% of GBQ cisgender men reported internalized homophobia, this difference is not statistically significant. Most LBQ cisgender women were out to their families (87%), to their straight friends (98%), and to their co-workers (73%), and about 66% were out to health care workers. More LBQ cisgender women than GBQ cisgender men were out to friends; however, more GBQ cisgender men than women were out to their co-workers and to health care workers.

Table 6. Sexual identity stigma among LGBQ cis women and men

	LBQ CIS WOMEN (N = 803)	GBQ CIS MEN (N = 704)
REPORTED A MODERATE LEVEL OF…		
Felt stigma (i.e., Most people where I live think less of a person who is LGB)	13.4%	12.1%
Internalized homophobia (i.e., I wish I weren't LGB)	0.3%^	1.3%
"OUTNESS" OF SEXUAL IDENTITY		
Out to family	86.8%	89.3%
Out to straight friends	97.8%	**94.3%**
Out to co-workers	72.9%	**79.6%**
Out to healthcare workers	65.5%	**75.6%**

Source: Generations Study data

Note: Bold numbers indicate statistically significant differences between that comparison group and LBQ women. ^Some estimates are based on too few respondents to be stable enough to represent the population estimate. We provide these but added ^ to indicate they should be interpreted with caution.

There were no differences in levels of felt stigma between lesbian and bisexual/queer cisgender women Additionally, about 1% of lesbian cisgender women felt a moderate level of internalized homophobia and no bisexual/queer cisgender women reported having felt that way. However, the two groups differed in levels of "outness." More lesbian than bisexual/queer cisgender women were "out" to their families (98% vs. 81%), their co-workers (93% vs. 64%), and health care workers (88% vs. 55%) (See Appendix A for Stigma tables).

LGB identity stigma experiences did not differ by race/ethnicity for LBQ cisgender women. Though close to 1% of people of color felt moderate levels of internalized homophobia, no White women reported feeling the same. Experiences of felt stigma and internalized homophobia looked similar for cisgender women under the age of 50 and those age 50 and above. However, the two groups differed in "outness" of their LGB identity. More LBQ cisgender women age 50 or older were out to their family, co-workers, and health care workers than were younger women (See Appendix A for Stigma tables).

DISCRIMINATION AND VICTIMIZATION

Often conceptualized as flowing from stigma and prejudice, experiences with discrimination and victimization are related but distinct forms of oppression that have remained an important focus of LGBT research and policy discussions.[56, 57] Discrimination often refers to inequitable treatment of a person or group based on their social identity or status at political, cultural, and structural levels, similar to the way some scholars describe "structural stigma."[58, 59, 60] Victimization refers specifically to physical, verbal, or emotional abuse, both experienced and threatened.[61, 62] We use data from LBQ women's responses to questions about ongoing and routine unfair treatment, as well as reports on types of violence experienced.

Everyday Discrimination

The Everyday Discrimination Scale examines the extent to which someone experienced routine unfair events in the past year. The nine-item scale includes the following statements: "You were treated with less courtesy than other people"; "You were treated with less respect than other people"; "You received poorer service than other people at restaurants or stores"; "People acted as if they thought you were not smart"; "People acted as if they were afraid of you"; "People acted as if they thought you were dishonest" ; "People acted as if they were better than you"; "You were called names or insulted"; "You were threatened or harassed." [63]

Most LBQ women (75%) experienced at least one everyday discriminatory event in the past year from when the survey was administered in 2016–2017. Compared with heterosexual women (59%), men (59%), and GBQ men (66%), more LBQ women experienced a discriminatory event (Table 7).

Table 7. Experiences with everyday forms of discrimination among LBQ women compared with other SOGI groups

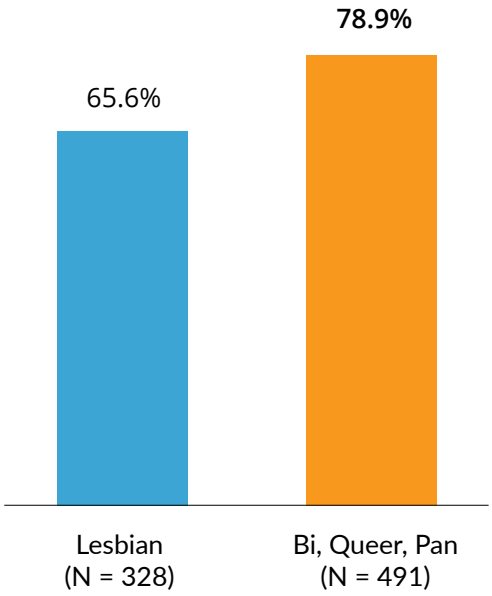
	LBQ CIS WOMEN (N = 803)	LBQ TRANS WOMEN (N = 68)	ALL LBQ WOMEN (N = 871)	STRAIGHT WOMEN (N = 276)	STRAIGHT MEN (N = 277)	GBQ MEN (N = 754)
Experienced at least one everyday discriminatory event in the past year	75.0%	81.3%	75.4%	**58.9%**	**58.5%**	**65.7%**

Source: Generations Study and TransPop Study data

Note: Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

Compared with 66% of lesbian women, 79% of bisexual, queer, or pansexual women experienced at least one everyday discriminatory event in the past year relative to when the survey was administered in 2016–2017 (Figure 3). LBQ women of color and White women reported everyday discrimination at similar rates, both close to three quarters for each group (Figure 4). More LBQ women under the age of 50 (78%) reported experiencing an everyday discriminatory event in the past year compared with those age 50 and older (61%) (See Appendix A for Stigma tables).

Figure 3. Experiences with everyday forms of discrimination among LBQ women by sexual identity group



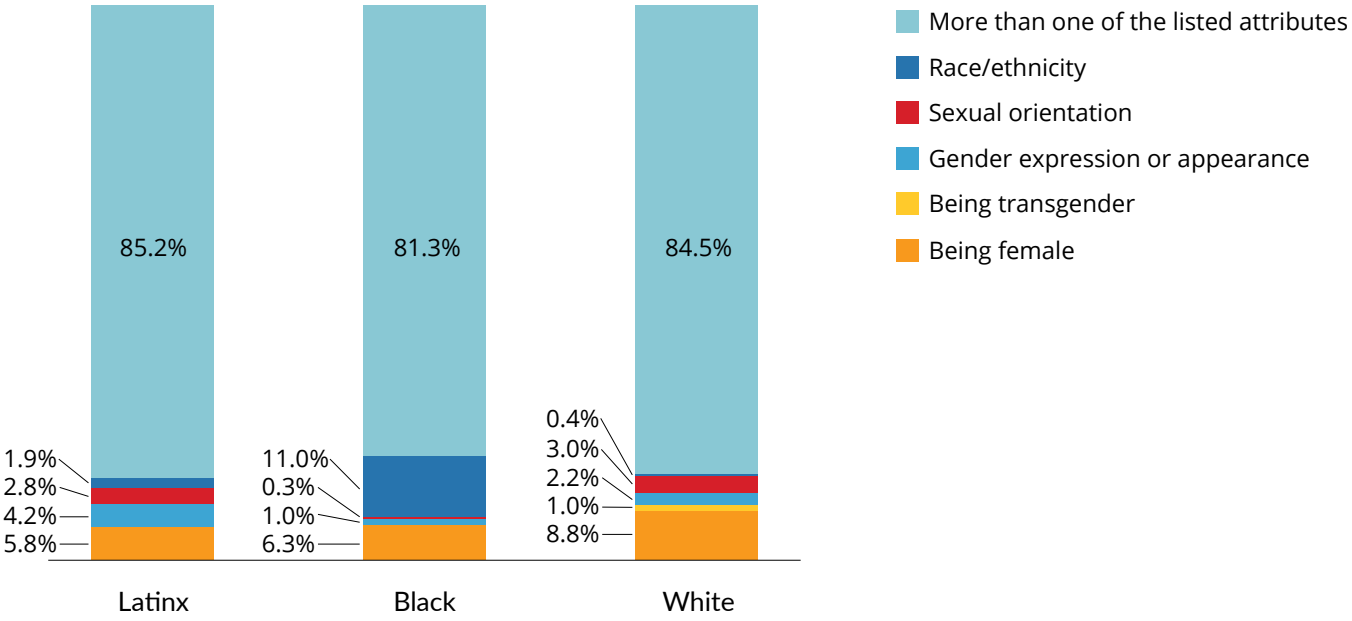
Source: Generations Study and TransPop Study data

Note: Bold numbers indicate statistically significant differences between that comparison group and lesbian women.

Understanding the root of unfair treatment in a specific situation can be challenging, but people's evaluations of the reason has been found to be associated with health outcomes.[64] We examined data on why respondents believed they experienced an everyday discriminatory event as this is a foundational indicator of the range of forms of stigma and oppression impacting LBQ women's lives. Among LBQ women who provided a reason, 7.5% believed it was solely because they were female. Most respondents (84.5%) listed more than one listed attribute as a reason for experiencing an everyday discriminatory event.

Across race/ethnicity of LBQ women, more Black LBQ women believed their race alone was the reason for being a victim of an everyday discriminatory event compared with Latinx and White women (Figure 4). A higher proportion of White LBQ women than Latinx or Black LBQ women believed that solely being female was the reason for experiencing an everyday discriminator event; however, this difference was not statistically significant. Most LBQ women listed more than one of the listed attributes.

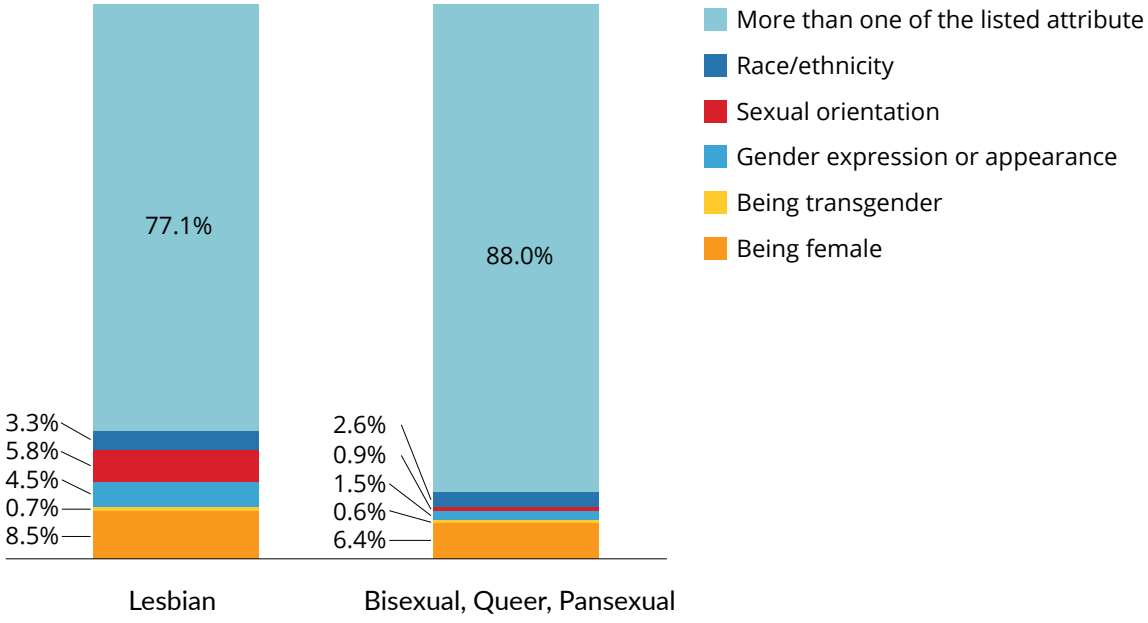
Figure 4. Perceived reasons for experiencing a discriminatory event among LBQ women, by race



Source: Generations Study and TransPop Study data

We noted above that bisexual women were more likely to report everyday discriminatory events than lesbians. When we look at the types of reasons why they felt they were mistreated, we see one major difference: more lesbians reported sexual orientation-based discrimination than bisexual women (both as the only reason or in combination with other reasons).

Figure 5. Perceived reasons for experiencing a discriminatory event among LBQ women, by sexual identity



Source: Generations Study and TransPop Study data

VICTIMIZATION

Data on perceived stigma is not collected among youth through national probability surveys. However, experiences with various forms of victimization are routinely tracked through the CDC's Youth Risk Behavior Surveillance System. Across multiple measures of safety concerns, including verbal and physical assault, LBQQ girls report higher levels, particularly when compared with heterosexual girls and boys (Table 8). In particular, LBQQ girls experienced forced sexual assault and violence at higher rates than all three groups.

Table 8. Experiences with bullying and violence among youth by sexual orientation and gender identity

	LBQQ GIRLS VS. OTHERS				TRANS YOUTH ONLY	
	LBQQ GIRLS (N = 18,446)	STRAIGHT GIRLS (N = 62,521)	STRAIGHT BOYS (N = 70,527)	GBQQ BOYS (N = 8,284)	LGBQQ TRANS YOUTH (N = 2,610)	STRAIGHT TRANS YOUTH (N = 729)
Missed school due to feeling unsafe	16.0%	**10.4%**	**8.1%**	18.1%	29.4%	**39.1%**
Injured or threatened (past 30 days)	8.9%	**5.9%**	8.3%	**17.2%**	25.0%	29.0%
Ever had forced sexual intercourse	19.5%	**10.0%**	**4.7%**	**12.0%**	23.7%	23.0%
Experienced sexual violence (past 12 mos)	23.7%	**14.9%**	**7.0%**	**14.9%**	32.1%	33.1%
Experienced sexual dating violence (past 12 mos)	16.5%	**8.6%**	**2.8%**	**12.2%**	26.0%	24.9%
Experienced physical dating violence (past 12 mos)	14.1%	**7.2%**	**5.4%**	14.8%	31.5%	34.2%
Bullied at school (past 12 mos)	28.8%	**19.8%**	**14.9%**	28.7%	44.0%	**32.4%**
Electronically bullied (past 12 mos)	23.7%	**16.8%**	**9.8%**	**20.6%**	36.1%	27.3%

Source: YRBS, 2019

Note: Bold numbers indicate statistically significant differences between LBQQ girls and each comparison group. Analyses of LBQQ girls compared to others include both cisgender and transgender youth.

We also looked at reports of victimization among adults. Compared with GBQ men and heterosexual men, more LBQ women experienced victimization in the form of physical and sexual assaults (Table 9). However, fewer LBQ women than GBQ men and heterosexual men reported victimization in the context of robbery. It's notable that there is some evidence, despite a lack of statistical significance, that trans LBQ women experienced some forms of victimization at very high rates compared with cis LBQ women and GBQ men, particularly direct threats of violence (approximately 71% vs 52% and 53%).

Table 9. Victimization and discrimination among LBQ women compared to other SOGI groups

	LBQ CIS WOMEN (N = 803)	LBQ TRANS WOMEN (N = 68)	ALL LBQ WOMEN (N = 871)	STRAIGHT WOMEN (N = 276)	STRAIGHT MEN (N = 277)	GBQ MEN (N = 754)
SINCE THE AGE OF 18…						
You were hit, beaten, physically attacked, or sexually assaulted	45.5%	49.3%	45.8%	**43.8%**	**33.4%**	**34.7%**
You were robbed or your property was stolen, vandalized, or purposely damaged	37%	57.4%	38.4%	**47.9%**	**59%**	**44.8%**
Someone tried to attack you, rob you, or damage your property, but they didn't succeed	18.8%	40.9%	20.4%	**15.7%**	**33.5%**	**26.7%**
Someone threatened you with violence	50.3%	70.7%	51.8%	**46.6%**	**62.3%**	**53.2%**
Someone verbally insulted or abused you	74.6%	80.6%	75.0%	**70.5%**	**73.6%**	**76.0%**

Source: Generations Study and TransPop Study data

Note: Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

White LBQ women and women of color did not differ in experiences with victimization. Older LBQ women (age 50 and above) reported a higher proportion of having been robbed or property stolen (64%) or damaged or having someone attempt to rob or damage their property (30%) compared with LBQ women under age 50 (35% and 19%, respectively) (See Appendix A for Stigma tables).

POLICY IMPLICATIONS — DISCRIMINATION, STIGMA, AND VICTIMIZATION

Our findings indicate that many LBQ women feel stigma around their sexual orientation and gender identity. For example, one-third of LBQ women view their city or area as not a good place for LGB people, and nearly one-half say their city or area is not a good place for transgender people. These negative perceptions were significantly higher for LBQ women than for GBQ men. In addition, 31% of LBQ transgender women said they avoid disclosing their gender identity, and 13% of LBQ cisgender women indicate that most people where they live think less of LGB people. Despite these experiences, almost all LBQ women were out to their families and friends. However, 44% were not out to their health care providers.

Many have also experienced discrimination and violence. Three-quarters of LBQ women had at least one discriminatory experience in the past year, and many report that they feel that discrimination is based on multiple aspects of who they are as woman, people of color, sexual minorities, etc. Significant percentages of LBQ women reported experiencing various forms of violence. LBQ

women were more likely than GBQ men to experience several types of violence, including being physically attacked or sexually assaulted.

These findings demonstrate the need for comprehensive non-discrimination protections from discrimination based on sex, sexual orientation, and gender identity. These policies should also expressly prohibit multiple and intersectional forms of discrimination. Currently, federal non-discrimination statutes and most state statutes do not expressly prohibit discrimination based on sexual orientation and gender identity.[65] However, several recently enacted or proposed policies have already or could, if enacted, significantly change the legal landscape in this area.

In June 2020, the U.S. Supreme Court affirmed in *Bostock v. Clayton County*[66] that Title VII of the Civil Rights Act of 1964 protects employees nationwide from discrimination based on their sexual orientation and gender identity. The Court held that discrimination based on these characteristics is a form of sex discrimination prohibited by the law. While the case directly addressed discrimination within the employment context, the reasoning adopted by the Court has implications for other civil rights laws that prohibit discrimination based on sex. Courts, including the Supreme Court, have frequently looked to Title VII case law when deciding how to interpret analogous provisions in other laws.[d] If all federal and state laws that prohibit discrimination based on sex are interpreted consistent with *Bostock*, LGBTQ people nationwide would be protected from discrimination in a range of settings including housing, public accommodations, health care, and credit, among others.

The Biden administration has already taken the position that the reasoning of *Bostock* applies across all federal laws that prohibit discrimination based on sex. On his first day in office, President Biden issued an executive order that directs all federal agencies to interpret and enforce all federal sex non-discrimination laws to prohibit discrimination based on sexual orientation and gender identity.[67] The order also requires agencies to prohibit intersectional forms of discrimination based on multiple marginalized identities. This policy is particularly important for LBQ women—and especially LBQ women of color—who are likely to experience discrimination because of their sexual orientation and gender identity as well as their race and sex.

The Equality Act, if enacted, could strengthen and expand protections extended to LBQ women under the *Bostock* decision and President Biden's executive order.[68] The act would amend several federal civil rights laws to expressly include sexual orientation, gender identity, and sex as protected characteristics. Specifically, the act would codify protections from discrimination based on sexual orientation and gender identity in employment, housing, public accommodations, education, credit, jury service, federally funded activities, and public facilities. The act would also extend protections from sex discrimination in public accommodations and federally funded activities, where existing civil rights laws do not prohibit such discrimination.[69]

---

[d] A non-exhaustive list of recent examples includes: *Doe* v. Univ. of Dayton, 766 F. App'x 275, 282 (6th Cir. 2019); Kinman v. Omaha Pub. Sch. Dist., 94 F.3d 463, 468 (8th Cir. 1996); Kappa Alpha Theta Fraternity, Inc. v. Harvard Univ., 397 F. Supp. 3d 97, 101 (D. Mass. 2019); Fox v. Pittsburg State Univ., 257 F. Supp. 3d 1112, 1128 (D. Kan. 2017) (*citing* Mabry v. St. Bd. of Comm. Colls. & Occupational Educ., 813 F.2d 311 (10th Cir. 1987); Adams by & through Kasper v. Sch. Bd. of St. Johns Cty., Fla., 318 F. Supp. 3d 1293, 1325 (M.D. Fla. 2018) (*citing* Whitaker By Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ., 858 F.3d 1034 (7th Cir. 2017) and Glenn v. Brumby, 663 F.3d 1312 (11th Cir. 2011)).

Additionally, the Equal Rights Amendment, if ratified, would amend the U.S. Constitution to prohibit government-based discrimination and distinctions that disadvantage groups and individuals based on their sex.[70] The amendment would strengthen existing constitutional protections from sex-based discrimination, including the Fourteenth Amendment right to equal protection. Although the ratification deadline expired before the required 38 states had voted in favor of ratifying the Equal Rights Amendment, bipartisan members of Congress have introduced a resolution to remove the ratification deadline.[71] The resolution, if passed, would allow the amendment to become part of the Constitution.

Together, the Equality Act, the Equal Rights Amendment, the Supreme Court's decision in *Bostock*, and President Biden's day-one executive order would provide a foundation of legal protection for LBQ women based on their multiple identities in all areas of their lives no matter where they live.

Our findings also indicate the need for stronger anti-violence protections for LBQ women and girls. Congress has the opportunity to ensure that survivors of intimate partner violence, dating violence, sexual assault, and stalking have access to resources and support by reauthorizing the Violence Against Women Act (VAWA).[72] VAWA creates and funds a number of services for violence survivors, including funding for assistance services such as crisis centers and hotlines,programs that target underserved and rural communities, legal aid programs, community violence prevention programs, protections from evictions related to incidents of intimate partner violence and stalking, and more.[73] VAWA also expressly prohibits discrimination against beneficiaries based on sexual orientation and gender identity.[74,75] In 2019, Congress allowed VAWA to expire during the government shutdown.[76] It has not been reauthorized since, and consequently, government agencies and service providers are hampered in their ability to meet the needs of survivors.[77] Reauthorization of VAWA would likely create more opportunities for LBQ survivors to have access to support and provide resources for law enforcement, educational professionals, and others to meet the needs of survivors.[78] In addition, Congress, state legislatures, and state and federal agencies could engage in violence prevention efforts aimed at reducing violence against LGBTQ communities, including LBQ women. These efforts could broadly include improving access to education, employment, housing, and health care for women and LGBTQ people in the ways described above, which have been shown to reduce violence against women.[79]

SOCIOECONOMIC STATUS AND ECONOMIC INSECURITY

Socioeconomic status refers to the "social standing or class of an individual or group. It is often measured as a combination of education, income and occupation."[80] Socioeconomic stability is one of the key areas in which pervasive disparities have been observed among women in the U.S. This is true, too, for sexual minority women.[81] Qualitative research on economic stability among LGBTQ people has further demonstrated the unique barriers experienced among all sexual minority women, but also between subgroups of women by race, sexual orientation, and gender identity.[82] Here we review current data on how LBQ women were faring on these multiple domains of economic stability prior to the COVID-19 pandemic.

In many surveys, including the ones we use in this section, LGBTQ people tend to be significantly younger on average than non-LGBTQ people. Age is an important determinant of socioeconomic status, so without adjustment the LGBTQ measures would tend to look worse than those for non-LGBTQ people simply because of that age skew. Accordingly, for this section of the report we adjust our data to control for age differences. In effect, we are comparing measures for LGBTQ groups as if they had the same age distribution as non-LGBTQ people. This adjustment mainly affects the comparisons of poverty rates, employment status, and home ownership.

EDUCATION

Education is a measure of economic status. Education can provide skills, knowledge, habits, and credentials that have value for people in the labor market. People with higher levels of education earn more, on average, than people with lower levels. The jump is particularly clear for people with college degrees. College graduates tend to have higher incomes, lower unemployment, lower poverty, a higher likelihood of marriage, and better health. Education is also a marker of economic status because of the resources required to attain higher levels of education. Many people might want to go beyond the legally mandated years of schooling, but their ability to do so depends on the cost of an education (tuition, fees, living expenses, and lost earnings from a job); the resources to pay for those costs (family wealth, income, and financial aid); and the expected benefits. Also, family expectations, encouragement, and other nontangible factors can influence people's decisions. Most data sources show that lesbian women have higher levels of education than do bisexual and heterosexual women.[83]

Table 10 shows education comparisons for people 25 and older, an age range by which most people have completed their education. Overall, LBQ women have higher levels of education than heterosexual men. GBQ men have higher levels of education than LBQ women. Among LBQ women, trans women have lower levels of education compared with cis women.

Table 10. Education completed among LBQ women compared to other SOGI groups

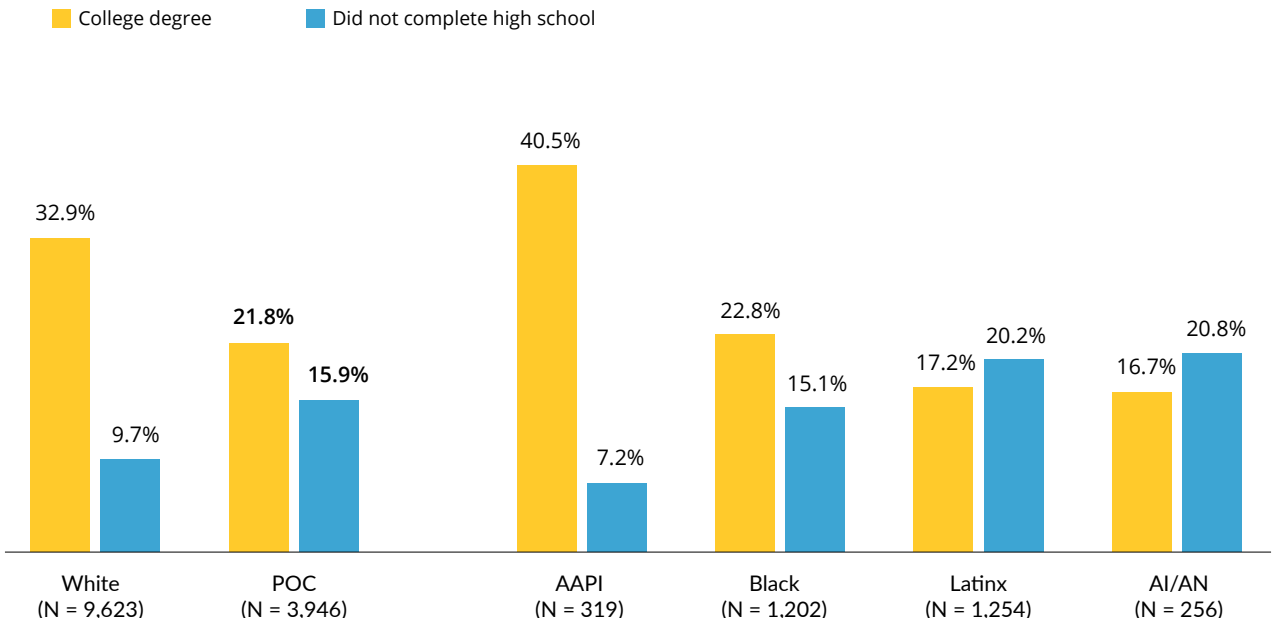
	LBQ CIS WOMEN (N = 13,270)	LBQ TRANS WOMEN (N = 299)	ALL LBQ WOMEN (N = 13,569)	STRAIGHT WOMEN (N = 341,391)	STRAIGHT MEN (N = 277,660)	GBQ MEN (N = 10,774)
Did not complete high school	11.6%	23.3%	11.8%	**11.3%**	**12.9%**	**10.4%**
Completed four-year degree or higher (among those 25+ years of age)	28.6%	14.7%	28.2%	**29.2%**	**26.2%**	**31.2%**

Source: BRFSS, 2017–2019

Note: Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

Looking within the group of LBQ women, we see some important differences by race and gender identity. LBQ women of color combined had significantly lower levels of education than do White LBQ women, and the differences are particularly stark between White LBQ women and Black, Latinx, and American Indian/Alaska Native women. For example, 33% of White LBQ women reported having a college degree, while 23% of Black LBQ women, 17% of Latinx LBQ women, and 17% of American Indian/Alaska Native LBQ women have a college degree. Black, Latinx, and American Indian/Alaska Native LBQ women also have much higher rates of not finishing high school than do White LBQ women (Figure 6). Finally, across the different categories, bisexual women reported having lower levels of education than did lesbians (See Appendix B for Economics tables).

Figure 6. Education completed among LBQ women, by race



Source: BRFSS, 2017–2019

Note: Bold numbers indicate statistically significant differences between that comparison group and White LBQ women.

Among youth, we see somewhat similar patterns in educational achievement for LBQQ girls and

LGBQQ trans youth. Fewer LBQQ girls reported receiving primarily A's and B's in high school than did heterosexual women, but more than did GBQQ boys (Table 11).

Table 11. High school grades among youth by sexual orientation and gender identity

	LBQQ GIRLS VS. OTHERS				TRANS YOUTH ONLY	
	LBQQ GIRLS (N = 18,446)	STRAIGHT GIRLS (N = 62,521)	STRAIGHT BOYS (N = 70,527)	GBQQ BOYS (N = 8,284)	LGBQQ TRANS YOUTH (N = 2,610)	STRAIGHT TRANS YOUTH (N = 729)
Get mostly A's and B's in school	71.7%	**82.6%**	70.9%	**64.9%**	63.8%	59.1%

Source: YRBS, 2019
Note: Bold numbers indicate statistically significant differences between LBQQ girls and each comparison group. Analyses of LBQQ girls compared to others include both cisgender and transgender youth.

Taken as a whole, we can see that LBQ women and girls have relatively high levels of educational achievement. That overall picture hides the fact that sexual minority women of color, trans women, and bisexual women still face disadvantages in graduating from high school and college.

ECONOMIC STABILITY

Income

Incomes of individuals provide an important summary measure of economic status. There are different ways of measuring income, but here we focus on household income level since it is available for the broadest range of sexual and gender minority groups. High levels of income for households means that there are more earners in the household or that members of the household are bringing in high earnings (wages) from jobs, more income from investments like rental property, or more income from other sources. Since earnings are an important component of household income, the impact of discriminatory treatment in pay will show up in this measure. Gender and racial wage gaps will also influence household income. For example, the gender gap leads us to expect that two women who are partnered are likely to have much a lower household income than two men or a male-female couple.[84]

In Table 12, we compare household incomes between LBQ women (heterosexual women, heterosexual men, and GBQ men. Each row represents a range of household income values. Starting from the highest end, we see the share of individuals in households with an income of $75,000 or more. One in four LBQ women's households falls in that range, a far smaller share than any of the other groups. Heterosexual men have the highest household incomes, with approximately 40% having incomes over $75,000. On the other end of the income spectrum, LBQ women have the highest share of people in the $10,000 or less category.

Table 12. Income levels among LBQ women compared to other SOGI groups

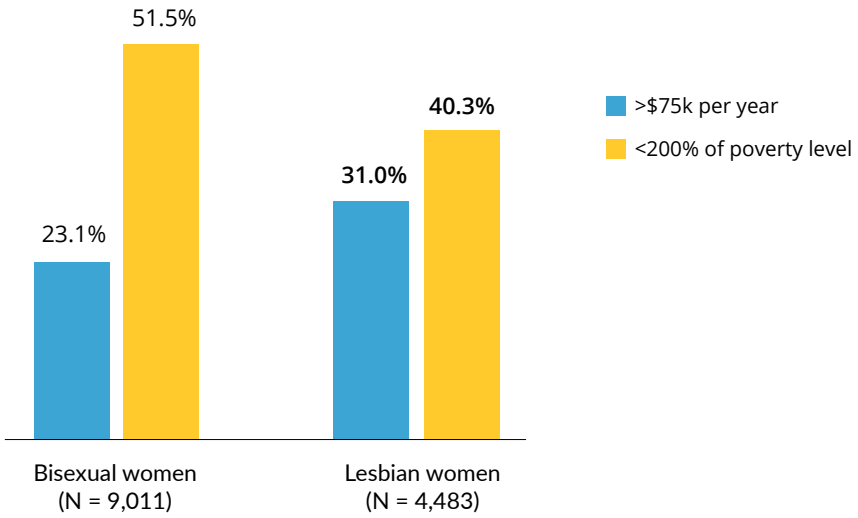
	LBQ CIS WOMEN (N = 13,270)	LBQ TRANS WOMEN (N = 299)	ALL LBQ WOMEN (N = 13,569)	STRAIGHT WOMEN (N = 341,391)	STRAIGHT MEN (N=277,660)	GBQ MEN (N = 10,774)
INCOME LEVELS						
Less than $10,000	7.7%	9.4%	7.7%	**5.5%**	**4.0%**	**5.6%**
$10,000 to less than $15,000	6.9%	8.1%	6.9%	**5.1%**	**3.8%**	**5.2%**
$15,000 to less than $20,000	10%	11.4%	10.1%	**7.9%**	**6.1%**	**8.0%**
$20,000 to less than $25,000	11.6%	12.5%	11.7%	**9.8%**	**8.0%**	**9.9%**
$25,000 to less than $35,000	11.8%	12.0%	11.7%	**10.8%**	**9.4%**	**10.8%**
$35,000 to less than $50,000	13.4%	13.0%	13.4%	**13.4%**	**12.7%**	**13.4%**
$50,000 to less than $75,000	13.6%	12.4%	13.5%	**15.0%**	**15.7%**	**15.0%**
$75,000+	25.1%	21.2%	25.0%	**32.5%**	**40.4%**	**32.2%**

Source: BRFSS, 2017–2019

Note: Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

Within the group of LBQ women, bisexual women have much lower household incomes than do lesbian women (controlling for age). For example, 31% of lesbians have household incomes of $75,000 or up, but only 23% of bisexual women do (Figure 7).

Figure 7. Income differences between lesbian and bisexual women

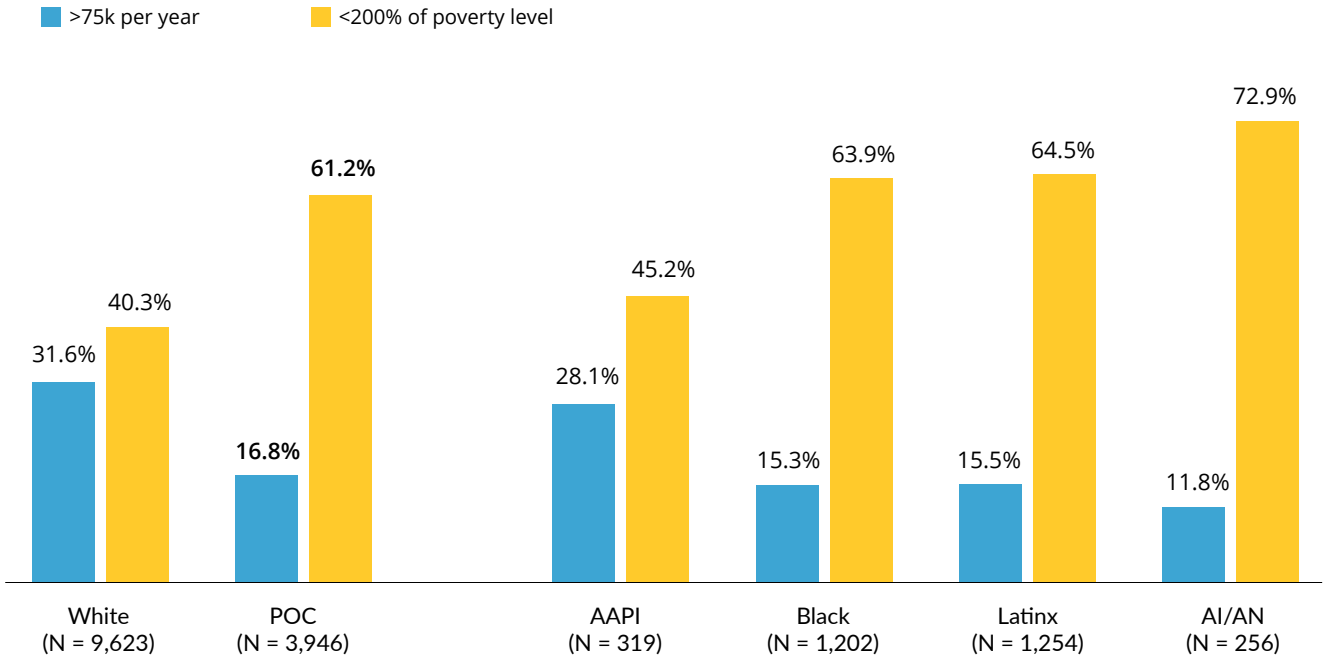


Source: BRFSS, 2017–2019

Note: Bold numbers indicate statistically significant differences between lesbian and bisexual women.

We also see big racial differences for LBQ women, where LBQ women of color have much lower household incomes. The highest income category includes 32% of White LBQ women but much lower shares of Black (15%), Latinx (16%), and American Indian/Alaska Native women (12%) (Figure 8).

Figure 8. Income disparity between white LBQ women and LBQ women of color



Source: BRFFS, 2017–2019

Note: Bold numbers indicate statistically significant differences between that comparison group and white LBQ women

These household income gaps are large for LBQ women, especially for bisexual and LBQ women of color. Household incomes are also affected by the number of earners, so these gaps may reflect a combination of differences in partnership rates, employment rates, and individual earnings that we are not able to sort out.

Living on a Low Income

Another way to assess economic status is to look at people on the very low end of the income distribution, or those experiencing economic hardship. Categorizing a household as "low income" usually refers to where an individual's or family's income sits in relationship to the federal poverty line. Past research has found that bisexual women and transgender women are more likely than either lesbians or heterosexual women to have incomes that put them below the federal poverty line, and some studies find a higher risk of poverty for same-sex couples and for lesbians.[85] The poverty line is very low, so for this study we double it, as is common in research and policy analysis. We define low income for a single person as a household income less than or equal to 200% of the federal poverty level, or approximately $25,500. For a family of four (including two children), low income is defined as a household income of $49,700 or less. We also assess other measures of family hardship here.

Table 13 shows the percentage of people whose household incomes are below 200% of the federal poverty line. LBQ women are the most likely to have reported this level of low income. Consistent with earlier poverty research, LBQ women of color and bisexual women were significantly more likely

to have very low household incomes than are White LBQ or lesbian LBQ women, as shown above in Figures 7 and 8. The gaps are large for Black, Latinx, and American Indian/Alaska Native LBQ women compared with White LBQ women.

Table 13. Percent of low income households among LBQ women compared to other SOGI groups

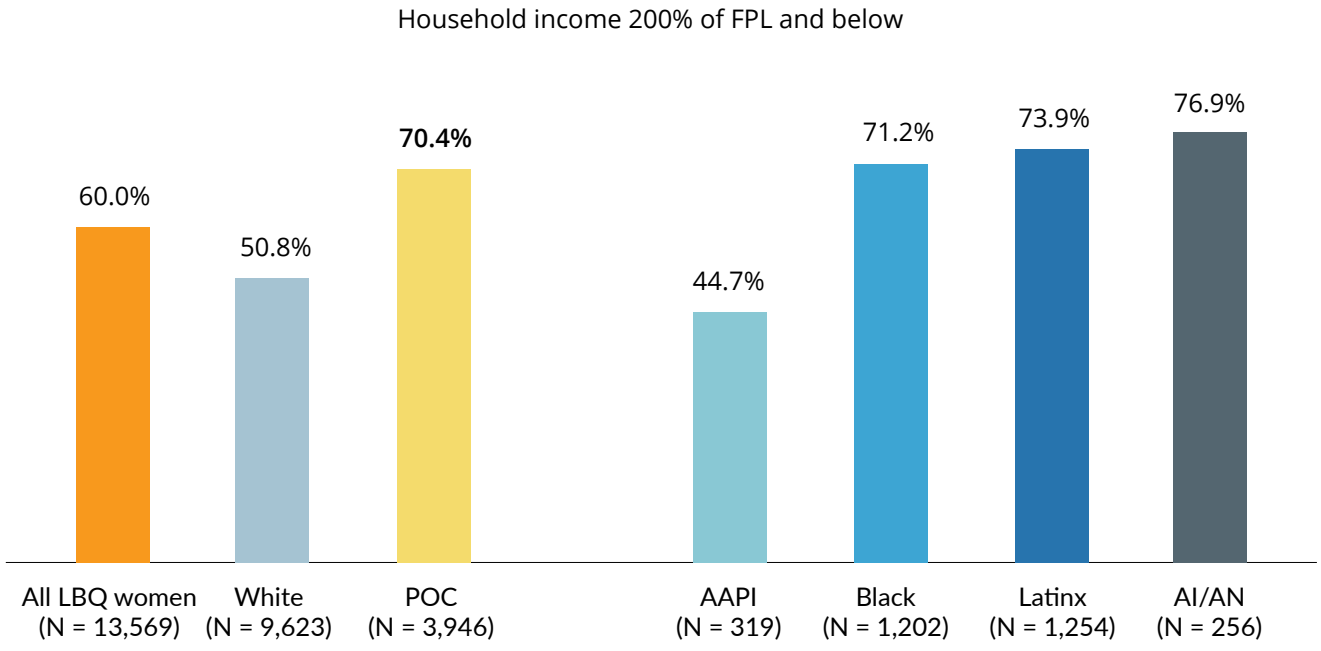
	LBQ CIS WOMEN (N = 13,270)	LBQ TRANS WOMEN (N = 299)	ALL LBQ WOMEN (N = 13,569)	STRAIGHT WOMEN (N = 341,391)	STRAIGHT MEN (N = 277,660)	GBQ MEN (N = 10,774)
200% FPL and under: Individuals	48.1%	45.4%	48.1%	**42.1%**	**33.8%**	**37.8%**
200% FPL and under: Parents	60.1%	53.6%	60.1%	**51.2%**	**39.5%**	**50.6%**
Received food stamps (2019 only)	15.9	7.7%	15.7%	13.1	**6.5%**	15.5

Source: BRFSS, 2017–2019

Note: Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

People with children living in their home experience unique economic stressors and barriers, as well as have access to specific forms of social benefits (such as Women, Infant, and Children or WIC supplements). As such, we assessed proportions of low income households separately among LBQ women with children. In Table 13 we see the rate of living with a low income was high for all groups of parents, but particularly so for LBQ women, with expected racial disparities (Figure 9).

Figure 9. Percentage of LBQ women with children living in a low income household by race

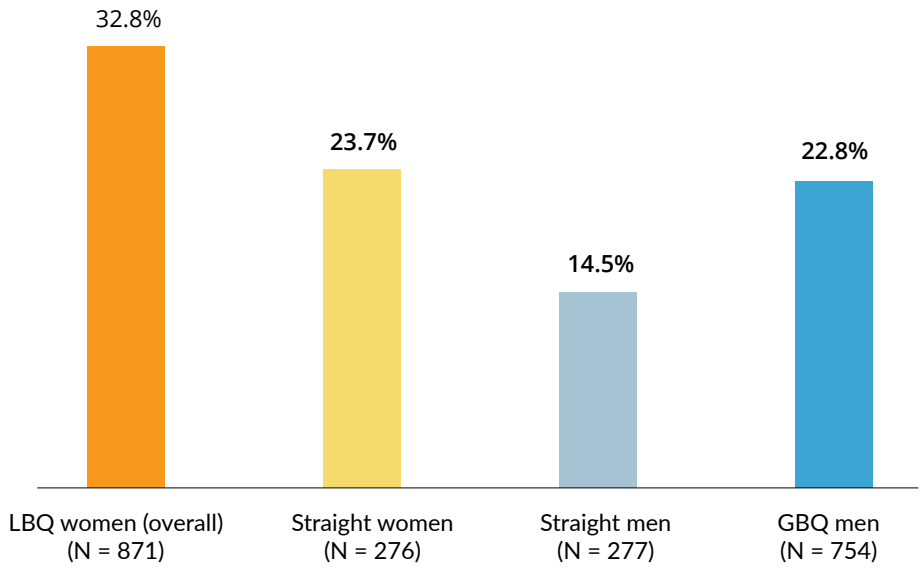


Source: BRFSS, 2017–2019

Note: Bold numbers indicate statistically significant differences between that comparison group and white LBQ women

Another indicator of economic security we examined was the experience of a major finance-related negative event. As seen in Figure E.5, approximately 33% of LBQ women experienced a major financial crisis, declared bankruptcy, or were more than once unable to pay their bills on time in the prior year. In contrast, far fewer GBQ men (approximately 23%) and heterosexual men (14%) reported the same experiences.

Figure 10. Ever experienced a major financial crisis among LBQ women compared to other SOGI groups



Source: Generations Study and TransPop Study data

Note: Bold numbers indicate statistically significant differences between that comparison group and LBQ women.

EMPLOYMENT

For most people, jobs are the primary source of individual and household earnings, making employment a key measure of economic well-being. The survey we used for these analyses allows us to see if respondents are employed, are out of work, or are not in the labor force (that is, they report being a homemaker, a student, retired, or unable to work). Table 14 shows that LBQ women have higher rates of being out of work than do heterosexual men and women. Surprisingly, and in contrast to other data sources, LBQ women are more likely than either heterosexual women or heterosexual or GBQ men to be out of the labor force.

We do not see meaningful differences in employment status for lesbian vs. bisexual women, but LBQ trans women were less likely to be employed and more likely to be out of the labor force than LBQ cis women. Also, there were no significant differences in these variables for LBQ women of color compared with LBQ White women (See Appendix B for Economics tables).

Table 14. Employment Status among LBQ women compared to other SOGI groups

	LBQ CIS WOMEN (N = 13,270)	LBQ TRANS WOMEN (N = 299)	ALL LBQ WOMEN (N = 13,569)	STRAIGHT WOMEN (N = 341,391)	STRAIGHT MEN (N = 277,660)	GBQ MEN (N = 10,774)
Employed	46.6%	32.6%	46.3%	**51.6%**	**63.9%**	**55.5%**
Out of work	6.1%	13.2%	6.3%	**5.2%**	**5.0%**	6.5%
Not in the labor force*	47.3%	54.2%	47.5%	**43.2%**	**31.1%**	**38.0%**

Source: BRFSS, 2017–2019

Note: **Not in labor force:* "A homemaker"; "A student"; "Retired"; or "Unable to work"; Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

The Generations Study and TransPop Study data (2016–2017) provide an additional lens on specific employment concerns such as being fired, laid off, or looking for a job for more than a month. Other job stressors we examined include problematic experiences on the job with bosses, co-workers, and job duties. LBQ women and GBQ men were similar in terms of experiencing employment concerns in the past year (relative to when the survey was administered in 2016–2017). However, a much higher proportion of LBQ women experienced job stressors compared with heterosexual women on almost all indicators: being fired or laid off, unemployed and looking for a job for more than a month or having trouble with boss or co-workers. Compared with heterosexual men, more LBQ women reported experiencing stress around finding a job they wanted but had similar experiences on other job-related stressors (Table 15).

Table 15. Stressful life events among LBQ women compared to other SOGI groups

	LBQ CIS WOMEN (N = 803)	LBQ TRANS WOMEN (N = 68)	ALL LBQ WOMEN (N = 871)	STRAIGHT WOMEN (N = 276)	STRAIGHT MEN (N = 277)	GBQ MEN (N = 754)
DURING THE LAST 12 MONTHS…						
Were you fired or laid off from a job?	15.5%	17.0%	15.6%	**6.7%**	**10.0%**	14.1%
Were you unemployed and looking for a job for more than a month?	34.7%	31.0%	34.5%	**13.3%**	**18.1%**	28.9%
Have you had trouble with your boss or a co-worker?	34.3%	41.5%	34.8%	**21.2%**	28.1%	29.8%
Did you change jobs, job responsibilities, or work hours?	50.6%	44.2%	50.1%	**35.6%**	39.4%	44.9%
CURRENTLY…						
Your job often leaves you feeling both mentally and physically tired	60.1%	54.3%	59.7%	60.6%	66.3%	61.4%
You are looking for a job and can't find the one you want	44.0%	32.2%	43.1%	**27.0%**	**27.6%**	38.8%

	LBQ CIS WOMEN (N = 803)	LBQ TRANS WOMEN (N = 68)	ALL LBQ WOMEN (N = 871)	STRAIGHT WOMEN (N = 276)	STRAIGHT MEN (N = 277)	GBQ MEN (N = 754)
SINCE THE AGE OF 18...						
Fired from your job or denied a job	38.3%	53.0%	39.4%	35.2%	44.1%	38.8%
Denied a promotion or received a negative evaluation	25.6%	57.0%	27.8%	25.4%	36.0%	28.9%

Source: Generations Study and TransPop Study data

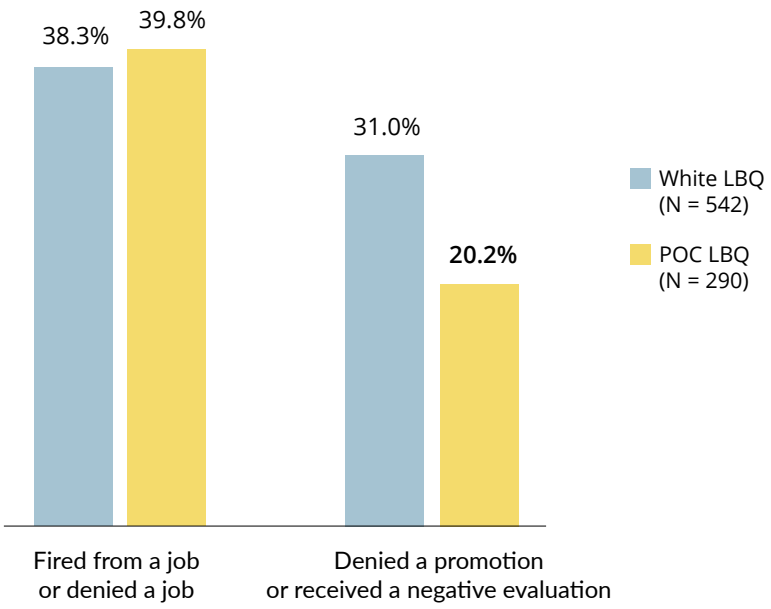
Note: Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

^Some estimates are based on too few respondents to be stable enough to represent the population estimate. We provide these but added ^ to indicate that they should be interpreted with caution.

On many employment-related stressors, lesbian and bisexual/queer women were similar. However, more bisexual/queer women experienced stressors related to their job and looking for a job they wanted (See Appendix B for Economics tables).

About 31% of White LBQ women were denied a promotion or received a negative evaluation compared with about 20% of women of color (Figure 11). On other job-related stressors shown in Appendix B, compared with White LBQ women in the past year (relative to when the survey was administered in 2016–2017), more women of color were fired or laid off from a job (12% vs. 21%), were unemployed and looking for a job for more than a month (28% vs. 44%), didn't have enough money to make ends meet (60% vs. 69%), and couldn't find a job they wanted (40% vs. 49%).

Figure 11. Stressful job experiences among LBQ women by race

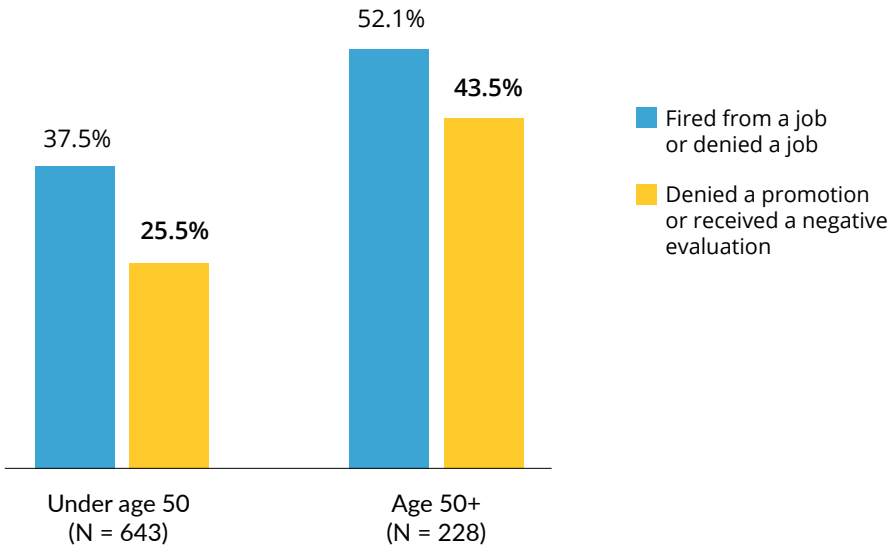


Source: Generations Study and TransPop Study data

Note: Respondents were prompted to include only experiences that took place *since the age of 18*; Bold numbers indicate statistically significant differences between that comparison group and White LBQ women.

LBQ women under the age of 50 were less likely than those age 50 and above to experience stressful job experiences in the previous year the study was conducted (Figure 12). About 44% of LBQ women age 50 and older were denied a promotion or received a negative evaluation compared with 26% of women under the age of 50. More than half (52%) of LBQ women age 50 and older were fired from or denied a job compared with about 38% of those younger than 50.

Figure 12. Stressful job experiences among LBQ women by age



Source: Generations Study and TransPop Study data

Note: Respondents were prompted to include only experiences that took place *since the age of 18*; Bold numbers indicate statistically significant differences between that comparison group and LBQ women under age 50.

HOUSING, HOMEOWNERSHIP, AND HOMELESSNESS

Home Ownership and Rental Housing

The extent to which people have stable and adequate housing is a core factor in people's overall wellness, as well as an indicator and factor in their economic stability. For example, having a reliable mailing address impacts one's ability to apply for jobs and public assistance and enroll children in school.[86] Here we use several different indicators to assess the housing stability of LBQ women.

As Table 16 shows, 60% of LBQ women own their own home, while 33% rent and 7% have some other arrangement (such as living in a group home or with friends or family). LBQ women are much less likely than heterosexual men and women to own their home, which means that LBQ women are much more likely than heterosexual people to rent or have other arrangements. There are no differences for LBQ women compared with GBQ men or between lesbians and bisexual women. We also see no differences by race (See Appendix B for Economics tables).

Table 16. Home ownership and rentership among LBQ women compared to other SOGI groups

	LBQ CIS WOMEN (N = 13,270)	LBQ TRANS WOMEN (N = 299)	ALL LBQ WOMEN (N = 13,569)	STRAIGHT WOMEN (N = 341,391)	STRAIGHT MEN (N = 277,660)	GBQ MEN (N = 10,774)
Own	60.1%	60.1%	60.1%	**69.1%**	**70.2%**	59.8%
Rent	32.5%	31.5%	32.5%	**25.1%**	**23.8%**	32.8%
Other arrangement	7.4%	8.4%	7.4%	**5.7%**	**6.0%**	7.3%

Source: BRFSS, 2017–2019

Note: Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

When we look at interactions between LBQ women and landlords or realtors, we also see key differences. LBQ women have faced barriers in the housing market, with approximately 9% reporting having been prevented from moving into or buying a place to live compared with 8% for GBQ men, although this difference is not statistically significant (Table 17). That figure is also higher for LBQ women of color than for White LBQ women and for LBQ women age 50 and older compared with younger LBQ women, but those differences are also not statistically significant (See Appendix B for Economics tables).

Table 17. Interactions with landlords/realtors among LBQ women compared to other SOGI groups

	LBQ CIS WOMEN (N = 803)	LBQ TRANS WOMEN (N = 68)	ALL LBQ WOMEN (N = 871)	STRAIGHT WOMEN (N = 276)	STRAIGHT MEN (N = 277)	GBQ MEN (N = 754)
Prevented from moving into or buying a house or apartment by a landlord or realtor	7.9%	27.9%	9.3%	9.4%	7.5%	7.6%

Source: Generations Study and TransPop Study data

Homelessness and Unstable Housing

Previous research has noted that LGBT adults have higher rates of lifetime and recent homelessness compared with cisgender straight adults.[87] A similar pattern has been found for LGBT youth.[88] When looking at the issue by gender among sexual minorities in more recent data, we see that this pattern persists. Among adults, LBQ transgender women have particularly high rates of recent homelessness. LBQ women have higher rates of homelessness when compared with heterosexual women, men, and GBQ men, but the differences are not statistically significant (Table 18). Among youth, LBQQ girls and trans youth report higher rates of homelessness compared with straight girls, but GBQQ boys have the highest rates of homelessness (Table 19).

Table 18. Recent experiences with homelessness among LBQ women compared to other SOGI groups

	LBQ CIS WOMEN (N = 803)	LBQ TRANS WOMEN (N = 68)	ALL LBQ WOMEN (N = 871)	STRAIGHT WOMEN (N = 276)	STRAIGHT MEN (N = 277)	GBQ MEN (N = 754)
Unstable housing in the last 12 months	2.2%	22.6%	3.6%	2.0%	2.1%^	2.6%^

Source: Generations Study and TransPop Study data

Note: *Homelessness* "lived in shelter, street, with friends or family"

^Some estimates are based on too few respondents to be stable enough to represent the population estimate. We provide these but added ^ to indicate that they should be interpreted with caution.

Table 19. Unstable housing experience among youth by sexual orientation and gender identity

	LBQQ GIRLS VS. OTHERS				TRANS YOUTH ONLY	
	LBQQ GIRLS (N = 18,446)	STRAIGHT GIRLS (N = 62,521)	STRAIGHT BOYS (N = 70,527)	GBQQ BOYS (N = 8,284)	STRAIGHT TRANS YOUTH (N = 729)	
In last 30 days, unstable housing	3.1%	**2.3%**	**3.0%**	**10.8%**	5.3%	N/A

Source: YRBS, 2019

Note: Bold numbers indicate statistically significant differences between LBQQ girls and each comparison group. Analyses of LBQQ girls compared to others include both cisgender and transgender youth

POLICY IMPLICATIONS — ECONOMIC SECURITY

Putting the findings on education, employment, income, and housing together suggests that LBQ women face serious challenges in meeting their economic needs. The relatively positive data on LBQ women's educational attainment contrasts sharply with evidence of lower household incomes and greater risk of poverty. Several measures strongly suggest that transgender LBQ women and LBQ women of color face additional barriers. The data also reveal a vulnerability to personal financial crises, such as those related to unemployment and stresses from job discrimination. Also, we may be seeing differential access to certain career paths when some subgroups (women of color, younger women) experience being fired and having trouble finding work but the comparison groups (older women, White women) also report more often being denied promotions, indicating they are in professions in which promotions are actually an option.

Those challenges could be ameliorated through public policies designed to level the playing field for sexual and gender minorities, such as the Equality Act[89] and other state and federal measures designed to prohibit discrimination based on sexual orientation or gender identity in a variety of contexts. Non-discrimination laws and policies that prohibit discrimination based on sexual orientation and gender identity have been linked to reductions in wage gaps between LGBTQ+ and non-LGBTQ+ people.[90] Existing research also suggests that the success of such policies may depend to some extent on the rigor of their enforcement by government agencies.[91] The differences seen in some measures between LBQ women and GBQ or heterosexual men—as well as the greater

challenges for LBQ women of color—are reminders that strong and effective enforcement of existing policies against race and sex discrimination are also necessary for ensuring equality for LBQ women. Further, qualitative research on the experiences of LGBTQ people experiencing poverty indicate that many LGBTQ people of color first experienced poverty as children within their families, highlighting the need to consider policy and service solutions aimed at dismantling structural racism as an approach to improving LGBTQ economic outcomes.

Policies related to increasing wages for all workers, such as the proposed $15 federal minimum wage,[e] are also important for addressing the needs of LBQ women who are low-wage workers.[92] In addition, updating the Equal Pay Act, which was originally introduced to eliminate unequal pay between members of the "opposite sex," to encompass disparities based on sexual orientation, gender identity, and race could help reduce wage and income disparities for LBQ women.[93] Our findings also suggest that assistance provided through the coronavirus relief package, including direct payments and extended unemployment benefits, would support many LBQ women who are more likely to live in lower income households and be unemployed even before the pandemic began. Policies aimed at supporting transgender workers and encouraging transgender-inclusive workplace practices would also likely help to address particularly high rates of unemployment among transgender women.

In addition, policies that reduce barriers to housing stability and ensure access to services for individuals experiencing homelessness are important for LBQ women—particularly transgender women.[f] Nationwide non-discrimination protections, such as the Equality Act and policies issued by the U.S. Department of Housing and Urban Development, could help to address higher rates of housing instability among LBQ women.[94] In addition, policies aimed at increasing access to the housing market for low-income and minority families (e.g., government-provided down-payment assistance)[95] would likely have a significant impact on LBQ women, many of whom are living in low-income households and raising children. Previous research has shown that same-sex couples and transgender people report lower rates of homeownership,[96] and they appear more likely to be denied access to certain types of mortgages.[97] Similarly, policies that specifically protect access to shelter services consistent with gender identity and require fair treatment of transgender people are important for ensuring that transgender women experiencing homelessness do not face barriers to services and safe shelter.[98]

[e] While later removed from the passed bill, such a provision was originally proposed as part of the American Rescue Plan Act of 2021. H.R. 1319, 117th Cong. (2021).

[f] Government estimates suggest that the number of adult transgender people experiencing homelessness has increased 88% since 2016 (with a 113% increase in those experiencing unsheltered homelessness in the same period). *See* MEGHAN ENRYETAL U.S. DEP'T OF HOUS. & URBAN DEV., (AHAR) TO CONGRESS – ART 1: ITEOH 10, .

PHYSICAL AND MENTAL HEALTH

Health status and the health inequities faced by LBQ girls and women are fundamentally affected by the social and policy environment. In the past two decades, research on the physical and mental health of LGBTQ populations has grown exponentially, as captured in two landmark federal reports a decade apart.[99, 100] Yet attention to the specific health experiences of diverse populations of sexual minority women—and implications for public health practitioners, policy makers, and community advocates—is lacking. In this section we highlight key indicators of population physical and mental health for LBQQ adolescent girls and for LBQ adult women. We examine these indicators in comparison with other population groups defined by sexual orientation and gender identity. In addition, previous research has highlighted heterogeneity of health outcomes among LBQ girls and women, particularly differential risk profiles by race/ethnicity and by sexual orientation (e.g., disproportionate burden of adverse health outcomes among bisexual compared with lesbian women in some health domains).[101] Thus, as in prior sections of the report, we highlight selected patterns and differences by race/ethnicity and sexual orientation among LBQ women. We also consider the implications of recent health-related policy initiatives for LBQ women's health status and health inequities and propose future policy directions to improve health and well-being for all LBQ girls and women.

YOUTH MENTAL AND BEHAVIORAL HEALTH

Youth Mental Health

We examined two key domains of mental health concerns for adolescents: self-reported depressive symptoms and suicidality. As Table 20 shows, in 2019 LBQQ girls (including both cisgender and transgender girls) were nearly two times more likely to report having felt sad or hopeless for two weeks or more (67%) compared with heterosexual girls (41%); the gaps were wider compared with heterosexual boys (25%) but smaller compared with GBQQ boys (45%). There was also a higher prevalence of having considered suicide among LBQQ girls compared with heterosexual girls and boys and GBQQ boys. Prevalence of each mental health indicator was higher among LGBQQ transgender youth compared with heterosexual transgender youth, although these differences were only statistically significant in three domains (feeling sad or hopeless, considering suicide, made a suicide plan).

Table 20. Mental health indicators by sexual orientation and gender identity among youth

	LBQQ GIRLS VS. OTHERS				TRANS YOUTH ONLY	
	LBQQ GIRLS (N = 18,446)	STRAIGHT GIRLS (N = 62,521)	STRAIGHT BOYS (N = 70,527)	GBQQ BOYS (N = 8,284)	LGBQQ TRANS YOUTH (N = 2,610)	STRAIGHT TRANS YOUTH (N = 729)
Reported feeling sad or hopeless for 2+ weeks	67.1%	**41.3%**	**25.2%**	**45.3%**	68.9%	**44.0%**
Considered suicide	43.7%	**18.3%**	**12.6%**	**32.1%**	50.3%	**27.0%**
Made suicide plan	36.0%	**14.4%**	**11.2%**	**26.3%**	43.4%	**31.5%**
Attempted suicide	20.1%	**7.5%**	**5.6%**	19.7%	27.1%	31.9%

Source: YRBS, 2019

Note: Bold numbers indicate statistically significant differences between LBQQ girls and each comparison group. Analyses of LBQQ girls compared to others include both cisgender and transgender youth.

Among LBQQ girls, Latinx girls had the highest prevalence of feeling sad or hopeless (72%), followed by White (69%), American Indian/Alaskan Native (69%), another race/ethnicity (67%), Black (57%), and Asian/Pacific Islander (55%). However, differences in feeling sad or hopeless between girls of color and White girls were not statistically significant. LBQQ girls of color were significantly more likely than were White girls to report having attempted suicide in 2019. Specifically, American Indian/Alaska Native (40%), Black (24%), and Latinx (23%) girls had the highest prevalence compared with White (18%), another race/ethnicity (18%), and Asian/Pacific Islander girls (9%) (See Appendix C for Health tables).

Bisexual girls had about 50% higher odds of feeling sad or hopeless compared with lesbian girls (72% vs. 62%). There were no significant differences between questioning girls (58%) and lesbian girls. Similar patterns were observed for suicidal ideation. However, lesbian and bisexual girls were equally likely to report having attempted suicide (22%), and this was significantly higher than the prevalence for questioning girls (14%) (See Appendix C for Health tables).

Youth Behavioral Health

As Table 21 shows, approximately 8% of LBQQ girls in high school reported any cigarette smoking in the past month (meaning, they smoked cigarettes on at least one day in the past 30 days). They were 2.8 times more likely to have smoked cigarettes compared with heterosexual girls (3%) and boys (5%). However, LBQQ girls were significantly less likely to report past month cigarette smoking compared with GBQQ boys (10%). Although sample size was limited, it is notable that LGBQQ trans youth were significantly more likely to report past month cigarette smoking compared with heterosexual trans youth (5.6 times greater odds). Cigarette smoking prevalence estimates varied across race/ethnicity for LBQQ girls, with the highest prevalence among American Indian/Alaska Native girls (16%), followed by multiracial (10%), White (9%), Latinx (8%), Black (4%), and Asian/Pacific Islander girls (3%). When racial/ethnic groups were combined for statistical analysis, there were no statistically significant differences in cigarette smoking between LBQQ White girls and LBQQ girls of color (See Appendix C for Health tables).

Prevalence estimates for having used any electronic vapor product in the past 30 days were substantially higher than prevalence estimates for cigarette use (Table 21); however, the patterns across sexual orientation and gender identity were similar. Patterning by race/ethnicity looked somewhat different, with LBQQ White girls reporting significantly higher odds of having used electronic vapor products than reported by LBQQ girls of color (See Appendix C for Health tables).

LBQQ girls had 10%–45% higher odds than other youth of reporting any alcohol use in the past month (meaning, at least one drink on at least one day in the past 30 days). LBQQ girls had significantly higher prevalence of binge drinking in the past month compared with heterosexual girls and boys, although there were no statistical differences between binge drinking for LBQQ girls and GBQQ boys. LBQQ girls had 30%–50% higher odds of reporting any marijuana use in the past month compared with other youth.

As with tobacco use, there was variation in alcohol use, binge drinking, and marijuana use by race/ethnicity, although overall differences between LBQQ White girls and LBQQ girls of color were not statistically significant. There were no significant differences in tobacco or alcohol use between lesbian and bisexual girls, whereas questioning girls were less likely to engage in any of these forms of substance use (See Appendix C for Health tables).

Table 21. Tobacco, alcohol, and other substance by sexual orientation and gender identity among youth

	LBQQ GIRLS VS. OTHERS				TRANS YOUTH ONLY	
	LBQQ GIRLS (N = 18,446)	STRAIGHT GIRLS (N = 62,521)	STRAIGHT BOYS (N = 70,527)	GBQQ BOYS (N = 8,284)	LGBQQ TRANS YOUTH (N = 2,610)	STRAIGHT TRANS YOUTH (N = 729)
Any cigarette smoking (past 30 days)	7.8%	**2.9%**	**5.1%**	**9.7%**	15.1%	21.9%
Any electronic vapor product (past 30 days)	26.1%	**21.6%**	**21.5%**	**23.0%**	31.9%	36.2%
Any alcohol use (past 30 days)	29.9%	**27.3%**	**22.8%**	27.0%	35.6%	41.9%
Any binge drinking (past 30 days)	13.4%	**11.5%**	**10.3%**	12.5%	22.3%	22.3%
Any marijuana use (past 30 days)	41.2%	**32.7%**	**31.7%**	**35.0%**	43.2%	42.8%

Source: YRBS, 2019

Note: Bold numbers indicate statistically significant differences between LBQQ girls and each comparison group. Analyses of LBQQ girls compared to others include both cisgender and transgender youth.

MENTAL HEALTH

LBQ women had nearly three times higher odds of being diagnosed with depression compared with their heterosexual female counterparts, five and a half times higher odds than heterosexual men, and nearly 2 times higher odds than GBQ men (Table 22, Figure 13). LBQ women were also more likely to report having experienced more days of poor mental health in the previous month compared to all other groups, with one in six LBQ women (17%) reporting 15–30 days of poor mental health in the past month.

LBQ women of color were significantly less likely to have ever been diagnosed with depression compared with LBQ White women (30% vs. 51%). Bisexual women also reported higher levels of depression than lesbian women (See Appendix C for Health tables).

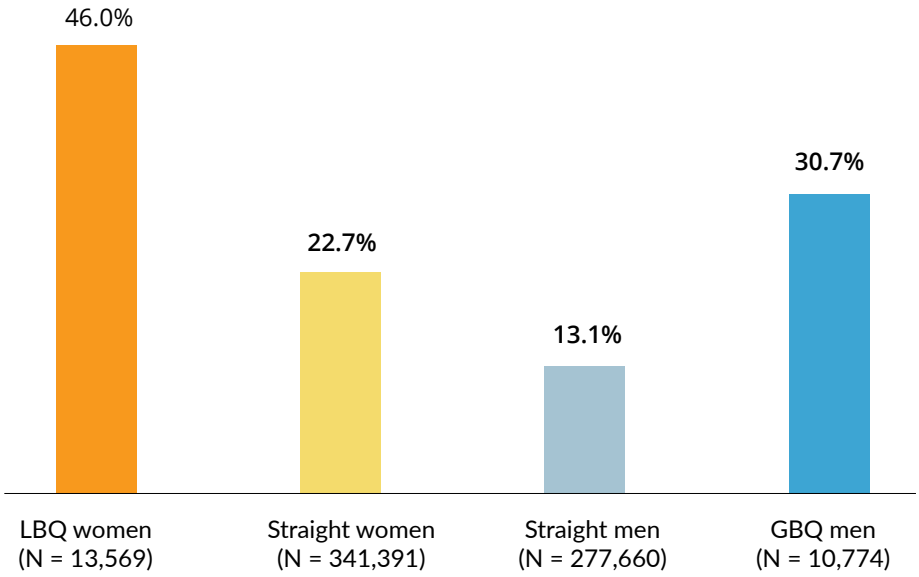
Table 22. Mental health indicators among LBQ women compared to heterosexual men and women and GBQ men

	LBQ CIS WOMEN (N = 13,270)	LBQ TRANS WOMEN (N = 299)	ALL LBQ WOMEN (N = 13,569)	STRAIGHT WOMEN (N = 341,391)	STRAIGHT MEN (N = 277,660)	GBQ MEN (N = 10,774)
Ever diagnosed with depression	45.9%	50.2%	46.0%	**22.7%**	**13.1%**	**30.7%**
POOR MENTAL HEALTH (# DAYS IN PAST 30)						
None	34.7%	26.1%	34.5%	**60.4%**	**70.0%**	**46.9%**
Mild (1–14 days)	40.8%	41.1%	40.9%	**29.4%**	**23.2%**	**36.8%**
High (15–30 days)	24.5%	32.9%	24.6%	**10.2%**	**6.9%**	**16.3%**

Source: BRFSS, 2017–2019

Note: Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

Figure 13. Mental health disparity by sexual orientation and gender identity



Source: BRFSS, 2017–2019

Note: Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

BEHAVIORAL HEALTH

Substance Use

Among adult women, as shown in Table 23, a higher proportion of LBQ women reported current cigarette smoking (25%) than either heterosexual women or men (14% and 18%), reflecting longstanding and well-documented inequities in cigarette smoking between LGBTQ and non-LGBTQ populations in the U.S.[102] Differences in smoking between LBQ women and GBQ men were not statistically significant. When examining LBQ women by race/ethnicity, American Indian/Alaska Native women reported the highest prevalence of current cigarette use (31%) and Asian/Pacific Islander women reported the lowest (11%) (See Appendix C for Health tables). Although sample sizes were too small for subgroup analysis, LBQ women of color overall were significantly more likely to use other smokeless tobacco products (e.g., chewing tobacco, snuff, snus) compared with White LBQ women, with Black LBQ women reporting the highest prevalence (5%), followed by American Indian/Alaska Native (4%), and Latinx (2%) women. Differences in current smoking between lesbian (23%) and bisexual (25%) women were not statistically significant (See Appendix C for Health tables).

Table 23. Tobacco and alcohol use among LBQ women compared with other SOGI groups

	LBQ CIS WOMEN (N = 13,270)	LBQ TRANS WOMEN (N = 299)	ALL LBQ WOMEN (N = 13,569)	STRAIGHT WOMEN (N = 341,391)	STRAIGHT MEN (N = 277,660)	GBQ MEN (N = 10,774)
Currently smoking	24.8%	20.2%	24.7%	**13.8%**	**17.5%**	23.2%
Using smokeless tobacco products	2.2%	4.1%	2.2%	**1.0%**	**6.4%**	**4.1%**
Any binge drinking in past 30 days	24.1%	17.7%	24.0%	**11.1%**	**21.2%**	25.0%
Mean # days consumed alcohol in past 30 days	3.2	3.9	3.2	**1.8**	**4.5**	**4.8**

Source: BRFSS, 2017–2019

Note: Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

Similar to the patterns in current smoking, a higher proportion of LBQ women reported any binge drinking in the past month (i.e., having four or more drinks on one occasion for women, or five or more drinks on one occasion for men; 24%) compared with either heterosexual women (11%) or heterosexual men (21%). Differences in binge drinking between LBQ women and GBQ men were not statistically significant. LBQ women reported a higher average number of days when they consumed alcohol in the previous month compared with heterosexual women (3.2 vs. 1.8 days in the past 30). However, men (both heterosexual and GBQ) on average consumed alcohol on significantly more days in the past month than did LBQ women.

There is variation in drinking patterns across racial/ethnic groups, although differences between White women and women of color combined are not statistically significant. Prevalence of binge drinking in the past month is highest among Latinx women (29%), followed by women of another race/ethnicity (27%), and then Black (25%), White (23%), American Indian/Alaskan Native (17%), and Asian/Pacific Islander (13%) women. Average number of days when alcohol was consumed in the past month followed a similar pattern. Further, heavy drinking (defined as averaging more than seven drinks per week in the past month) is most prevalent among Latinx (14%) women, followed by Black (13%) women, then another race/ethnicity (12%), White (11%), American Indian/Alaska Native (6%), and Asian/Pacific Islander (6%) women (See Appendix C for Health tables).

Regarding differences between lesbian and bisexual women, bisexual women have about 25% higher odds of binge drinking in the past month compared with lesbian women (25% vs. 21%). There are no differences between lesbian and bisexual women in terms of days of consuming alcohol or heavy drinking (See Appendix C for Health tables).

PHYSICAL HEALTH

Self-Reported Overall Health

As Table 24 shows, a significant proportion of LBQ women, particularly transgender women, reported

being in fair or poor health, a widely used indicator of health problems. These analyses were adjusted for age, given that overall health status is associated with older age.[103] More LBQ women reported fair or poor overall health (28%) than did heterosexual women and men (both 18%) and GBQ men (21%).

Table 24. Age-adjusted percentage who reported fair or poor health among LBQ women compared with other SOGI groups

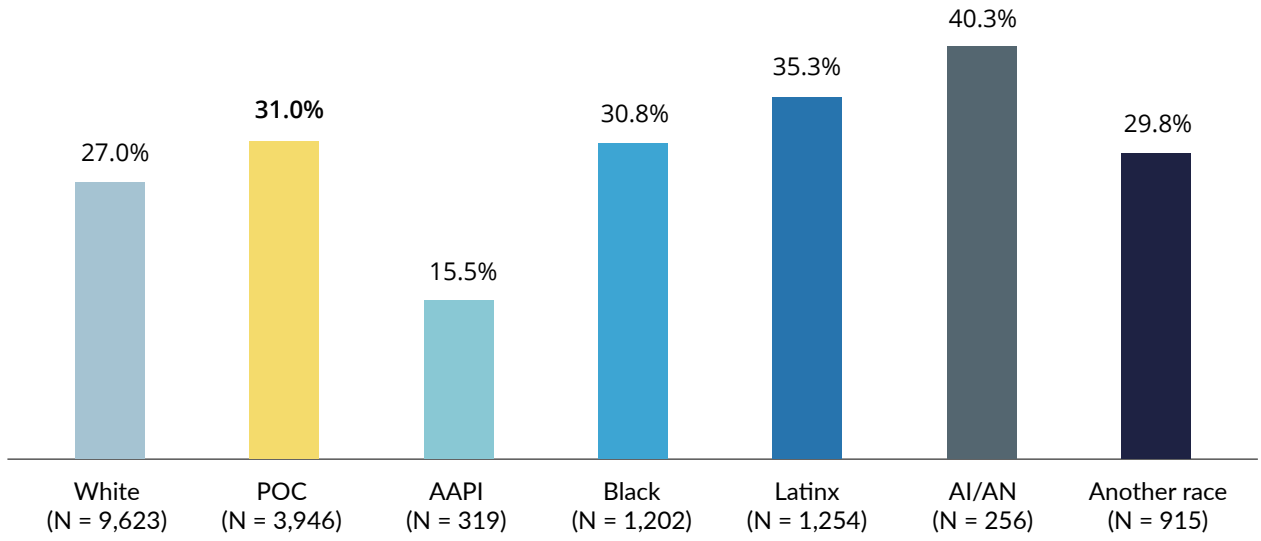
	LBQ CIS WOMEN (N = 13,270)	LBQ TRANS WOMEN (N = 299)	ALL LBQ WOMEN (N = 13,569)	STRAIGHT WOMEN (N = 341,391)	STRAIGHT MEN (N = 277,660)	GBQ MEN (N = 10,774)
Fair or poor health	28.4%	31.6%	28.5%	**18.5%**	**18.0%**	**21.0%**

Source: BRFSS, 2017–2019

Note: Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

LBQ women of color, with the exception of Asian/Pacific Islander women, had higher age-adjusted probability of fair or poor health compared with White women. Specifically, American Indian women had the highest predicted probability, with over one in three (40%) having fair or poor health, followed by Latinx (35%), Black (31%), another race/ethnicity (30.9%), White (27%), and Asian/Pacific Islander (16%) women (Figure 14). Bisexual women had significantly higher prevalence of fair or poor health (31%) compared with lesbian women (23%) (See Appendix C for Health tables).

Figure 14. Physical health disparity among LBQ women, by race/ethnicity



Source: BRFSS, 2017–2019

Note: Bold numbers indicate statistically significant differences between White LBQ women and LBQ women of color.

Stigmatized Health Factors: Weight and Disability Status

There is increasing recognition that the health of marginalized populations, including LBQ women, must be understood within the context of interlocking processes of power and oppression, such as

stigmatization and discrimination.[104, 105] Both weight and disability status are commonly discussed as health outcomes in themselves, although scholars and advocates have critiqued this approach, noting that the extent to which these factors impact poor outcomes is a function of the social environment rather than something inherent to weight or disability status. Many health issues are stigmatized (e.g., HIV); however, the very framing of weight and disability as health issues can in fact reinforce systems of social inequality and the stigmatizing medicalization of bodies deemed "different." In order to offer a snapshot of the role these stigmatized health factors may play in the lives of LBQ women, we examined prevalence of several levels of disability and multiple ranges of weight (as measured by body mass index, or BMI) among LBQ women compared to other subgroups.[106]

As shown in Table 25, we used as an indicator of disability status the number of days adults felt limited because of poor physical health in the previous month. All models of disability status were adjusted for age. A higher proportion of LBQ women (35%) had mild disability compared with heterosexual women, heterosexual men, and GBQ men (28%, 25%, and 30%). The same pattern held true for those with more severe disability (at least 15 days of limitations in the previous month). Among LBQ women by race/ethnicity, American Indian/Alaska Native women (21%) and women of another race/ethnicity (19%) had the highest prevalence of severe disability, followed by White (18%), Latinx (16%), Black (13%), and Asian/Pacific Islander (10%) women. Bisexual women are more likely to report severe disability (18%) compared with lesbian women (15%), after adjusting for age (See Appendix C for Health tables).

Regarding weight status, overall, LBQ women have significantly higher odds of being in higher BMI categories relative to heterosexual women and GBQ men and lower odds of being in higher BMI categories relative to heterosexual men. There are no statistically significant differences between women of color and White women and between bisexual and lesbian women (See Appendix C for Health tables).

Table 25. Distribution of disability status and body mass index among LBQ women compared with other SOGI groups

	LBQ CIS WOMEN (N = 13,270)	LBQ TRANS WOMEN (N = 299)	ALL LBQ WOMEN (N = 13,569)	STRAIGHT WOMEN (N = 341,391)	STRAIGHT MEN (N = 277,660)	GBQ MEN (N = 10,774)
DISABILITY (# DAYS IN PAST 30 WITH LIMITATIONS DUE TO POOR HEALTH)						
None	48.2%	48.1%	34.5%	**60.4%**	**70.0%**	**46.9%**
Mild (1–14 days)	35.1%	35.1%	40.9%	**29.4%**	**23.2%**	**36.8%**
High (15–30 days)	16.7%	16.8%	24.6%	**10.2%**	**6.9%**	**16.3%**
BODY MASS INDEX (BMI)						
BMI < 18.5	1.7%	2.9%	1.8%	**2.0%**	1.6%	**2.3%**
BMI 18.5–24.9	30.6%	41.5%	30.9%	**33.7%**	**28.7%**	**36.4%**
BMI 25.0–29.9	35.3%	33.3%	35.3%	35.1%	35.2%	34.7%
BMI ≥ 30.0	32.4%	22.3%	32.1%	**29.2%**	**34.5%**	**26.7%**

Source: BRFSS, 2017–2019

Note: Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

Lifetime Chronic Conditions

In Table 26, we present the proportions of LBQ women and those in other subgroups who have been diagnosed with chronic health conditions at some point in their lives. We examined the probability of being diagnosed with such conditions adjusting for age, given that many of the health outcomes listed below are associated with older age.[107] As Table 26 shows, after accounting for age, LBQ women had a significantly higher likelihood of being diagnosed with asthma, some form of arthritis (including rheumatoid arthritis, gout, lupus, and fibromyalgia), and any cancer other than skin cancer, compared with heterosexual women, heterosexual men, and GBQ men.

Further, LBQ women had a higher likelihood of being diagnosed with angina or heart disease, diabetes, high cholesterol, and high blood pressure compared with heterosexual women. However, LBQ women had a *lower* likelihood of ever having been diagnosed with high blood pressure compared with heterosexual and GBQ men and a lower risk of skin cancer than GBQ men. Although the sample size is too small for statistical comparison, in some health domains, such as angina/heart disease, high blood pressure, and diabetes, LBQ transgender women appeared to have markedly higher prevalence than LBQ cisgender women and all other groups; there is a need for future research to investigate these patterns.

Table 26. Age-adjusted percentage reporting chronic conditions among LBQ women compared to other SOGI groups

	LBQ CIS WOMEN (N = 13,270)	LBQ TRANS WOMEN (N = 299)	ALL LBQ WOMEN (N = 13,569)	STRAIGHT WOMEN (N = 341,391)	STRAIGHT MEN (N = 277,660)	GBQ MEN (N = 10,774)
Asthma (ever)	21.9%	20.1%	23.7%	**16.3%**	**11.7%**	**17.5%**
Angina or Heart Disease	4.7%	13.4%	4.9%	**3.2%**	5.6%	5.7%
Any form of arthritis	36.6%	40.1%	36.7%	**29.2%**	**23.0%**	**24.8%**
Diabetes	12.2%	21.5%	12.5%	**10.6%**	12.5%	12.8%
High cholesterol	33.1%	52.4%	33.6%	**31.2%**	34.6%	34.5%
High blood pressure	33.1%	41.7%	33.4%	**30.6%**	**37.1%**	**38.7%**
Skin cancer	5.9%	21.6%	6.3%	6.2%	7.3%	**8.4%**
Any other cancer	10.7%	15.4%	10.8%	**8.2%**	**6.3%**	**7.4%**

Source: BRFSS, 2017–2019

Note: For each chronic condition, participants were asked, "Have you ever been told by a doctor, nurse, or other health professional that you have ... ?" Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

For some chronic conditions there were no significant differences in age-adjusted predicted probabilities between White LBQ women and LBQ women of color (namely, asthma, cancer other than skin cancer, and high cholesterol). For skin cancer and arthritis, White women had significantly elevated odds of having ever been diagnosed with these conditions, relative to women of color. For angina/heart disease, diabetes, and high blood pressure, women of color had significantly higher

odds of having ever been diagnosed with these conditions, relative to White women. Substantial variation in patterns across racial/ethnic groups was also observed (See Appendix C for Health tables).

HIV

Less than 1% of LBQ women in a recent study were living with HIV compared with 8% of GBQ men. However, when LBQ women were separated by gender identity, different patterns emerged, for example, 7% of transgender LBQ women reported living with HIV. Because of sample size limitations, we are unable to statistically test if this difference is significant (See Appendix C for Health tables).

In this same study, about 1% of Latinx and no Black LBQ women reported living with HIV. Among White LBQ women, 0.5% reported living with HIV. All statistical comparisons by race/ethnicity are between women of color (Latinx and Black) and White LBQ to assess how women of color compare with a more socioeconomically dominant group. No bisexual women, about 0.5% of queer and pansexual women, and 1% of lesbian women reported living with HIV. A similar percentage of LBQ women under age 50 and age 50 and above live with HIV (See Appendix C for Health tables).

HEALTH CARE ACCESS

Health Insurance and Regular Source of Care

Averaging over the years 2017-2019, nearly one in six LBQ women (14%) reported having no current health insurance coverage, substantially higher than the national prevalence of 11% of adults for this time period.[108] In our comparisons between LBQ women and other groups, LBQ women were significantly more likely to be uninsured compared with heterosexual women (10%). A higher proportion of LBQ women were insured via Medicaid (13%) compared with all other groups; however, these differences were only statistically significant between LBQ women and men. Similar to patterns in being uninsured, LBQ women were significantly more likely than heterosexual women to report that they do not have a personal doctor, nurse, or other healthcare provider, a key indicator of lacking a regular source of care (Table 27).

Table 27. Insurance coverage and access to a regular source of care among LBQ women compared with other SOGI groups

	LBQ CIS WOMEN (N = 13,270)	LBQ TRANS WOMEN (N = 299)	ALL LBQ WOMEN (N = 13,569)	STRAIGHT WOMEN (N = 341,391)	STRAIGHT MEN (N = 277,660)	GBQ MEN (N = 10,774)
No insurance coverage	14.3%	21.0%	14.4%	**10.1%**	13.5%	15.1%
Covered by Medicaid	13.3%	1.5%	13.1%	10.7%	**6.1%**	**5.1%**
No regular healthcare provider	29.3%	22.9%	29.2%	**15.7%**	**27.0%**	28.0%

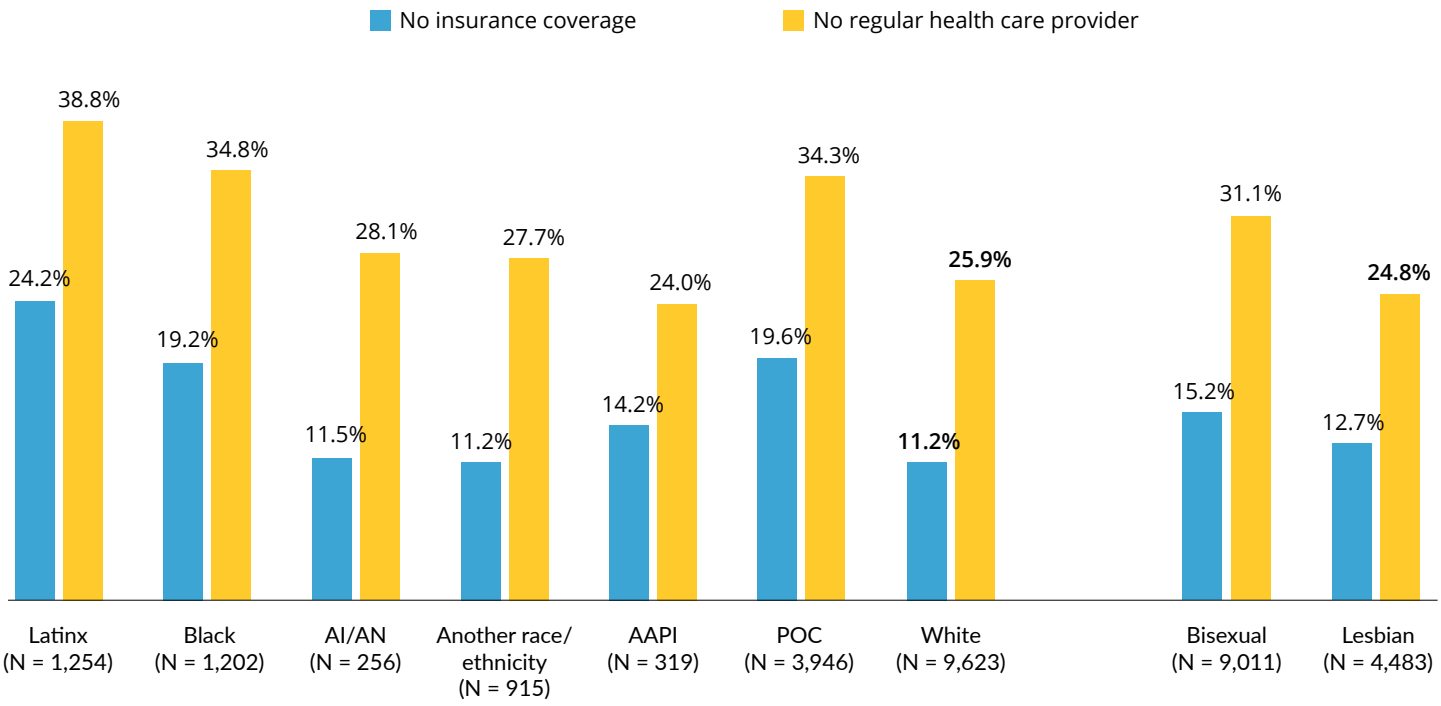
Source: BRFSS, 2017–2019 (30 states where SOGI questions were asked)

Note: Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

LBQ women of color were significantly more likely to be uninsured and to report no regular health care provider compared with LBQ White women (Figure 15). Latinx women had the highest prevalence of being uninsured (24%), followed by Black women (19%), Asian/Pacific Islander women (14%), White women (11%), women of another race/ethnicity (11%), and American Indian/Alaska Native women (11%). Patterns were similar for lack of regular source of care.

Compared with 13% of lesbian women, 15% of bisexual women were uninsured; however, these differences are not statistically significant. There are significant differences in having a personal health care provider, with bisexual women having 35% higher odds than lesbian women of reporting no regular health care provider (31% vs. 25%) (Figure 15).

Figure 15. Insurance coverage and access to a regular provider among LBQ women by race/ethnicity and sexual orientation identity



Source: BRFSS, 2017–2019

Note: Bold numbers indicate statistically significant differences between White LBQ women and LBQ women of color, and between bisexual compared with lesbian women.

Experiencing Stereotypes in Healthcare and Access to LGBT Health Care

Fear of experiencing prejudice and in turn receiving poorer quality of care can be a barrier to accessing health care for marginalized populations in the U.S.[109] Using the four-item Healthcare Stereotype Threat Scale, we assessed how much LBQ women worried about being negatively judged by their health care providers, with responses ranging from "Strongly agree" to "Strongly disagree." More GBQ men agreed or strongly agreed with the statement "I worry that diagnosis of my health may be negatively affected by my sexual orientation or gender identity [SOGI]" than did LBQ women, although LGBQ men and women did not differ on other indicators (Table 28).

Table 28. Perceived health care stereotypes among LBQ women compared to other SOGI groups

	LBQ CIS WOMEN (N = 803)	LBQ TRANS WOMEN (N = 68)	ALL LBQ WOMEN (N = 871)	GBQ MEN (N = 754)
I am being negatively judged because of my SOGI (in health care setting)	52.7%	72.2%	54.1%	56.8%
Evaluations of me may be negatively affected by my SOGI (in a health care setting)	49.0%	69.5%	50.4%	54.7%
Diagnosis of my health may be negatively affected by my SOGI	43.8%	68.7%	45.6%	**54.2%**
I might confirm negative stereotypes about LGBT people	38.0%	64.7%	39.9%	45.2%

Source: Generations Study and TransPop Study data

Note: SOGI = sexual orientation and/or gender identity. % indicates how many selected agree or strongly agree. Bold numbers indicate statistically significant differences between LBQ women and GBQ men. Analyses of LBQ women compared to others include both cisgender and transgender adults.

Compared with LBQ women, more GBQ men visited LGBT-specific clinics or providers in the past (10% vs. 23%) and felt it very important they visited a LGBT-specific clinic or provider in the future (17% vs. 25%). Among LBQ women, more transgender women than cisgender women felt it important to access LGBT-specific care. For example, more LBQ transgender women (46%) than LBQ cisgender women (8%) accessed an LGBT-specific clinic or provider in the past five years (Table 29). There were no significant differences between lesbian and bisexual/queer/pansexual women (See Appendix C for Health tables).

Table 29. Utilization and desire for LGBT-specific health care among LBQ women compared to GBQ men

	LBQ CIS WOMEN (N = 803)	LBQ TRANS WOMEN (N = 68)	ALL LBQ WOMEN (N = 871)	GBQ MEN (N = 754)
IN THE PAST 5 YEARS, HOW OFTEN HAVE YOU BEEN TO AN LGBT-SPECIFIC CLINIC OR PROVIDER FOR YOUR HEALTHCARE?				
Often/sometimes	8.3%	46.3%	10.3%	**22.6%**
Never	91.8%	53.7%	89.7%	**77.4%**
DURING THE PAST 12 MONTHS, HAVE YOU LOOKED FOR INFORMATION ONLINE ABOUT CERTAIN HEALTH OR MEDICAL ISSUES?				
No	27.3%	24.7%	27.2%	25.4%
Only LGBT-specific website	1.7%	18.0%	2.9%	3.6%
Only general website	64.5%	24.6%	61.6%	53.5%
Both LGBT and general website	6.4%	32.7%	8.3%	**17.5%**
IN THE NEXT YEAR, IF IT WERE POSSIBLE FOR YOU TO DO SO, HOW IMPORTANT WOULD IT BE FOR YOU TO GO FOR HEALTH CARE AT AN LGBT-SPECIFIC CLINIC OR PROVIDER?				
Very important	13.7%	72.0%	16.8%	**24.6%**
Somewhat important	37.9%	11.5%	36.5%	31.4%
Not important	48.4%	16.4%	46.7%	44.0%

Source: Generations Study and TransPop Study data

Note: Bold numbers indicate statistically significant differences between LBQ women and GBQ men. Analyses of LBQ women compared to others include both cisgender and transgender adults.

In terms of utilization of LGBT-specific healthcare, there were no differences by sexual identity except around patterns of searching for health issues or concerns online. A higher proportion of bisexual/queer/pansexual women compared to lesbians searched online for health issues from both general websites and LGBT websites. There were no differences among LBQ women by race/ethnicity for the four individual items in the Healthcare Stereotype Threat Scale. On average, 16% of White and 13% of women of color scored a moderate level of health care stereotype threat. However, it was more important for women of color to go to an LGBT-specific healthcare provider (See Appendix C for Health tables).

LBQ women under age 50 and those 50 and older are similar in terms of worrying about being stereotyped by health care providers because of their sexual orientation and gender identity. About 17% of women under age 50 and 12% of women age 50 and older reported moderate levels of health care stereotype threat. The two groups were also similar in terms of utilization and desire to access LGBT-specific health care (See Appendix C for Health tables).

REPRODUCTIVE HEALTH, RIGHTS, AND JUSTICE

Reproductive justice refers to "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[110] As a concept and a movement, reproductive justice grew out of a Black feminist response to a middle-class White-centered approach to sexual health and a narrow focus on abortion access.[111] In this way, reproductive justice moves beyond but is also inclusive of sexual health and reproductive rights, which center on public health outcomes and legal solutions, respectively. Rather, a reproductive justice framework, which is based on the scholarship, activism, and advocacy of Black women and other women of color, incorporates an intersectional understanding of the barriers to and facilitators of achieving bodily autonomy in relationship to childbearing among women and other people who are not cisgender males. A number of issues are addressed under the domain of reproductive justice, including maternal health, breastfeeding rights and practice, access to sexual and reproductive health care, access to abortion, rights to refuse sterilization or other medicalized contraception methods, maternal mortality, and access to comprehensive sexuality education. Specific to LBQ women, another area of concern is access to alternative insemination methods and other alternative methods of reproduction and family formation.

Unfortunately, there is very little national data available in many of these areas of the reproductive justice domain, and far less that include measures of sexual orientation and gender identity. The typical available data detail sexual heath behaviors and risks, such as condom use, HIV and sexually transmitted infection (STI) testing, and "risky" sexual behavior frequency. Prevalence estimates for these indicators are well documented in the scientific literature (at least for LBQ cisgender women; the data for LBQ transgender women remain scarce) and are not repeated in detail here. To summarize, research tends to show that LBQ women are more likely to get tested for HIV and engage in sexual behavior that may put them at risk for HIV and other STIs and that young LBQ and other sexual minority cisgender women are more likely to have unintended pregnancies compared with their heterosexual female counterparts.[112] [113] [114] [115] [116] Further, research has demonstrated disparities in reproductive-related cancer-testing, albeit with mixed results.[117,] [118] The remainder of this section focuses on a few key areas relevant to current RJ-related public policy debates and discussions.

Family Formation and Pregnancy

Research shows that approximately 25% of cisgender and genderqueer LBQ women and 34% of transgender women are parents.[119] [120] Using the CDC adult health survey data, we found that 27% of LBQ women (including cis and trans) reported having a child under the age of 18 currently in their household. Previous research indicates that there are many paths to parenthood for LGBTQ people.[121] However, it is challenging to find updated data on these various pathways, which means it is also challenging to identify where there may be barriers to parenthood. A limitation of these large general population health datasets is that they center on the experiences of heterosexual and cisgender people. The Generations Study, a population survey focused on the experiences of cisgender sexual minorities, asked LGBT-relevant questions about family formation and experiences. In this survey, 23% of LBQ cisgender women and 8% of GBQ cisgender men who were parents became a parent through being in a relationship with a partner/spouse who already had a child (i.e., step-parenthood). Around 11% of GBQ men and 5% of LBQ women adopted a child. Most respondents became a parent through a current or previous sexual relationship. Data on the ways transgender sexual minorities build their families to include children were not available and is a major gap in policy-relevant research.

Table 30. Family formation approaches among cisgender LBQ women and GBQ men, among those with children

	LBQ CIS WOMEN (N = 118)	GBQ CIS MEN (N = 39)
THE FOLLOWING IS A LIST OF DIFFERENT WAYS PEOPLE BEGIN PARENTHOOD. PLEASE MARK ALL THE CATEGORIES THAT APPLY TO YOUR CHILDREN. DID YOU HAVE A CHILD THROUGH...		
A relationship with a partner/spouse who already had a child	23.3%	8.0%^
A surrogate who gave birth to the child, using donor sperm	0.2%^	0%^
A surrogate who gave birth to child, using your and/or your partner's/ spouse's sperm	0.0%	5.1%^
Donor insemination, and your partner/spouse gave birth to the child	4.2%	0.0%
Donor insemination, and you gave birth to the child	6.2%	0.0%
Donating sperm and co-parenting with someone who is not your partner/spouse	0.6%^	2.6%^
Adoption of a child born outside of your relationship	4.7%^	10.7%^
Current or previous sexual relationship	79.8%	75.8%
Becoming a legal or informal guardian of a child born outside of your relationship (e.g., kin care)	0.3%^	7.9%^

Source: Generations Study data

Note: Columns will not add to 100% because respondents could select multiple responses and refer to multiple children. ^Some estimates are based on too few respondents to be stable enough to represent the population. We provide these but added ^ to indicate that they should be interpreted with caution.

As can be seen above in Table 30, it is common for LBQ women to become parents through giving birth or partnering with someone who gave birth to their children. As documented in the scientific literature, LBQ girls and women have, on average, an earlier age of first pregnancy compared with heterosexual women. We have provided a brief snapshot of this trend in a population-based sample of (presumably cisgender) women ages 18–49 years (Table 31). Sample sizes were very small for the number of lesbian-identified women reporting pregnancy in these data, which do not allow for more nuanced analyses. However, the trend appears to suggest that while lesbians and bisexual girls were equally as likely to be pregnant as teenagers, lesbians were slightly more likely than bisexual women (24% vs 9%) to have been pregnant for the first time when they were 25 years or older. (See Appendix Tables- Reproductive Health). There still remains a need for research to better understand the social and structural processes driving these trends.

Table 31. Age at first pregnancy among cisgender LBQ and non-LBQ women

	LBQ CIS WOMEN (N = 345)	STRAIGHT CIS WOMEN (N = 2,462)
AGE FIRST PREGNANCY		
10–19 years	47.9%	36.9%
20–24	41.2%	**30.7%**
25+	10.9%	**32.4%**

Source: NSFG, 2017–2019

Note: Bold numbers indicate statistically significant differences between that comparison group and LBQ women.

More research is also needed on family formation desires, as well as needs for fertility services, among LBQ women. Compared with 8% of heterosexual women and 7% of heterosexual men, 18% of LBQ women reported wanting children but are not able to have children. Among LBQ women, more transgender women than cisgender women reported this concern (Table 32).

Table 32. Family formation desire among LBQ women compared to other SOGI groups

	LBQ CIS WOMEN (N = 803)	LBQ TRANS WOMEN (N = 68)	ALL LBQ WOMEN (N = 871)	STRAIGHT WOMEN (N = 276)	STRAIGHT MEN (N = 277)	GBQ MEN (N = 754)
You wish you could have children but you cannot	15.3%	47.9%	17.7%	**7.6%**	**7.2%**	20.6%

Source: Generations Study and TranPop study data

Note: Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

Access to Reproductive and Sexual Health Care

An important but extreme indicator of access to quality reproductive care is maternal mortality, meaning rates of women dying during or related to pregnancy and childbirth. The CDC estimates that in 2018 there were 17.4 deaths of birthing mothers for every 100,000 live births, and this national average is drastically different across ethnic groups. Black women in the U.S. have a rate of 37.3

maternal deaths per 100,000 live births.[122] The data collected to report these population statistics (death certificates, hospital records) do not include measures of sexual orientation. As such, we have no direct information on population estimates of maternal mortality among cisgender LBQ minority women.

Other key indicators of access or access needs with regard to reproductive health care include use of services intended to achieve pregnancy (insemination) or prevent it (contraceptives, abortion). LBQ cisgender women of childbearing age (18–49 years) had an abortion in their lifetime at similar rates to heterosexual cisgender women (Table 33). The lack of difference between groups in this case is useful information. It indicates that sexual minority women need these services as much as heterosexually identified women, and that both groups have something to gain by increased access to these reproductive health services. Additionally, the extent to which health care providers offer pregnancy-related services to sexual minority women may be important for ensuring access. In contrast, here we find that LBQ cisgender women were proactively asked by a doctor about their interest in getting pregnant less often than heterosexual cis women.

Table 33. Reproductive health care services among cisgender LBQ women and heterosexual women

	LBQ CIS WOMEN (N = 345)	STRAIGHT CIS WOMEN (N = 2,462)
Doctor asked if you want to get pregnant?	24.9%	**32.8%**
Used insemination service	14.6% ^	19.1%
Had an abortion (in lifetime)	22.8%	17.3%

Source: NSFG, 2017–2019

Note: Analysis includes women ages 18-49; Bold numbers indicate statistically significant differences between that comparison group and LBQ women.

^Some estimates are based on too few respondents to be stable enough to represent the population estimate. We provide these but added ^ to indicate they should be interpreted with caution.

It is notable that there are no available population-based data on how transgender women navigate reproductive health services, including access to cryopreserving sperm for pregnancy with a partner or surrogate. However, it is very likely that many LBQ transgender women in the U.S. experience significant barriers to accessing reproductive health services and assisted reproductive technologies when desired. As a potential indicator of access to this care, 15% of LBQ transgender women from the USTS 2015 study reported they had been denied coverage by a health insurance company for services typically considered gender-specific, including routine sexual or reproductive health screenings (such as Pap smears, prostate exams, and mammograms).[123]

For LBQ cisgender women, we also examined access to several key areas of reproductive health services, including HPV vaccination status (asked of adults under 50 years old), having had a Pap test (i.e., cervical cancer screening) in the past five years, and ever having had a mammogram (among adults ages 40 and older). As shown in Table 34, LBQ women were significantly more likely

to have received the HPV vaccine compared with all other groups; note that these analyses were not adjusted for age and therefore a younger mean age of LBQ women in this dataset may play some role in these differences.[g]

Table 34. HPV vaccination among LBQ women compared with other SOGI groups

	ALL LBQ WOMEN (N = 982)	STRAIGHT WOMEN (N = 13,603)	STRAIGHT MEN (N = 11,780)	GBQ MEN (N = 633)
Received HPV vaccination	37.1%	**22.6%**	**8.8%**	**18.7%**

Source: BRFSS, 2017–2019
Note: Asked of those ages 18–49 years; Bold numbers indicate statistically significant differences between LBQ women and each comparison group.

With regard to screenings for reproductive-related cancers, such as cervical cancer and breast cancer, we find that LBQ women are less likely to have gotten a Pap test within a minimum recommended timeframe (five years) and less likely to have had a mammogram (Table 35).

Table 35. Access to reproductive health screenings and sexual health care among LBQ and heterosexual women

	LBQ WOMEN (N = 4,100)	STRAIGHT WOMEN (N = 108,624)
Had Pap test in past 5 years	69.4%	**79.7%**
Ever had mammogram	42.8%	**70.8%**

Source: BRFSS, 2018–2019
Note: These questions only asked of those coded as female on BRFSS; Pap test restricted to those ages 18–65 and mammogram restricted to ages 40+.; Bold numbers indicate statistically significant differences between that comparison group and LBQ women.

HIV AND STI TESTING AMONG ADOLESCENTS

Regular testing for HIV and other STIs is a key sexual health promotion strategy contingent on accessible sexual health care for adolescents and adults. Among high school youth studied, LBQQ girls were significantly less likely to have ever received an HIV test compared with GBQQ boys but were significantly more likely than either heterosexual girls or boys to have ever received an HIV test or an STI test in the previous year before the survey (Table 36). LBQQ girls were less likely than GBQQ

[g] These data could not be examined by race/ethnicity or sexual orientation among LBQ women due to sample size limitations. Further, we did not assess any transgender-specific estimates for these reproductive-related cancer screenings and vaccines. We also did not include indicators that may be relevant to those women who have prostates, testicles, or penises because of documented concerns about the data quality for sex-specific categorization of transgender respondents in BRFSS that are likely to impact responses to reproductive health care measures. See, e.g., Cicero, E. C. EC, Reisner, S. L. SL, Merwin, E. I. EI, Humphreys, J. C. JC, Silva, S. G. (2020) SG. Application of behavioral risk factor surveillance system sampling weights to transgender health measurement. *Nursing Research*, *69*(4):307–315. doi:10.1097/NNR.0000000000000428. PMID: 32084102; PMCID: PMC7329606

boys to have received an HIV test, but there was no difference in STI testing between these groups. Transgender youth had higher prevalence of HIV and STI testing than all other groups.

Black and Latinx LBQQ girls had the highest prevalence of having accessed HIV testing (19% and 14%, respectively). Black LBQQ girls and those of another race/ethnicity had the highest prevalence of having accessed STI testing (18% and 16%, respectively). There were no differences between lesbian, bisexual, and questioning girls in likelihood of HIV or STI testing (See Appendix C for Health tables).

Table 36. HIV and sexually transmitted infection (STI) testing by sexual orientaion and gender identity among youth

	LBQQ GIRLS VS. OTHERS (INCLUDES CIS AND TRANS YOUTH				TRANS YOUTH ONLY	
	LBQQ GIRLS (N = 18,446)	STRAIGHT GIRLS (N = 62,521)	STRAIGHT BOYS (N = 70,527)	GBQQ BOYS (N = 8,284)	LGBQQ TRANS YOUTH (N = 2,610)	STRAIGHT TRANS YOUTH (N = 729)
Tested for HIV (lifetime)	13.8%	**10.6%**	**11.3%**	**16.7%**	21.1%	21.4%
Tested for another STI (past year)	13.0%	**9.4%**	**9.6%**	13.5%	31.9%	36.2%

HIV Testing among Adults

LBQ cisgender and transgender women reported testing for HIV at similar frequencies. However, compared with GBQ men (41%), fewer LBQ women (32%) tested for HIV about once a year or more frequently. As Table 37 shows, 33% of LBQ women and 25% of GBQ men had never been tested for HIV.

Table 37. HIV testing among LBQ women compared with other SOGI groups

	LBQ CIS WOMEN (N = 803)	LBQ TRANS WOMEN (N = 68)	ALL LBQ WOMEN (N = 871)	STRAIGHT WOMEN (N = 276)	STRAIGHT MEN (N = 277)	GBQ MEN (N = 754)
TESTING FREQUENCY FOR HIV						
About once a year or more frequently	32.1%	31.3%	32.1%	17.1%	6.2%	**41.1%**
About once every 2 years or less often	10.2%	11.7%	10.3%	11.3%	12.9%	11.6%
I only get tested if I feel I am at risk	24.6%	26.3%	24.8%	39.9%	32.1%	22.6%
I've never been tested for HIV	33.0%	30.8%	32.8%	31.7%	48.8%	24.7%

Source: Generations Study and TransPop Study Data

Note: Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

In this same study, we examined HIV testing between women of color (Latinx and Black) and White LBQ women. LBQ women of color (40%) were more likely to get tested for HIV at least once a year compared with White LBQ women (27%). Among LBQ women, there were no statistically significant differences in HIV testing frequencies between lesbian women and bisexual, queer, or pansexual women. More LBQ women under the age of 50 (35%) were tested at least once a year for HIV compared with LBQ women age 50 and above (9%). Almost 50% of LBQ women age 50 and above, compared with 21% of women under age 50, only got tested if they felt they were at risk of HIV (See Appendix C for Health tables).

Relationships and Parenting

There is a rich literature on the parenting outcomes of LBQ women, particularly cisgender lesbians.[124] This research shows that the well-being of children living in women's same-sex households have comparable outcomes to children from different-sex households. Recent literature has provided information on the relationship and partnership characteristics of LBQ women, including lesbian, bisexual, and queer/pansexual women. This work has indicated that among LBQ cisgender women who are partnered, lesbian women are more likely to be partnered with other women or with transgender partners than are either bisexual or queer/pansexual women.[125] This research also demonstrated that partnership characteristics were associated with decreased mental health.

Here we present some additional data on relationship-focused chronic stressors among LBQ women and non-LBQ women. On almost all indicators, more LBQ women experienced relationship-focused stressors than did heterosexual women, heterosexual men, and GBQ men (Table 38). In particular, LBQ women, like straight women, were more likely to be managing the stress of caring for a parent or child with serious issues.

Table 38. Stressful life events and relationship chronic strains among LBQ women compared with other SOGI groups

	LBQ CIS WOMEN (N = 803)	LBQ TRANS WOMEN (N = 68)	ALL LBQ WOMEN (N = 871)	STRAIGHT WOMEN (N = 276)	STRAIGHT MEN (N = 277)	GBQ MEN (N = 754)
STRESSFUL LIFE EVENTS						
DURING THE LAST 12 MONTHS						
Did you get separated or divorced or break off a steady relationship?	20.9%	19%	20.8%	**9.9%**	**3.7%**	**15.4%**
CHRONIC STRAINS						
CURRENTLY						
You have a lot of conflict with your partner/boyfriend/ girlfriend	27.9%	17.8%	27.2%	25.8%	19.8%	**17.3%**
Your parents do not approve of your partner/boyfriend/ girlfriend	22.0%	21.3%	50.5%	**29.2%**	**32.2%**	53.1%

	LBQ CIS WOMEN (N = 803)	LBQ TRANS WOMEN (N = 68)	ALL LBQ WOMEN (N = 871)	STRAIGHT WOMEN (N = 276)	STRAIGHT MEN (N = 277)	GBQ MEN (N = 754)
CHRONIC STRAINS						
CURRENTLY						
You are alone too much	50.1%	55.2%	50.5%	**29.2%**	**32.2%**	53.1%
You wonder whether you will ever find a partner or spouse	41.9%	50.4%	42.5%	**23.6%**	**28.3%**	**49.7%**
You have a parent, child, or a spouse or partner who is in very bad mental, emotional or physical health	43.0%	42.6%	42.9%	42.5%	**20.0%**	**36.3%**
A child's behavior or mood is a source of serious concern to you	41.9%	37.9%	41.6%	42.5%	37.3%	**33.1%**

Source: Generations Study and TranPop Study data

Note: Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

With regard to parenting stress, we examined reports of concerns about the possibility of having children or maintaining legal relationships with one's children. Of those who have children, nearly 22% of LBQ cisgender women had at least one child for whom they were not legally recognized as the parent or guardian (Table 39). About 28% of LBQ cisgender women felt it very or extremely likely to have children in the future compared with about 19% of GBQ cisgender men.

Table 39. Children and desire to become a parent among LBQ cis women and GBQ cis men

	LBQ CIS WOMEN (N = 118)	GBQ CIS MEN (N = 39)
WHICH OF THE FOLLOWING BEST DESCRIBES YOUR RELATIONSHIP TO YOUR CHILD(REN)? *		
Legally recognized as parent/guardian for at least one child	92.4%	92.8%
Not legally recognized parent/guardian for at least one child	21.8%^	24.8%^
Unsure about legal status as parent/guardian of at least one child	8.5%^	19.3%^
How important is it to you to have children one day?		
Not at all important	43.9%	52.4%
Somewhat important	28.0%	28.3%
Very/extremely important	28.1%	**19.2%**
Thinking about the future, how likely do you think it is that you will have children?		
Not at all likely	40.4%	54.6%
Somewhat likely	27.8%	31.0%

	LBQ CIS WOMEN (N = 118)	GBQ CIS MEN (N = 39)
THINKING ABOUT THE FUTURE, HOW LIKELY DO YOU THINK IT IS THAT YOU WILL HAVE CHILDREN?		
Very/extremely likely	31.8%	**14.4%**

Source: Generations Study and TranPop Study data
Note: Bold numbers indicate statistically significant differences between that comparison group and LBQ women.
*Values for this item will not add to 100% because respondents indicated statuses of multiple children.
^Some estimates are based on too few respondents to be stable enough to represent the population estimate. We provide these but they should be interpreted with caution.

There were no differences in legal parental status by sexual identity. Lesbian and bisexual/ queer/ pansexual women were just as likely to have at least one child for whom they were a legally recognized parent. The two groups felt similarly about the importance and likelihood of having a child in the future (See Appendix C for Health tables).

White LBQ women and LBQ women of color did not differ by parental legal status. However, a higher proportion of White women than women of color felt it was not important to have children one day and also felt it was unlikely they would have children. Women of color were more likely to feel it was very or extremely likely they would have children one day (See Appendix C for Health tables).

Sexual minority women under age 50 and those 50 and above were similar in the percentage who reported they were a legal parent or guardian to at least one child. (See Appendix C for Health tables).

POLICY IMPLICATIONS — HEALTH AND HEALTHCARE ACCESS

Our findings indicate that LBQ women and girls are more likely to experience a number of negative physical and mental health outcomes compared with heterosexual girls/women, heterosexual boys/men, and GBQ men/boys. These outcomes include higher rates of fair or poor general health, depression, and some lifetime chronic conditions among adults, and increased substance use and suicidality among adolescents. In addition, many LBQ transgender women are living with HIV.

Our findings also indicate that many LBQ women face barriers to health care access. LBQ women were significantly more likely to be uninsured and lack a regular health care provider compared with heterosexual women. Uninsurance rates and lack of a regular provider were particularly high for Black and Latinx LBQ women. In addition, many LBQ women reported that they worried about being stigmatized or discriminated against by health care providers, which may make them reluctant to seek needed care.

These findings demonstrate the need for health policies and interventions that are inclusive of LBQ women and take into account the unique challenges and experiences facing these communities. Congress, state legislatures, and state and federal administrative agencies could take several actions to ensure that laws, policies, and programs are responsive to these needs in order to improve the health and well-being of LBQ women.

Though the data presented here do not empirically connect health with experiences of stigma and discrimination, the relationship between these issues is well documented. LGBTQ-inclusive non-

discrimination laws and policies, for example, would likely improve the health and well-being of LBQ women in several ways. First, non-discrimination laws—and more supportive legal landscapes generally—have been linked to improved health outcomes among LGBTQ people.[126] For example, a 2009 study found that an unsupportive state-level legal landscape for LGB people was associated with "higher rates of psychiatric disorders across the diagnostic spectrum, including any mood, anxiety, and substance use disorder" in the LGB population than found in LGB populations in states with more supportive laws.[127] A 2010 study by the same authors found that rates of anxiety, mood disorders, and alcohol use disorder increased significantly for LGB respondents after their state passed a constitutional ban on marriage for same-sex couples, while rates were unchanged in states that did not pass such bans.[128] Second, as described above in the Stigma, Discrimination, and Victimization Section, a comprehensive federal non-discrimination law—such as the Equality Act—and similar state laws in states that do not currently have these policies would likely reduce experiences and fear of discrimination in health care among LBQ women and ensure uniform protections from discrimination across the country.[129] Further, as described in the Stigma, Discrimination, and Victimization Section, LBQQ girls experience elevated risk of sexual violence and victimization, which has been linked to myriad adverse health outcomes. This underscores the need for stronger anti-violence protections for LBQ women and girls and for including these initiatives (e.g., the reauthorization of the Violence Against Women Act, discussed below) in health policy advocacy.

Laws and policies that increase access to health insurance and expand coverage for services that LBQ women need would likely improve the health and well-being of LBQ women. For example, lowering barriers to joining Medicaid—including by reducing administrative barriers to enrolling and staying enrolled, encouraging states to adopt Medicaid expansion, and revising Section 1115 waiver approval criteria—would likely result in more LBQ women being eligible for and enrolling in the program.[h] Other financial incentives aimed at increasing insurance rates—such as caps on the amount paid for health insurance premiums and additional tax credits—would likely also impact the uninsurance rates of LBQ women.

In addition, laws and policies that expand insurance coverage for certain types of services that LBQ women, particularly transgender women, need would improve both their physical and mental health. For example, a nationwide policy requiring state Medicaid programs to cover gender-affirming care would ensure that transgender women are able to get needed care no matter where they live.[130] Research shows that access to gender-affirming care improves the well-being of transgender people, including being associated with a lower prevalence of suicide attempts and thoughts.[131] Additionally, given that transgender women are at increased risk for HIV infection,[132] expanding coverage for PrEP—a highly effective tool to prevent the transmission of HIV[133]—could reduce infection rates and improve overall health among transgender women.

Laws and policies focused on supporting LGBTQ youth would also likely improve mental health outcomes and reduce substance use among LBQQ girls. For example, laws that ban the use of conversion therapy on youth by licensed health care professionals would likely improve their health

[h] For example, the Williams Institute previously estimated that 49.3% of uninsured LGBT Virginians—approximately 21,000 people—along with 53.4% of uninsured non-LGBT Virginians, likely became eligible for coverage upon the expansion of Medicaid in Virginia. Goldberg, S. K., & Conron, K. J. (2018). *The impact of Medicaid expansion in Virginia on uninsured LGBT Adults.* Los Angeles: The Williams Institute.

and well-being. Research shows that experiences of conversion therapy are linked to increased suicide attempts and thoughts and other negative outcomes. One 2020 article found that LGB people who have experienced conversion therapy are nearly twice as likely to think about and attempt suicide as compared with those who did not.[134] An estimated 700,000 LGBT people have been subjected to conversion therapy[135]—half of whom were assigned female at birth.[i] In addition, enumerated anti-bullying laws that include sexual orientation and gender identity would likely improve mental health outcomes for LBQQ girls. Research shows that anti-bullying laws that expressly protect youth based on sexual orientation are associated with fewer suicide attempts among all youth—including both LGBT and non-LGBT youth—and with fewer reported experiences of stressors among students, including feeling unsafe at school.[136] High levels of school-based victimization have also been associated with higher levels of alcohol and other drug use and risky sexual behavior.[137] Finally, non-discrimination laws and other, broader LGBTQ-supportive laws at the state and federal levels would likely benefit LBQ girls even if such laws are not focused on youth. Research has linked health disparities and risk behaviors among LGBTQ+ youth to unsupportive environments: A 2017 study found that marriage equality at the state level was associated with a statistically significant decline (14%) in the proportion of LGB youth reporting suicide attempts in the past year.[138] Similarly, a 2011 study of youth in Oregon found that LGB youth in unsupportive school environments were at a 20% greater risk of attempting suicide than were LGB youth in supportive school environments.[139]

Reproductive Health, Rights, and Justice

Our findings indicate that a significant number of LBQ women become pregnant in their teen years—nearly half of LBQ women who have become pregnant—and over one-fifth of LBQ women who had sexual intercourse with a cisgender man reported having an abortion. These findings demonstrate that sexual and reproductive health laws, policies, and services must be inclusive of and respond to the needs of LBQ women, rather than rest on assumptions that only heterosexual women and girls benefit from these policies and interventions.

Several laws, policies, and programs aimed at expanding access to sexual and reproductive care would benefit LBQ women and girls. For example, repeal of the Title X gag rule[140] would likely increase access to care by ensuring reproductive health care providers receive federal funding.[j] Similarly, laws expanding both Medicaid eligibility and coverage would likely increase access to abortion as well, given significant restrictions on abortion-related coverage in many states and the often-prohibitive costs associated with such procedures[140]—in particular for those who are uninsured and lack access to financial support programs.

[i] Unpublished analysis by the Williams Institute using data collected through the NIH-funded Generations Study. See generally *Generations*. Los Angeles: The Williams Institute. (Data on file with authors.) Retrieved February 26, 2021 from https://williamsinstitute.law.ucla.edu/projects/generations/

[j] According to one estimate, the capacity of the Title X network was reduced by half as a result of the gag rule. Ruth Dawson, *Trump Administration's Domestic Gag Rule Has Slashed the Title X Network's Capacity by Half*,Guttmacher Inst. (Feb. 5, 2020), https://www.guttmacher.org/article/2020/02/trump-administrations-domestic-gag-rule-has-slashed-title-x-networks-capacity-half.

Our findings also indicate that many LBQ women are parenting or seek to become parents. Of LBQ women who are parents, about one-fifth (21.8%) were parenting children to whom they did not have a legally recognized relationship. Another 8.5% were unsure whether they had a legally recognized relationship to their children. Nearly one third (31.8%) said they were very or extremely likely to form families in the future.

These findings indicate that LBQ women will benefit from laws and policies that make it easier for people to be recognized as parents and to become parents. Many state laws create burdens to establishing legal relationships between parents and their children who are not biologically related. For example, the vast majority of states and U.S. territories require that couples get married to allow the legal adoption of a partner's biological child.[141] Additionally, most states lack mechanisms through which to recognize the non-gestational, non-genetic parents of children born through assisted reproduction if the couple is not married.[142] Such legal landscapes are likely to be especially burdensome for parents in same-sex couples, where at least one parent always lacks a direct biological relationship with the child. Amending these laws to ensure that mechanisms for parental recognition reflect the experiences of same-sex couples, LGBTQ people, and unmarried couples generally, would benefit a substantial number of LBQ women and their families.

In addition, LBQ women may face barriers to becoming parents due to discrimination in adoption and foster care. Currently, no federal law prohibits discrimination based on sexual orientation and gender identity against prospective parents in child welfare settings, and only 25 states, the District of Columbia, and Guam prohibit such discrimination.[143] Eleven states currently allow child welfare providers to turn away prospective LGBTQ+ individuals and same-sex couples if they allege that doing so would conflict with their religious beliefs.[144] Moreover, religious child welfare providers are increasingly seeking similar exemptions from complying with sexual orientation and gender identity non-discrimination laws through the courts in order to turn away prospective LGBTQ+ and same-sex couples.[k] The U.S. Supreme Court is set to decide in 2021 whether religious providers have a constitutional right to discriminate based on these characteristics.[145] Laws such as the Equality Act that prohibit discrimination based on sexual orientation and gender identity in public accommodations and government services would ensure that LBQ women have opportunities to form families no matter where they live.

[k] A non-exhaustive list of recent examples includes: New Hope Family Servs., Inc. v. Poole, No. 518CV1419MADTWD, 2020 WL 5887296 (N.D.N.Y. Oct. 5, 2020) (granting an agency's requested preliminary injunction against a New York non-discrimination policy, which the Court found would have effectively required it to "say that placement with unmarried or same sex couples is in the best interests of the child."); St. Vincent Catholic Charities v. Gordon, No. 1:19-CV-286, 2020 WL 7872348 (W.D. Mich. May 5, 2020) (maintaining a preliminary injunction preventing the state from enforcing contract terms requiring that a religious adoption agency not turn away same-sex couples); *cf.* Blais v. Hunter, No. 2:20-CV-00187-SMJ, 2020 WL 5960687 (E.D. Wash. Oct. 8, 2020) (denying a request that the state provide a foster care license to individuals with "stringent religious views on same-sex marriage," but only on the grounds that the request was premature as they needed to complete the process of seeking licensure first).

Our findings also underscore the need for laws and policies that support parents, particularly working parents. Laws and policies aimed at ensuring access to affordable childcare, helping families with childcare costs, and guaranteeing comprehensive paid leave for working parents would benefit all parents,[I] including the many LBQ women who are parenting or plan to become parents. These laws will likely benefit children too; they will gain security and stability from parents who have greater ability to care for them and meet their needs during the most vulnerable periods in their lives, including being able to provide them with more nutritious food and consistent medical care. [146]

[I] The federal Family and Medical Leave Act provides only *unpaid* leave for parents to care for their children and partners; very few states require that such leave be paid, though not all of them provide coverage for care of partners outside of a legally recognized relationship. See Movement Advancement Project. (2021).*See* State Family Leave Laws—Spouse and Partner. Retrieved from), https://www.lgbtmap.org/img/maps/citations-fmla-spouse.pdf

SYSTEM INVOLVEMENT

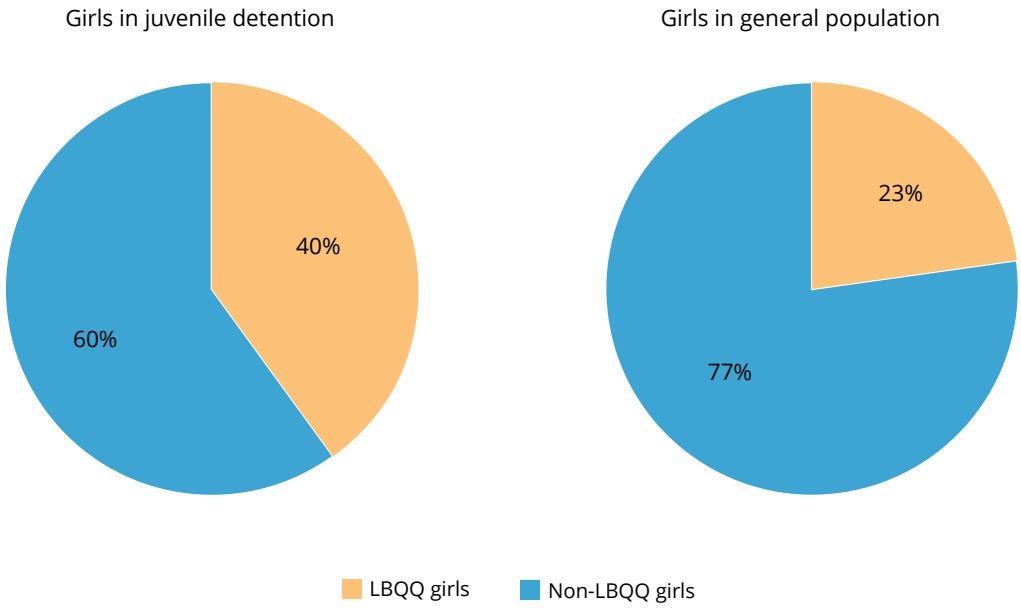
The term we use to refer to people's interactions with the child welfare and/or criminalization systems is "system-involved." System involvement has long been identified as an area in which racial and socioeconomic disparities exist.[147, 148] Women, too, have been found to experience involvement in these systems at disproportionately high rates, although less attention is received on this issue, particularly with regard to sexual minority women of color.[149, 150, 151] Our previous research has highlighted the overrepresentation of LGBT youth and adults in these systems, noting the high rates among LGBT youth and adults who are also racial minority women.[152, 153] Here we highlight findings from these prior studies that describe the system involvement of sexual minority women and girls.

CRIMINALIZATION SYSTEM

Youth

Previous research has shown that sexual minority youth, particularly girls, are overrepresented in the juvenile detention system.[154, 155] In a 2017 study we conducted, we found that 39.4% of girls who were in juvenile detention facilities were LBQQ; as noted in the demographics section of this report, LBQQ girls make up 23% of girls in the general population, indicating overrepresentation within these facilities (Figure 16). It was also demonstrated that sexual minority girls, like sexual minority boys, experienced sexual violence from their peers more often than did straight or heterosexual girls. It is notable that, like other areas of system involvement, when we are talking about sexual minority girls in juvenile detention facilities, we are talking about predominantly girls of color, as can be seen in Table 40. Further, we found that LBQQ girls were more likely than straight/heterosexual identified girls to be held in custody for longer periods of time and to experience sexual victimization by their peers.

Figure 16. Proportion of LBQQ girls in the juvenile detention system vs the general population



Source: LAFYS, 2017; YRBS, 2019

Table 40. Demographics and victimization among girls in juvenile detention facilities by sexual orientation

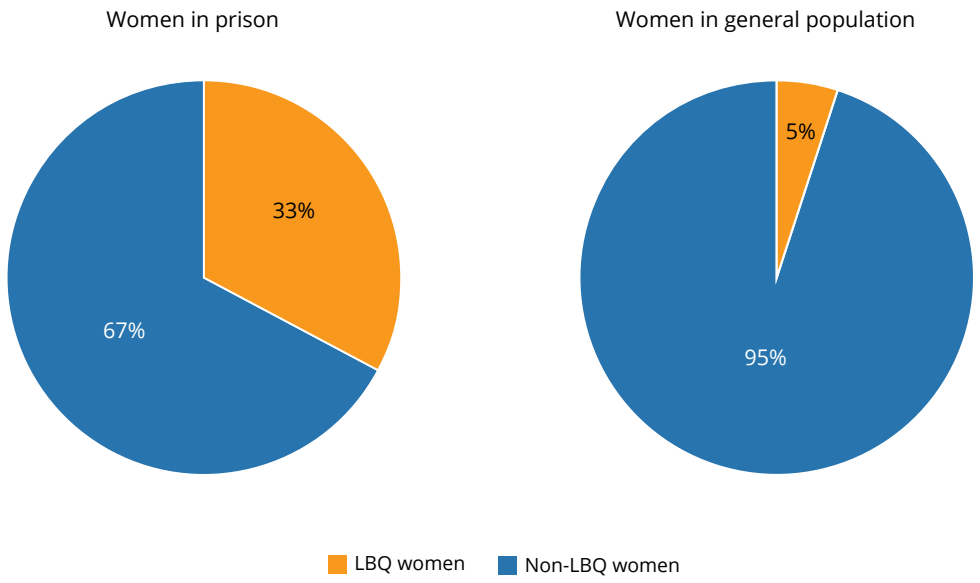
	LBQQ GIRLS (N = 314)	STRAIGHT GIRLS (N = 331)
RACE/ETHNICITY		
White	36.3%	49.2%
Black	34.4%	30.5%
Hispanic	25.1%	**15.0%**
Other	4.2%	5.2%
TIME IN CUSTODY		
6–12 months	35.0%	**26.4%**
1 year or more	17.0%	**9.1%**
VICTIMIZATION		
Any sexual contact with staff	4.6%	2.2%
Force by other youth	6.7%	**4.1%**

Source: Partial table reprint from Wilson et al. (2017), using the National Survey of Youth in Custody (NSYC-2), 2012[156]
Note: Bold numbers indicate statistically significant differences between that comparison group and LBQQ girls.

Adults

Reflecting patterns that we see among youth in juvenile detention facilities, sexual minority women are also overrepresented in adult prisons and jails. LBQ women make up 33% of women in prison (Figure 17). Compared with the percentage that LBQ women make up of the general population (5%), this indicates a high overrepresentation of LBQ women in incarcerated settings. Also similar to what we see among youth is the overrepresentation of women of color among all women who are incarcerated, including LBQ women. The 2017 study also showed that LBQ women in prisons were incarcerated with longer sentences and experienced more sexual assaults by other inmates (Table 41).

Figure 17. Percent of LBQ women in prisons vs the general population



Source: NIS, 2011–2012; BRFSS, 2017–2019

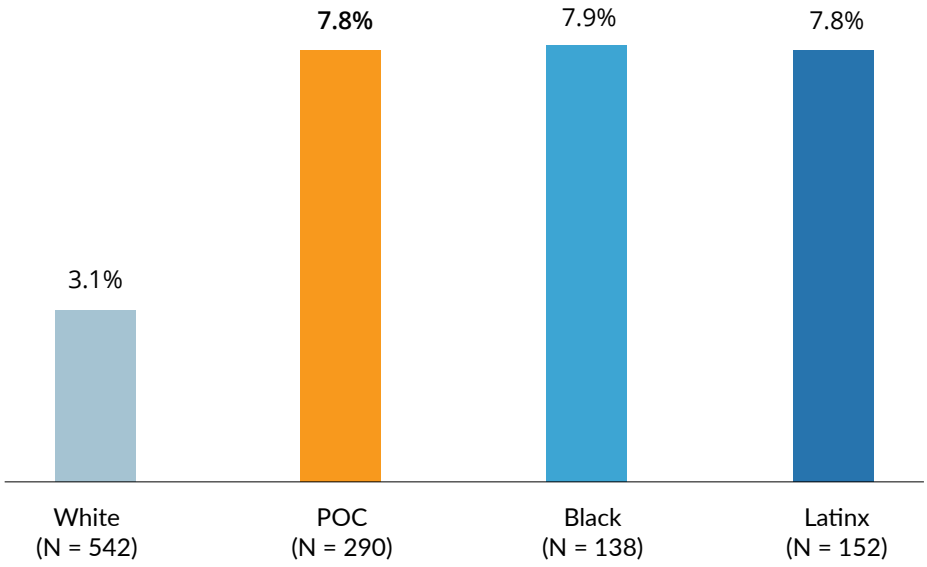
Table 41. Incarcerated women by sexual orientation and race

	WOMEN IN PRISONS	
	LBQ WOMEN (N = 2,334)	STRAIGHT WOMEN (N = 4,055)
RACE		
Black	24%	**22%**
Hispanic	20%	21%
White	39%	45%
Other	17%	**13%**
LONG SENTENCE LENGTHS		
10–20 years	15.2%	**10.3%**
More than 20 years (including life and death)	13.6%	**8.4%**
SEXUAL VICTIMIZATION		
Has been assaulted by staff	3.3%	1.7%
Has been assaulted by another inmate	11.4%	**4.5%**

Source: Partial table reprint from Meyer et al. (2017), using the National Inmate Survey (NIS-3), 2011–2012[157]
Note: Bold numbers indicate statistically significant differences between that comparison group and LBQ women.

A major weakness in the research literature on LGBTQ people and criminalization system is a lack of evidence regarding how and when disproportional representation in the system begins. The youth detention data and persistent overrepresentation of LBQ women in prisons seem to indicate that theories about the school-to-prison pipeline apply to LBQQ girls as well.[158] However, there are likely multiple points that impact the ultimate incarceration rates and length of sentences among LBQ women, from community conditions to police surveillance to decisions about probation. In an effort to understand what role police interactions may play in adult incarceration among LBQ women, we examined data on experiences with police. Approximately 5% of LBQ women overall reported having "serious trouble with the police or the law" in the prior year of the survey; the percent of LBQ women did not differ significantly from GBQ men. Among LBQ women, 7% of lesbians and 5% of bisexual and queer/pansexual women reported this experience with police, however this difference was not statistically significant. Fewer LBQ women under 50 years old reported serious trouble with police or the law compared to women 50 years and older (6% vs 1%). When looking at race/ethnicity, LBQ women of color were significantly more likely to report problems with the police or the law in the prior year (Figure 18).

Figure 18. Reported serious problems with police or the law in the previous year among LBQ women, by race



Source: Generations Study and TranPop Study data

Note: Bold numbers indicate statistically significant differences between that comparison group and White LBQ women.

CHILD WELFARE

Data on sexual orientation and gender identity within the child welfare system is challenging to obtain. However, prior research has shown that LGBTQ youth are overrepresented in this system in the U.S. One population-based study conducted in California middle and high schools showed that approximately 26% of the youth who said they were in foster care identified as LGBTQ.[159] When looking at youth from the foster care population itself, there is similar evidence of overrepresentation.[160, 161] Further, paralleling what was observed among those who are incarcerated, LGBTQ youth in the foster care system are also disproportionately children of color.

These general findings regarding LGBTQ youth in out of home care are reflected in the data when examined by gender. Using the 2014 Los Angeles Foster Youth Survey data,[m] we found that LBQQ girls (including trans and cis girls) in foster care made up 9% of the total foster care population (Figure 19). At the time of the study, LBQQ girls only made up approximately 7% of the general youth population.[162] Further, like all groups of youth in foster care, the majority of sexual minority girls are youth of color, indicating a pervasive racial disproportionality in the system. In particular, nearly 30% of the LBQQ girls in foster care were Black in a city (Los Angeles) where Black people comprise only 9% of the population.[163]

[m] Since conducting this study, other reports on sexual minority youth in foster care have been published. However, these other datasets either defined LGBTQ status differently than the current study or are not publicly available. As such, we relied on the data obtained from 2014 LAFYS study, which were collected by the first author of this report, for these estimates specific to girls in out-of-home care.

Figure 19. Sexual orientation and gender of youth in foster care

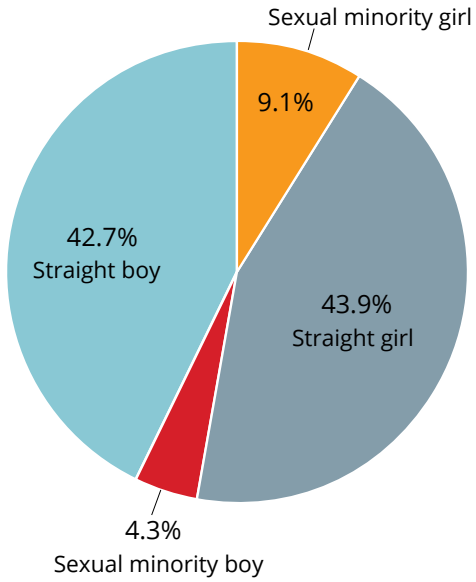


Table 42. Youth in foster care by race and sexual orientation among cis and trans youth

	LBQQ GIRLS (N = 73)	STRAIGHT GIRLS (N = 349)	STRAIGHT BOYS (N = 31)	LBQQ BOYS (N = 288)
White	10.6%	10.4%	8.8%	10.6%
POC	89.4%	89.6%	91.2%	89.4%

Source: LAFYS, 2014[164]

Adults

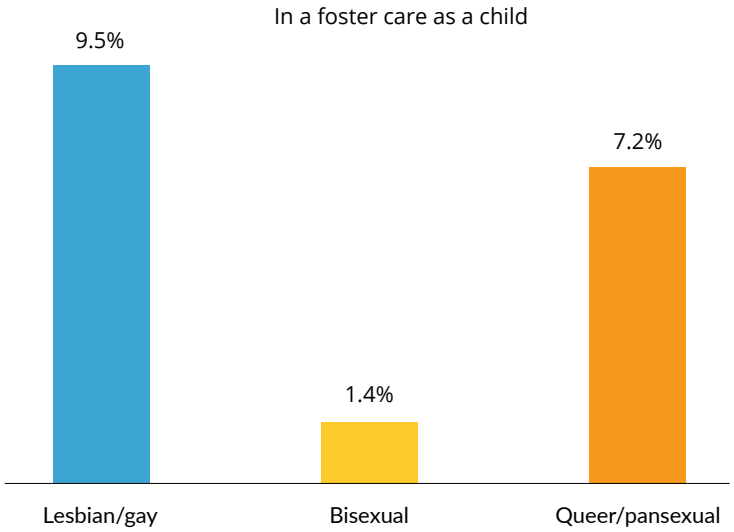
Compared with what we know about LGBTQ youth in foster care, we have very little data on the lifetime experiences of LGBTQ adults with the child welfare system. In the general population, a recent study found that among adults ages 18–44 years, 2.6% of adults reported a history of being in foster care, and the percentage was higher among women (3%) than men (2%).[165] In the Generations Study, respondents were asked whether or not they had been involved in the foster care system as a minor. After restricting the data to the first two cohorts (up to age 41) to approximate the general population study cited above, we found that 4% of LBQ women had been in foster care compared with no GBQ men reporting this experience. The sample size was too small to accurately assess whether the proportion of LBQ women who had a history with foster care from our study is significantly higher than what has been found in the U.S. general population of women; additionally, the national study cited above did not examine the rates of foster care experience by sexual orientation even though the data were available to them. Nonetheless, it is clear that from the perspectives of youth and adults, foster care is a significant type of system involvement in the lives of LBQ women and girls.

Further, among the LGBQ women and men in the Generations Study who had child welfare experiences, 40% reported that they moved to different placements because of how people treated them due to their minority sexual orientation or gender identity. Additionally, 17% of those with child

welfare experience were ordered to move out of their home at some point in their life. Of the 17%, 25% were ordered to leave home because of their LGBTQ identity

By sexual identity, there was some evidence that slightly more lesbian (approximately 9%) and queer/pansexual women (7%) had experienced living in a foster home compared with bisexual women (1%) (Figure 20). By race/ethnicity, 4% of White and 5% of women of color had lived in a foster home. By age, about 4% of LBQ women under age 50 and 2% of LGQ women age 50 and older had lived in a foster home at some point in their childhood. However, none of these differences were statistically significant. Small sample sizes are most likely the reason that we do not see significant difference between some of the groups (See Appendix D for Criminalization tables).

Figure 20. History of foster care among sexual minority women ages 18–41 years



Source: Generations Study and TranPop Study data

POLICY IMPLICATIONS — SYSTEM INVOLVEMENT

Our findings indicate that LBQ women and girls face over-incarceration. The proportions of LBQQ girls and LBQ women in prisons, jails, and youth facilities exceed the proportions of LBQ women and girls in the general population. These differences are even greater for LBQ women and girls of color. In addition to over incarceration, our findings show that LBQQ girls are more likely to experience victimization by staff and other youth while detained compared with heterosexual girls. LBQQ girls are also, on average, detained for longer periods than heterosexual girls. Adult LBQ women of color are also more likely than LBQ White women to have had serious trouble with the police.

Our findings indicate that criminal legal system reforms aimed at ending over-incarceration and over-policing generally, and in particular for people of color and LGBTQ people, would benefit LBQ women and girls. Although our findings do not provide evidence for any one policy solution, these reforms could include, for example, redirecting funding away from incarceration and policing, reforming laws and school disciplinary policies that disproportionately impact LGBTQ youth and adults, and/

or addressing underlying factors that lead to incarceration.[n] Other laws and policies could ensure that LBQ women and girls are protected from violence when incarcerated.[o] These laws and policies could, for example, strengthen and expand protections from LGBTQ harassment and discrimination in carceral settings; require that transgender people be housed according to their gender identity; and ensure that incarcerated LGBTQ people have access to needed health care, including gender-affirming care and culturally competent gynecological care.[p] Finally, it is important that funding is made available to support program evaluations of these types of policy interventions to ensure they have the intended effects.

Our findings also indicate that LBQQ girls are overrepresented in the foster care system, and LBQQ girls in the foster system are disproportionately youth of color. These findings indicate that policies and practices within the foster care system, including strategies to achieve placement permanency, must take into account the unique needs and challenges facing LBQQ girls.[166] For example, nationwide laws prohibiting discrimination against LGBTQ youth and LGBTQ prospective parents in the foster care and adoption system would help to ensure fair treatment of LGBTQ youth and may increase the likelihood of placements by expanding the pool of possible permanent homes.[q] In addition, state and federal agencies could develop resources and guidelines to help foster care providers support both LGBTQ+ youth involved in the foster care system and parents of LGBTQ+ system-involved children. Throughout the U.S., cultural competency trainings and best practices guides for working with LGBTQ youth and their parents have been developed,[167,] however evaluations of the impact of these efforts and related policy solutions are needed.

Looking across both of these systems, it is important to acknowledge a growing awareness that dually-involved system youth (those with child welfare and juvenile criminalization system experiences) are a uniquely vulnerable subpopulation.[168] In addition to the need for services for

---

[n] These suggested reforms are based in part on proposals from federal policymakers intended to "reduce incarceration rates and reshape the American legal system." *See* Recognizing that the United States has a Moral Obligation to Meet its Foundational Promise of Guaranteed Justice for All, H.R. 702, 116th Cong. (2019); *The Biden Plan for Strengthening America's Commitment to Justice*, JoeBiden.com, https://joebiden.com/justice/ (last visited Mar. 1, 2021).

[o] A 2016 Williams institute study found that transgender people in jails and prisons are at increased risk of sexual victimization, and are more likely than cisgender inmates to report experiencing assault or injury from assault by both other inmates and staff. Jody L. Herman,Taylor N.T. Brown, Bianca D.M. Wilson, Ilan H. Meyer, & Andrew R. Flores,Williams Inst., Prevalence, Characteristics, and Sexual Victimization of Incarcerated Transgender People in the United States: Results from the National Inmate Survey (NIS-3)(2016), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Incarceration-Violence-Oct-2016.pdf..

[p] *Compare* Fed. Bureau of Prisons, U.S. Dep't of Justice, Transgender Offender Manual (2017), https://www.bop.gov/policy/progstat/5200.04.pdf *with* Fed. Bureau of Prisons, U.S. Dep't of Justice, Transgender Offender Manual (2018), https://www.documentcloud.org/documents/4459297-BOP-Change-Order-Transgender-Offender-Manual-5.html (noting changes in policy made at the federal level with respect to incarcerated transgender people, including requirements that biological sex now serve as the "initial determination" for housing). *See also The Biden Plan to Advance LGBTQ+ Equality in America and Around the World*, JoeBiden.com, https://joebiden.com/lgbtq-policy/ (last visited Mar. 1, 2021) (expressing the Biden Administration's intent to reverse the policy changes made in 2018 and create additional policies aimed at "[i]ncreas[ing] safety for incarcerated transgender individuals.").

[q] Legislation to this effect has been previously introduced, but not formally enacted. *E.g.*, Every Child Deserves a Family Act, S. 1791, 116th Cong. (2019) (proposing federal non-discrimination protections on the bases of sexual orientation and gender identity, among others, for children, families, and individuals involved with child welfare services).

dually-involved youth, increased infrastructure for data sharing across these systems in order to track characteristics and outcomes of this population is an important policy and administrative practice implication. A recent report by the Office of Justice Program's Dual Systems Youth Study Linked Administrative Data Subcommittee and the Jurisdictional Case Studies Subcommittee noted a number of challenges and promising cases for tracking information on youth who have interactions with both child welfare and juvenile criminalization systems.[169] However, very little attention was given to the challenges of collecting information on sexual orientation and gender identity among dual-system youth. Our findings here clearly indicate that LBQQ girls are likely to be an overrepresented population among those dually-involved youth, including the various forms of dual involvement (crossover youth, dual system, etc.), and more research and policy attention should be focused on this population.

RESILIENCE AND RESISTANCE

RESILIENCY FACTORS

Resilience refers to surviving and thriving despite ongoing challenges, and the concept has a particularly relevance for understanding how LGBTQ people negotiate oppression and minority stress.[170] This next section examines indicators of and resources for resilience through different support systems, using questions asked in the Generations/TransPop surveys. LGBT community connectedness examines how connected an individual feels with the LGBT community and with the community that shares their gender identity. Cisgender LBQ adults were asked how connected they felt to the LGBT community with the statement, "You feel you're part of the LGBT community," with responses ranging from "Strongly agree" to "Strongly disagree." LBQ transgender adults were asked to rate their agreement level using a range from "Strongly agree" to "Strongly disagree" on a similar measure, "I feel connected to other people who share my gender identity." Respondents who indicated "Strongly agree" or "Agree" are presented in Table 43.

Connectedness to one's racial/ethnic identity can also be a source of support. Using the Multigroup Ethnic Identity Measure (MEIM), which includes statements such as "I have a strong sense of belonging to my own race/ethnic group" and "I understand pretty well what my race/ethnic group membership means to me," we assessed how connected LBQ women felt to their race/ethnic community.[171] Mean scores range between 1 and 5, with 5 representing greater connectedness to one's race/ethnicity.

Using two other metrics of support, we assessed how much social support LBQ women felt they received and how they viewed their "circumstances and functioning in society."[172] The Multidimensional Scale of Perceived Social Support, a 12-item scale that includes statements such as "My family really tries to help me" and "There is a special person who is around when I am in need" with response options ranging from "Very strongly disagree" to "Very strongly agree," provides a range of 1–7, with 7 representing greater social support.[173] Compared with 37.9% of transgender LBQ women, 61.6% of cisgender LBQ women felt moderate levels of social support, scoring an average of 5 or above. The Social Well-Being scale is a 15-item scale that includes statements such as "The world is becoming a better place for everyone," "I cannot make sense of what's going on in the world," and "I have something valuable to give to the world" that respondents rate from "Strongly agree" to "Strongly disagree" with a scale that ranges between 1 and 7.[174] Negatively worded statements are reverse coded, and a higher value indicates greater social well-being.

Table 43. Social support among LBQ women compared with other SOGI groups

	LBQ CIS WOMEN (N = 803)	LBQ TRANS WOMEN (N = 68)	ALL LBQ WOMEN (N = 871)	STRAIGHT WOMEN (N = 276)	STRAIGHT MEN (N = 277)	GBQ MEN (N = 754)
LGB community connectedness	65.8%	N/A	65.8%	N/A	N/A	64.4%
Gender identity community connectedness	N/A	67.5%	67.5%	N/A	N/A	**43.0%**

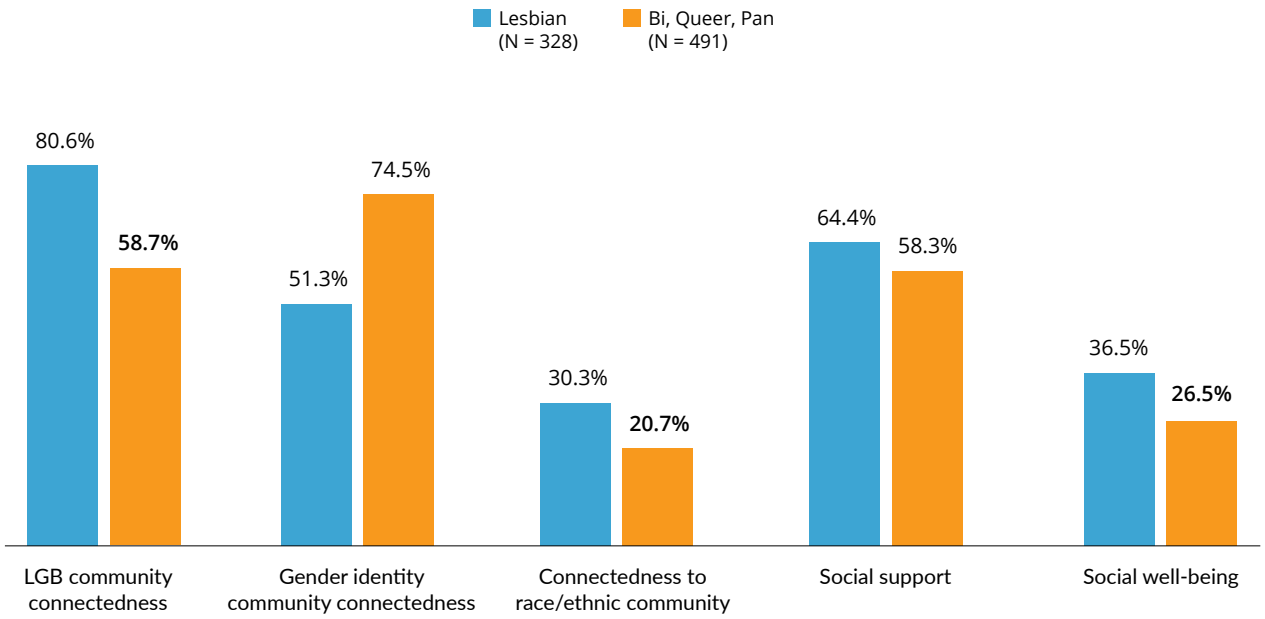
	LBQ CIS WOMEN (N = 803)	LBQ TRANS WOMEN (N = 68)	ALL LBQ WOMEN (N = 871)	STRAIGHT WOMEN (N = 276)	STRAIGHT MEN (N = 277)	GBQ MEN (N = 754)
Connectedness to race/ethnic community	24.6%	7.1%	23.3%	25.2%	33.0%	23.6%
Social support	61.6%	37.9%	59.9%	**76.4%**	70.8%	63.3%
Social well-being	28.9%	40.3%	29.8%	**41.8%**	**50.4%**	**37.1%**

Source: Generations Study and TransPop Study data
Note: Bold numbers indicate statistically significant differences between LBQ women and each comparison group. Analyses of LBQ women compared to others include both cisgender and transgender adults.

In terms of social support and well-being, fewer LBQ women (59.9%) felt social support compared with heterosexual women (76.4%). Additionally, fewer LBQ women felt moderate levels of social well-being. Compared with 37.1% of GBQ men, 41.8% of heterosexual women, and 50.4% of heterosexual men, approximately 30% of LBQ women felt moderate levels of social well-being. Among LBQ women, more cis LBQ women (25%) felt connected to their racial/ethnic community compared with transgender women (7.1%), and this difference was statistically significant. About 40% of LBQ transgender women and 29% of LBQ cisgender women reported moderate levels of social well-being, scoring an average of 5 or above, although this difference was not statistically significant.

Figure 21 shows that compared with bisexual/queer women, more lesbian women felt connected to the LGB community (80.6% vs. 58.7%) and to their racial/ethnic identity (20.7% vs. 30.3%) as well as reported moderate levels of social well-being (27.5% vs. 36.5%). They did not differ in terms of connectedness to their gender identity community and social support.

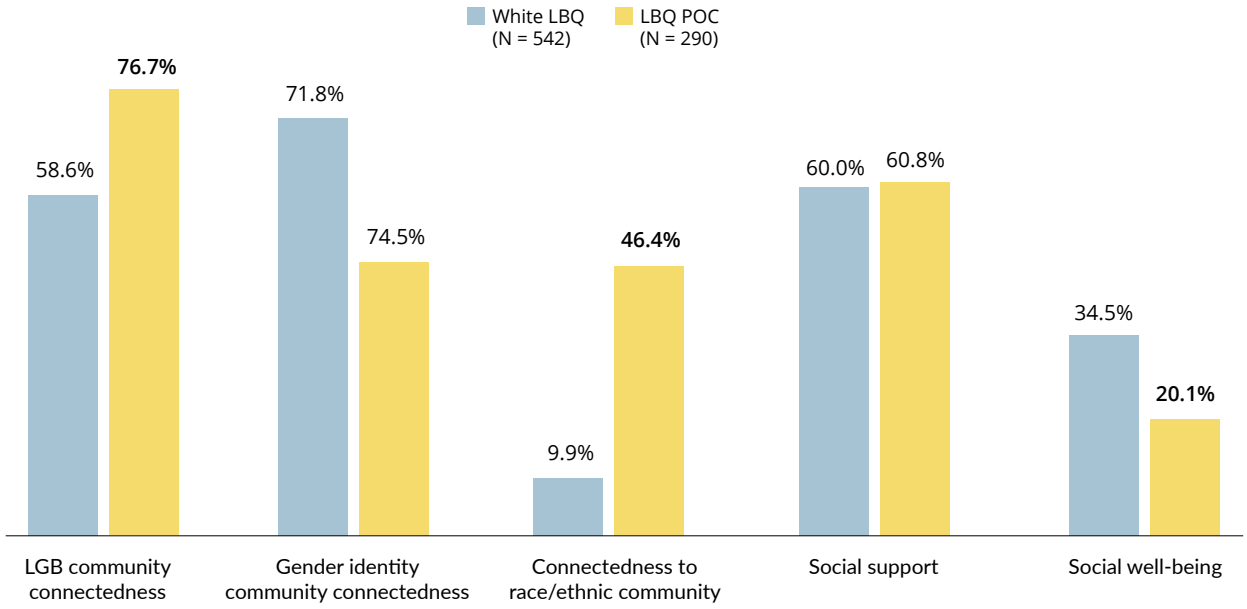
Figure 21. Resiliency factors by sexual identity



Source: Generations Study and TransPop Study data
Note: Bold numbers indicate statistically significant differences between that comparison group and lesbian women.

As Figure 22 shows, a higher proportion of LBQ women of color (76.7%) felt connected to the LGB community than did White LBQ women (58.6%), and more LBQ women of color (46.4%) felt connected to their racial/ethnic community than was reported by White LBQ women (9.9%). On the other hand, more White LBQ women than women of color (20.1%) felt moderate levels of social well-being (34.5%).

Figure 22. Resiliency factors by race/ethnicity

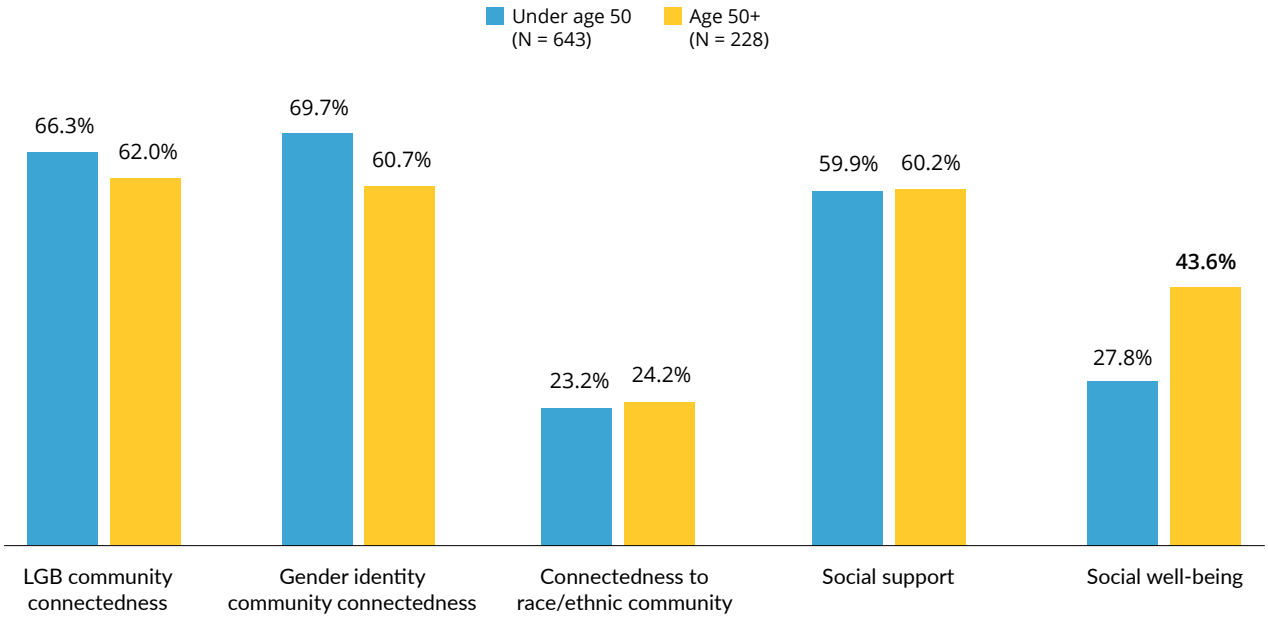


Source: Generations Study and TransPop Study data

Note: Bold numbers indicate statistically significant differences between that comparison group and White LBQ women.

Most sexual minority women felt similarly in terms of connectedness to the LGB community, gender identity community, racial/ethnic community, and levels of social support regardless of age differences. They differed only on levels of social well-being, 44% of sexual minority women age 50 and older reporting moderate levels of social well-being compared with 28% of sexual minority women under age 50 (Figure 23).

Figure 23. Resiliency factors by age



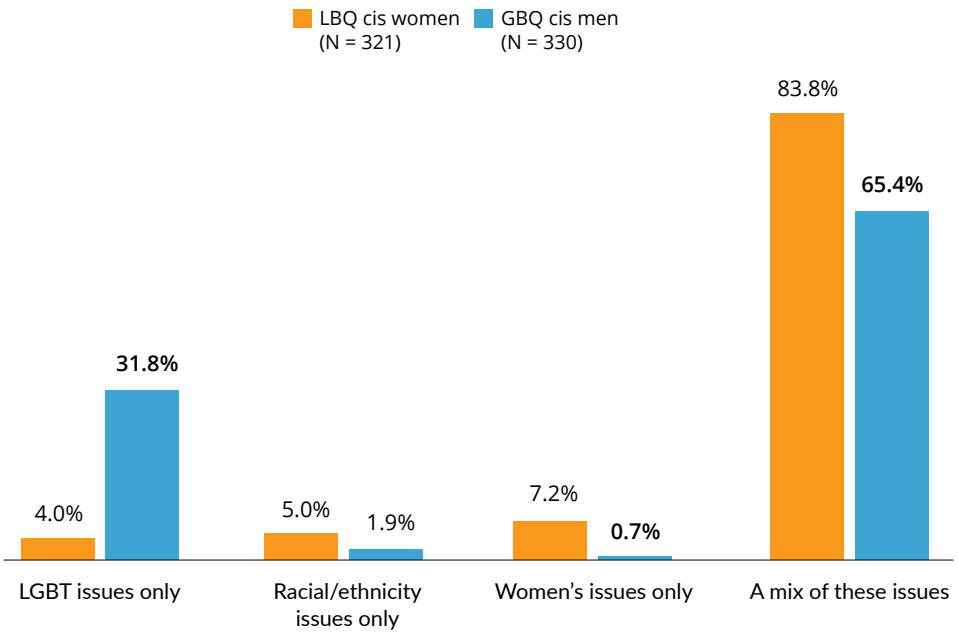
Source: Generations Study and TransPop Study data

Note: Bold numbers indicate statistically significant differences between that comparison group and LBQ women under age 50.

POLITICAL INVOLVEMENT

Being engaged in social movements and being politically involved to change the direction of social issues can be an indication of resiliency[175] as well as an important coping mechanism against oppression.[176] Almost all LBQ cisgender women and GBQ men (about 98%) were involved in a political activity in the past year relative to when the survey was administered in 2018–2019. Political activities included donating money to a cause or organization; signing a petition; advertising one's opinion regarding social issues through stickers, yard signs, or buttons; responding to posts about social issues online; doing things to help improve an area or neighborhood; volunteering with a community group or organization; creating art or content to express views about social issues; working or volunteering for a political campaign; joining a protest march or demonstration; contacting a public official to let them know how you feel about an issue; and posting content online. Among those politically involved, most of the LBQ cisgender women (approximately 84%) were involved in more than one issue, participating in activities around women's issues, racial/ethnicity issues, and LGBT issues. Few women were involved with only one of these issues. However, the pattern differed from what participation looked like among GBQ cisgender men. More GBQ cisgender men participated in only LGBT issues and fewer participated in a mix of the issues than did LBQ women (Figure 24).

Figure 24. Types of political activities involved in among LBQ cis women and GBQ cis men



Source: Generations Study and TransPop Study data

Note: Bold numbers indicate statistically significant differences between that comparison group and LBQ cis women.

The pattern of participation among LBQ cisgender women looks similar by sexual identity. Almost all lesbian (99%) and bisexual/queer (97%) cisgender women were involved in a political activity in the past year relative to when the survey was administered in 2018–2019. There were also no differences by race/ethnicity among LBQ women. Most White LBQ women and LBQ women of color engaged in political activities and participated in various issues. This is also the case between LBQ women under the age of 50 and LBQ women age 50 and above (See Appendix E for Resilience Tables).

POLICY IMPLICATIONS — SUPPORTING RESILIENCE RESOURCES

These findings highlight important resources for efforts to support resilience among LBQ women, because the majority feel connected to various communities and also feel that they have a support network. Additionally, many LBQ women engage in a range of political activities which can be a resource for resilience and social change. Yet these data on resources of resilience also highlight some areas of need in that LBQ women, particularly bisexual women, feel less supported and report lower social well-being compared with other groups. More research is needed on the political participation and issues of interest among sexual minority women. The recent survey conducted by Project LPAC is a useful example of efforts to increase representative data in this area of resiliency[r]. However, across all of the sources we have identified, there needs to be greater precision in identifying LBQ trans women's civic and political engagement in order to assess the ways sexual orientation is a significant factor affecting trans women's concerns.

[r] https://www.projectlpac.org/press-release-january-20

CONCLUSION

The aim of this report was to provide an updated account of the social, structural, and health outcomes of LBQ women and girls and to understand how they have fared compared with other groups. The expectation is that this report will serve as a resource for advocacy groups and service providers as well as a template for future reports. We achieved our aims through analyses of multiple datasets, most of which came from national probability sample studies, providing high confidence that the results reflect the population of LBQ women. Our research highlighted the significance of sexual orientation in the lives of women in the U.S., but also served as a consistent reminder that sexual orientation alone is likely not driving all disparities. It is important for us to keep in mind a more complex picture that takes into account sexual identity, race, age and gender.

Across the many issues we covered, it is clear that there are multiple areas of vulnerability in every policy domain for LBQ women and girls. Across the many issues we covered, it is clear that there are multiple areas of vulnerability in every policy domain for LBQ women and girls. Some of these areas of vulnerability are particularly heightened for sexual minority women (e.g., poverty, depression; criminalization); others are shared with either heterosexual women (e.g., physical and sexual assault) or sexual minority men (e.g., bullying, lack of healthcare access and insurance). In this way, the findings indicate areas where the intersectional space of LBQ womanhood is uniquely important for some issues as well as areas that highlight the salience of sexual orientation or gender differences specifically. Also, the findings illustrate multiple ways that other social statuses intersect with LBQ women status, such as being a woman of color, bisexual, lesbian, and older. Theoretical frameworks highlighting the impact of multiple forms of oppression and the social ecology on the individual lives of queer women influenced our approach to documenting LBQ women's experiences in health, criminalization, and economic systems. However, tests of group differences are only a starting place to assessing the impact of intersecting oppressions and social systems. Future research should use more advanced statistical techniques to identify the true level of impact of these intersectional issues, as well as employ qualitative research to identify how social and structural forms of stigma and discrimination play out in the day-to-day lives of LBQ women.

Though our research presented here covers a broad range of topics of particular importance to contemporary public policy issues related to the status of women and sexual minorities, we of course did not cover all issues important to LBQ women. Some issues clearly pertinent to public policy, like additional indicators of maternal health and mortality, the impact of immigration-related policy and abuse, rates of interpersonal violence (IPV), and types of occupations, are not easily (or at all) available in national or state data systems that also include sexual orientation and gender identity. Of particular importance is the role of gender expression among LBQ women in its impact on economic outcomes, health, and well-being. Also, there is a major absence of data on topics like sex work both as an economic and a criminalization issue, which gets very little attention in general population research or LGBTQ research.

Finally, this report implies the persistent gap in SOGI data for adults and youth and the need for more efforts to include these in population-based surveys and administrative data systems, including death and child welfare records. Although we were able to successfully use several datasets that assess gender identity, most did not truly allow for us to distinguish current gender identity from

sex assigned at birth, especially the youth data. In the absence of this, we are compelled to always frame binary-identified trans youth as simply transgender and never as the gender they identify with, such as "girls." Many of the adult surveys, particularly those focused on reproductive health, do not assess gender identity at all. With regard to sexual orientation, some of the differences we identified between queer/pansexual participants and other sexual identities from the Generations/TransPop surveys indicate a need to test how best to include additional sexual and gender (e.g., nonbinary) identities into large-scale surveys. However, we do not recommend doing this without testing and planning as research indicates that the meaning and saliency of identities such as queer, pansexual, and nonbinary differ widely in ways[177, 178] that can become obscured if casually placed into survey response options and assumed to be a homogenous group.

An important point to make about the findings from this study across so many topics in this moment is that all the data were collected before the Covid-19 pandemic. At this point, many of us understand that the nation's history will be divided to some extent between a pre-COVID and a post-COVID period. Given the known mental and physical health and economic impacts of the COVID-19 pandemic, all of these findings must be understood in the context of vulnerability to the impact of the pandemic and essentially considered a baseline for what we see moving forward. For example, our data indicating the high rate of parenting among LBQ women and combined with economic insecurity indicate an area where LBQ women might be disproportionately affected due to loss of jobs and loss of childcare during the pandemic. Gender-focused research over the next five years should specifically look at not just women's well-being as a function of the pandemic but also the role of sexual orientation in those outcomes.

AUTHORS

Bianca D.M. Wilson, Ph.D., is a Senior Scholar of Public Policy at the Williams Institute and an Associate Researcher at the UCLA School of Law.

Allegra R. Gordon, Sc.D., M.P.H., is an Assistant Professor in the Department of Community Health Sciences at Boston University School of Public Health and an Instructor at Boston Children's Hospital and Harvard Medical School.

Christy Mallory, J.D., is the Renberg Scholar of Law and Legal Director at the Williams Institute.

Soon Kyu (Soonie) Choi, M.P.P., M.Sc., is a Project Manager and the Richard Taylor Public Policy Fellow at the Williams Institute.

M. V. Lee Badgett, Ph.D., is a Professor of Economics at the University of Massachusetts Amherst, and a senior scholar at the Williams Institute.

ACKNOWLEDGMENTS

The completion of this report was made possible by several co-authors not listed individually in the by-line but listed under LBQ Women's Report Team. In addition to the byline authors who primarily conceptualized and wrote the report, several project staff members completed literature and policy reviews, analyses, data tables, and report formatting (listed alphabetically): Lauren Bouton, MA (Research Intern, Williams Institute), Angel Kastanis, MPP (Analyst), Dr. Andy Lin (Statistical consultant and Analyst, UCLA Institute for Digital Research and Education), Winston Luhur, B.S. (Research Assistant), Dr. Chris Smith (former postdoctoral fellow, Williams Institute), and Luis A. Vasquez, J.D. (Scholar of Law, Williams Institute).

We also deeply appreciate the feedback and energy of our Review and Advisory Group at various time points throughout the project. Please see their bios on the next page. Their comments on project plans and drafts of the written report helped to ground the final product and increase the opportunities for it to be useful to a broad spectrum of stakeholders. In addition to the formal Review and Advisory Group, we greatly appreciate the feedback from Ena Suseth Valladares, MPH (Director of Programs, California Latinas for Reproductive Justice) early in the report planning process.

This work was generously supported by the following: Tegan and Sara Foundation, Rabbi Barbara Zacky, and Dr. Nanette Gartrell and Dr. Diane Mosbacher.

Correction September 12, 2022: An earlier version of this report listed the percentage of LBQ women who had not had a pap smear was 13.2%. That value should be 31%. The data have been corrected and the measure revised to reflect the percentage of women who have had the procedure.

SUGGESTED CITATION

Wilson, B.D.M, Gordon, A.R., Mallory, C., Choi, S.K., Badgett, M.V.L., & LBQ Women's Report Team. (2021). Health and Socioeconomic Well-Being of LBQ Women in the U.S. Williams Institute, Los Angeles.

REVIEW AND ADVISORY GROUP BIOS

Madina Agénor, ScD, MPH (she/her) is the inaugural Gerald R. Gill Assistant Professor of Race, Culture, and Society in the Department of Community Health at Tufts University. She is also Adjunct Faculty in the Department of Obstetrics and Gynecology at Tufts University School of Medicine and The Fenway Institute at Fenway Health. A social epidemiologist, Dr. Agénor investigates sexual and reproductive health and cancer screening and prevention inequities in relation to sexual orientation and heterosexism, race/ethnicity and racism, and gender identity and transphobia using an intersectional lens

Dr. Sean Arayasirikul, Ph.D. (they/them, he/him) is a medical sociologist and scholar on sexual and gender minority health with expertise in intersectionality, mobile health interventions, and anti-oppression health equity research. They are a Senior Research Scientist at the Trans Research Unit for Equity and the Center for Public Health Research at the San Francisco Department of Public Health, and an Assistant Professor at the University of California, San Francisco.

Candace Bond-Theriault (she/her/hers) is a Black queer feminist lawyer, writer, social justice advocate and self-care guru working at the intersections of law, policy, reproductive health, rights and justice, racial justice, economic justice, and LGBTQ+ liberation. Candace received her dual LL.M. degree in Gender & the law and Politics & Legislation from the American University Washington College of Law, her J.D. from North Carolina Central University School of Law, and her B.A. from the College of William and Mary Her writing has appeared in SELF magazine, Colorlines, the Root, Blavity, Out magazine, Rewire, Ms. magazine, the Advocate, the Grio, and the Huffington Post.

Madelyn Mills, MA (she/her) is a politically active gay woman living in the Seattle area. She has served in a volunteer, organizing, or board member capacity for several organizations committed to LGBTQ+ rights and health. In her professional career, she works in Marketing Technology for a large healthcare organization

Photo credit Copyright 2021 Jurek Wadjowicz

Urvashi Vaid is President of The Vaid Group, a mission driven consulting and innovation firm. Vaid has worked as: Executive Director of Arcus Foundation; Deputy Director of the Governance and Civil Society Unit at Ford Foundation; Director of Engaging Tradition Project, at Center for Gender & Sexuality Law at Columbia Law School; Senior Fellow at CUNY Graduate Center Department of Sociology; Executive Director of National LGBTQ Task Force; and Staff Attorney at National Prison Project, ACLU. Vaid is co-founder of Donors of Color Network, LPAC, National LGBTQ Anti-Poverty Action Network, LGBT/HIV Criminal Justice Working Group, National Religious Leadership Roundtable, the Federation of Statewide LGBTQ Organizations (which became Equality Federation), and the Creating Change Conference.

ABOUT THE WILLIAMS INSTITUTE

The Williams Institute is dedicated to conducting rigorous, independent research on sexual orientation and gender identity law and public policy. A think tank at UCLA Law, the Williams Institute produces high-quality research with real-world relevance and disseminates it to judges, legislators, policymakers, media, and the public. These studies can be accessed at the Williams Institute website.

FOR MORE INFORMATION
The Williams Institute, UCLA School of Law
Box 951476, Los Angeles, CA 90095-1476
williamsinstitute.law.ucla.edu

RESEARCH THAT MATTERS

ENDNOTES

[1] LGBT Demographic Data Interactive. (2019, January). Los Angeles: The Williams Institute.

[2] Agénor, M., Muzny, C. A., Schick, V., Austin, E. L., & Potter, J. (2017). Sexual orientation and sexual health services utilization among women in the United States. *Preventive Medicine*, *95*, 74–81. doi.org/10.1016/j.ypmed.2016.11.023

[3] Baptiste-Roberts, K., Oranuba, E., Werts, N., & Edwards, L. V. (2017). Addressing health care disparities among sexual minorities. *Obstetrics and Gynecology Clinics of North America*, *44*(1), 71–80. doi.org/10.1016/j.ogc.2016.11.003

[4] Rizer, A. M., Mauery, D. R., Haynes, S. G., Couser, B., & Gruman, C. (2015). Challenges in intervention research for lesbian and bisexual women. *LGBT Health*, *2*(2), 105–112. doi.org/10.1089/lgbt.2014.0122

[5] Pennay, A., McNair, R., Hughes, T., Leonard, W., Brown, R., & Lubman, D. (2017). Improving alcohol and mental health treatment for lesbian, bisexual and queer women: Identity matters. *Australian and New Zealand Journal of Public Health*, *42*(1), 35–42. doi:.org/10.1111/1753-6405.12739

[6] Hayman, B., Wilkes, L., Halcomb, E. J., & Jackson, D. (2013). Marginalised mothers: lesbian women negotiating heteronormative healthcare services. *Contemporary Nurse*, *44*(1), 120–127. doi.org/10.5172/conu.2013.44.1.120

[7] Razzano, L. A., Cook, J. A., Hamilton, M. M., Hughes, T. L., & Matthews, A. K. (2006). Predictors of mental health services use among lesbian and heterosexual women. *Psychiatric Rehabilitation Journal*, *29*(4), 289–298. doi.org/10.2975/29.2006.289.298

[8] Blosnich, J. R., Farmer, G. W., Lee, J. G., Silenzio, V. M., & Bowen, D. J. (2014). Health inequalities among sexual minority adults: evidence from ten U.S. states, 2010. *American Journal of Preventive Medicine*, *46*(4), 337–349. doi.org/10.1016/j.amepre.2013.11.010

[9] Saleh, L., & Sood, N. (2020). Vibrant *yet under-resourced: The state of lesbian, bisexual, and queer movements.* New York and Amsterdam: Astraea Lesbian Foundation for Justice and Mama Cash.

[10] Robertson, P. A., & Dibble, S. L. (2015). Lesbian and bisexual women's health research: Building the evidence for best practices. *LGBT Health*, *2*(2), 89–90. doi:10.1089/lgbt.2015.0027

[11] Goldberg, S. (2021). Fair Play: The Importance of Sports Participation for Transgender Youth, Center for American Progress, Washington D.C.

[12] The African American Policy Forum (AAFP). 2015. "Say Her Name." Retrieved 5/01/2016: http://www.aapf.org/sayhername/.

[13] Taub, A. (2020, September 26). Pandemic will 'take our women 10 years back' in the workplace. *The New York Times.* Retrieved from https://www.nytimes.com/2020/09/26/world/covid-women-childcare-equality.html

[14] Cahn, N. R., and McClain, L.C. (2020, October 16). Gendered complications of COVID-19: Towards a feminist recovery plan. *Georgetown Journal of Gender and the Law*, *2020*, Virginia Public Law and Legal Theory Research Paper No. 2020-67, Boston Univ. School of Law, Public Law Research Paper No. 20–30. Retrieved from, https://ssrn.com/abstract=3689285

[15] Lindberg, L. DLD., VandeVusse, A., Mueller, J., & Kirstein, M. (2020). *Early impacts of the COVID-19 pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences.* New York: Guttmacher Institute. Retrieved from https://www.guttmacher.org/report/early-impacts-covid-19-pandemic-findings-2020-guttmacher-survey-reproductive-health

[16] Institute of Medicine Committee on Quality of Health Care in America. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academies Press.

[17] Please see Note 2.

[18] Baptiste-Roberts, K., Oranuba, E., Werts, N., & Edwards, L. V. (2017). Addressing health care disparities among sexual minorities. *Obstetrics and Gynecology Clinics of North America*, *44*(1), 71–80. doi:10.1016/j.ogc.2016.11.003

[19] See Note 3.

[20] See Note 5.

[21] See Note 6.

[22] See Note 7.

[23] See Note 8.

[24] See Note 9.

[25] See Note 10.

[26] Habarth, J. M. (2015). Development of the Heteronormative Attitudes and Beliefs Scale. *Psychology & Sexuality*, *6*(2), 166–188. doi:10.1080/19419899.2013.876444

[27] National Academies of Sciences, Engineering, and Medicine (2020). *Understanding the well-being of LGBTQI+ populations*. Washington, DC: The National Academies Press. doi:10.17226/25877

[28] Kelly, J. G. (1966). Ecological constraints on mental health services. *American Psychologist*, 21(6), 535–539. doi:10.1037/h0023598

[29] Bronfenbrenner, U. (2005). Ecological systems theory (1992). In U. Bronfenbrenner (Ed.), *Making Human Beings Human: Bioecological Perspectives on Human Development* (pp. 106–173). Thousand Oaks, CA: Sage Publications Ltd.

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

[31] Solar, O., &, Irwin, A. (2007). A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice).

[32] Logie, C. H. (2002, July 1). Carmen The case for the World Health Organization's Commission on the Social Determinants of Health to Address Sexual Orientation. *American Journal of Public Health*, *102*(7), 1243–1246.

[33] Meyer I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674–697. doi:10.1037/0033-2909.129.5.674

[34] Gordon, A. R., & Meyer, I. H. (2007). Gender nonconformity as a target of prejudice, discrimination, and violence against LGB individuals. *Journal of LGBT Health Research*, *3*(3), 55–71. doi:10.1080/15574090802093562

[35] Collins, P. H. (1986). Learning from the outsider within: The sociological significance of Black feminist thought. *Social Problems*, 33(6), S14–S32. doi:10.2307/800672

[36] Combahee River Collective (1995). A Black feminist statement. In B. Guy-Sheftall (Ed.) *In Words of Fire: An Anthology of African-American Feminist Thought* (232–240). New York: New Press.

[37] Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: Black feminist critique of antidiscrimination

doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, *1989*(1), 139–168.

[38] Greene, B. (1997). Lesbian women of color: Triple jeopardy. *Journal of Lesbian Studies*, *1*(1), 109–147. doi:10.1300/J155v01n01_09

[39] Crenshaw, K., & Bonis, O. (2005). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Cahiers du Genre*, *2*(2), 51–82. doi:10.3917/cdge.039.0051

[40] Gee, G. C., & Ford, C. L. (2011). Strucural racism and health inequalites: Old issues, new directions. *Du Bois Review: Social Science Research on Race*, *8*(1), 115–132. doi:10.1017/S1742058X11000130

[41] Jones, J.M. (2021, February 24). *LGBT identification rises to 5.6% in latest U.S. estimate.* Gallup. Retrieved from https://news.gallup.com/poll/329708/lgbt-identification-rises-latest-estimate.aspx

[42] Kerr, D., Santurri, L., & Peters, P. (2013). A comparison of lesbian, bisexual, and heterosexual college undergraduate women on selected mental health issues. *Journal of American College Health*, *61*(4), 185194. doi:10.1080/07448481.2013.78761

[43] Arayasirikul, S., Pomart, W. A., Raymond, H. F., & Wilson, E. C. (2018). Unevenness in health at the intersection of gender and sexuality: sexual minority disparities in alcohol and drug use among transwomen in the San Francisco Bay Area. *Journal of Homosexuality*, *65*(1), 66–79. doi:10.1080/00918369.2017.1310552

[44] Herek G.M., Chopp R., Strohl D. (2007). Sexual stigma: Putting sexual minority health issues in context. In: Meyer I.H., & Northridge M.E. (Eds.),*) The Health of Sexual Minorities*. Boston: Springer. doi:10.1007/978-0-387-31334-4_8

[45] Beals, K. P., Peplau, L. A., & Gable, S. L. (2009). Stigma management and well-being: the role of perceived social support, emotional processing, and suppression. *Personality & Social Psychology Bulletin*, *35*(7), 867–879. doi:10.1177/0146167209334783

[46] Bostwick, W. (2012). Assessing bisexual stigma and mental health status: A brief report. *Journal of Bisexuality*, *12*(2), 214–222. https://doi.org/10.1080/15299716.2012.674860

[47] Veldhuis, C.B., Drabble, L., Riggle, E.D.B., Wootton, A. R, & Hughes, T. L. (2018). We won't go back into the closet now without one hell of a fight: Effects of the 2016 presidential election on sexual minority women's and gender minorities' stigma-related concerns. *Sexuality Research and Social Policy 15*, 12–24. doi:10.1007/s13178-017-0305-x

[48] Mallory, C., Vasquez, L., Brown, T., Momen, R., & Sears, B. (2021). *The impact of stigma and discrimination against LGBT people in West Virginia.* Los Angeles: The Williams Institute. Retrieved from: https://williamsinstitute.law.ucla.edu/wp-content/uploads/Impact-LGBT-Discrimination-WV-Feb-2021.pdf

[49] Logie C.H., & Earnshaw V. (2015). Adapting and validating a scale to measure sexual stigma among lesbian, bisexual and queer women. *PLoS ONE*, *10*(2): e0116198. doi:10.1371/journal.pone.0116198

[50] Luhtanen, R. K. (2002). Identity, stigma management, and well-being. *Journal of Lesbian Studies*, *7*(1), 85–100. doi, :10.1300/J155v07n01_06

[51] Link, B., & Phelan, J. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363–385. Retrieved February 22, 2021, from http://www.jstor.org/stable/2678626

[52] Testa, R.J., Habarth, J., Peta, J., Balsam, K. & Bockting, W. (2015). Development of the gender minority stress and resilience measure. *Psychology of Sexual Orientation and Gender Identity*, 2 (1), 65–77. https://doi.org/10.1037/sgd0000081

[53] See Note 52.

[54] Herek, G.M. (2008). Hate crimes and stigma-related experiences among sexual minority adults in the United States: Prevalence estimates from a national probability sample. *Journal of Interpersonal Violence*, *24*(1). doi:10.1177/0886260508316477

[55] Herek, G.M., Gillis, J.R. & Cogan, J.C. (2009). Internalized stigma among sexual minority adults: Insights from a social psychological perspective. *Journal of Counseling Psychology*, *56*(1). doi:10.1037/a0014672

[56] Balsam K. F. (2003). Traumatic victimization in the lives of lesbian and bisexual women. *Journal of Lesbian Studies*, *7*(1), 1–14. doi:10.1300/J155v07n01_01

[57] Cramer, R. J., McNiel, D. E., Holley, S. R., Shumway, M., & Boccellari, A. (2012). Mental health in violent crime victims: Does sexual orientation matter? *Law and Human Behavior*, *36*(2), 87–95. doi:10.1037/h0093954

[58] Hatzenbuehler, M. L., & Link, B. G. (2014). Introduction to the special issue on structural stigma and health. *Social Science & Medicine*, *103*, 1–6. doi:10.1016/j.socscimed.2013.12.017

[59] Bostwick, W. B., Boyd, C. J., Hughes, T. L., West, B. T., & McCabe, S. E. (2014). Discrimination and mental health among lesbian, gay, and bisexual adults in the United States. *The American Journal of Orthopsychiatry*, *84*(1), 35–45. doi:10.1037/h0098851

[60] Badgett, L.M.V. (2006). Discrimination based on sexual orientation: A review of the literature in economics and beyond. In W.William M. Rodgers III (Ed.), *Handbook on the Economics of Discrimination*. Cheltenham, U.K.: Edward Elgar Publishing, 161-186.

[61] Morris, J. F., & Balsam, K. F. (2003). Lesbian and bisexual women's experiences of victimization: Mental health, revictimization, and sexual identity development. *Journal of Lesbian Studies*, *7*(4), 67–85. doi:10.1300/J155v07n04_05

[62] Hughes, T. L., Johnson, T. P., Steffen, A. D., Wilsnack, S. C., & Everett, B. (2014). Lifetime victimization, hazardous drinking, and depression among heterosexual and sexual minority women. *LGBT health*, *1*(3), 192–203. doi:10.1089/lgbt.2014.0014

[63] Williams, D.R., Yu, Y., Jackson, J.S., & Anderson, N.B. (1997). Racial differences in psychical and mental health: Socioeconomic status, stress, and discrimination. *Journal of Health Psychology*, 2(3), 335–351. https://doi.org/10.1177/135910539700200305

[64] Potter, L., Zawadzki, M. J., Eccleston, C. P., Cook, J. E., Snipes, S. A., Sliwinski, M. J., & Smyth, J. M. (2019). The intersections of race, gender, age, and socioeconomic status: Implications for reporting discrimination and attributions to discrimination. Stigma and Health, 4(3), 264–281. https://doi.org/10.1037/sah0000099

[65] Mallory, C., Vasquez, L. A., & Meredith, C. (2020). Legal protections for LGBT people after Bostock v. Clayton County. Los Angeles: The Williams Institute. Retrieved from https://williamsinstitute.law.ucla.edu/publications/state-nd-laws-after-bostock (2020), https://williamsinstitute.law.ucla.edu/publications/state-nd-laws-after-bostock/.

[66] 140 S. Ct. 1731 (2020).

[67] *Executive Order on Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation*, WhiteHouse.Gov (January 20, 2021). Retrieved from), https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-preventing-and-combating-discrimination-on-basis-of-gender-identity-or-sexual-orientation/

[68] H.R. 5, 117th Cong. (2021).

[69] Section 201 of the Civil Rights Act of 1964, 42 U.S.C. § 2000a(a) (2009).

[70] S.J. Res. 1, 117th Cong. (2021).

[71] H.R. Rep. No. 116-378, at 4–6 (2020) (Comm. Rep.). Retrieved from.), https://www.congress.gov/116/crpt/hrpt378/CRPT-116hrpt378.pdf.

[72] 34 U.S.C. § 12291 (1994).

[73] U.S. Department of Justice. (2019, February 5). *OVW grants and programs*. Retrieved from), https://www.justice.gov/ovw/grant-programs

[74] U.S. Department of Justice. (2014, April 9). *VAWA 2013 nondiscrimination provision: Making programs accessible to all victims of domestic violence, sexual assault, dating violence, and stalking*. Retrieved from https://www.justice.gov/archives/ovw/blog/vawa-2013-nondiscrimination-provision-making-programs-accessible-all-victims-domestic

[75] 34 U.S.C. § 12291(b)(13)(A) (2017).

[76] Violence Against Women Reauthorization Act of 2019, H.R. 1585, 116th Cong. (2019); American Bar Association (2019, May 16). *Violence Against Women Act threatened*. Retrieved from https://www.americanbar.org/advocacy/governmental_legislative_work/publications/washingtonletter/may2019/vawa_update/

[77] *Letter from twenty-three attorneys general to Congress.* (May 4, 2020). Retrieved from, https://portal.ct.gov/-/media/AG/Press_Releases/2019/VAWA-Reauth-Ltr-State-AGs-May-2020.pdf

[78] Sacco, L. N. (2019). The Violence Against Women Act (VAWA): Historical overview, funding, and reauthorization. Congressional Research Service, 26. Retrieved from 26 https://fas.org/sgp/crs/misc/R45410.pdf

[79] Centers for Disease Control and Prevention. (2020, November 30). *Technical packages*. Retrieved from, https://www.cdc.gov/violenceprevention/communicationresources/pub/technical-packages.html.

[80] American Psychological Association, Task Force on Socioeconomic Status. (2007*). Report of the APA Task Force on Socioeconomic Status*. Washington, DC: American Psychological Association. Retrieved from:

https://www.apa.org/pi/ses/resources/publications/task-force-2006.pdf

[81] Badgett, M. V. L., Choi, S. K., & Wilson, B. D. M., (2019, October). *LGBT poverty in the United States: A study of differences between sexual orientation and gender identity groups.* Los Angeles The Williams Institute. Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/National-LGBT-Poverty-Oct-2019.pdf; In addition, lesbians are not more likely to be poor than straight women (Badgett, M.V.L. (2018). Left out? Lesbian, gay, and bisexual poverty in the U.S.. *Population Research and Policy Review*, *37*, 667–702. doi:10.1007/s11113-018-9457-5); Badgett, M. V. L., Choi, S. K., & Wilson, B. D. M., (2019, October). LGBT poverty in the United States: A study of differences between sexual orientation and gender identity groups. Los Angeles, CA: The Williams Institute. Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/National-LGBT-Poverty-Oct-2019.pdf; However, in the American Community Survey, female same-sex couples and male same-sex couples are more likely to be poor than different-sex couples (Schneebaum, A., & Badgett, L. M. V. (2019) Poverty in US Lesbian and Gay Couple Households, *Feminist Economics*, *25*(1), 1–30, doi:10.1080/13545701.2018.1441533). Bisexual men (but not gay men) are more likely to be poor in some studies (Badgett, M.V.L. (2018). Left out? Lesbian, gay, and bisexual poverty in the U.S. *Population Research and Policy Review*, *37*, 667–702. doi:10.1007/s11113-018-9457-5).

[82] Wilson, B.D.M., Gomez, A. G. H., Sadat, M., Choi, S.K., & Badgett, M. V. L. (2020, October). *Pathways into poverty: Lived experiences among LGBTQ people*. Los Angeles: The Williams Institute. Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/Pathways-Overview-Sep-2020.pdf

[83] Badgett, M.V.L., Carpenter, C., & Sansone, D. (in press) LGBTQ economics. *Journal of Economic Perspectives*.

[84] National Academies of Sciences, Engineering, and Medicine. (2020). *Understanding the well-being of LGBTQI+ populations*. Washington, DC: The National Academies Press. doi:10.17226/25877; see Note 90.

[85] See Note 81.

[86] Schwartz, A. F. (2014). *Housing policy in the United States*. New York: Routledge. doi:10.4324/9780203458204

[87] Wilson, B. D. M., Choi, S. K., Harper, G. W., Lightfoot, M., Russell, S., & Meyer, I.H. (2020). *Homelessness among LGBT adults in the U.S.* Los Angeles: The Williams Institute. Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Homelessness-May-2020.pdf

[88] Dworsky, A., Van Drunen, M., & Gitlow, E. (2017). *Voices of Youth Count (VoYC) youth count and brief youth survey: Technical report.* Chicago: Chapin Hall at the University of Chicago.

[89] H.R. 5, 117th Cong. (2021).

[90] Klawitter, M. M. (2011). Multilevel analysis of the effects of antidiscrimination policies on earnings by sexual orientation. Journal *of Policy Analysis and Management*, 30(2), 334–358; Burn, I. (2018). Not all laws are created equal: Legal differences in state non-discrimination laws and the impact of LGBT employment protections. *Journal of Labor Research*, 39, 462-497.

[91] Dillbary, J. S., & Edwards, G. (2019). An empirical analysis of sexual orientation discrimination. *University of Chicago Law Review*, *86*(1), 1–76 (noting consistent discrimination against same-sex male couples attempting to access loans insured by the Federal Housing Administration, despite the existence of policies specifically prohibiting same by lenders).

[92] Conron, K. J., & Goldberg, S. K. (2019) *Raising the Federal Minimum Wage*. Los Angeles: The Williams Institute. Retrieved from), https://williamsinstitute.law.ucla.edu/publications/raising-fed-min-wage-lgbt-adults/

[93] Romero, A. P. (2019). Does the Equal Pay Act prohibit discrimination on the basis of sexual orientation or gender identity? *Alabama Civil Rights and Civil Law Review*, 10, 35-94. https://www.law.ua.edu/acrcl/files/2019/06/2.-Romero_Published.pdf

[94] Romero, A. P., Goldberg, S. K., & Vasquez, L. A. (2020). *LGBT people and housing affordability, discrimination, and homelessness.* Los Angeles: The Williams Institute. Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Housing-Apr-2020.pdf

[95] Office of Policy Development & Research. (2012). Paths to homeownership or low-income and minority households. Retrieved from, https://www.huduser.gov/portal/periodicals/em/fall12/highlight1.html

[96] Romero, A.P., Goldberg, S.K., & Vasquez, L.A. (2020). LGBT People and Housing Affordability, Discrimination, and Homelessness. The Williams Institute. Conron, C. (2019). *Financial services and the* and the *LGBTQ+ community: A review of discrimination in lending and housing.* Testimony before the Subcommittee on Oversight and Investigations. Los Angeles: The Williams Institute. Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/Testimony-US-House-Financial-Services-Oct-2019.pdf Meyer, I. H., ET AL. (2020). *Findings from a U.S. transgender population study* [Paper presentation]. United States Professional Association for Transgender Health Conference, Washington, D.C., Los Angeles: The Williams Institute. (Data on file with authors.)

[97] Sun, H., & Gao, L. Lending practices to same-sex borrowers. *Proceedings of the National Academy of Sciences, USA*, *116*(19), 9293–9302. Retrieved from https://www.pnas.org/content/pnas/116/19/9293.full.pdf

[98] Coolhart, D., & Brown, M. T. (2017). The need for safe spaces: Exploring the experiences of homeless LGBTQ youth in shelters. *Child and Youth Services Review*, 82, 230. doi:10.1016/j.childyouth.2017.09.021

Shelton, J. (2015). Transgender youth homelessness: Understanding programmatic barriers through the Lens of Cisgenderism. *Child and Youth Services Review*, *59*, 10. doi:10.1016/j.childyouth.2015.10.006See Note 101.

[99] See Note 30.

[100] National Academies of Sciences, Engineering, and Medicine. (2020). *Understanding the well-being of LGBTQI+ populations*. Washington, DC: The National Academies Press. doi:10.17226/25877

[101] See Note 30

[102] Blosnich, J., Lee, J. G. L., and Horn, K. (2013). A systematic review of the aetiology of tobacco disparities for sexual minorities. *Tobacco Control, 22*(2), 66–73. doi:10.1136/tobaccocontrol-2011-050181

Lee, J. G., Griffin, G. K., & Melvin, C. L. (2009). Tobacco use among sexual minorities in the USA, 1987 to May 2007: a systematic review. *Tobacco control*, *18*(4), 275–282. doi.org/10.1136/tc.2008.028241

Wheldon, C. W., Kaufman, A. R., Kasza, K. A., & Moser, R. P. (2018). Tobacco Use Among Adults by Sexual Orientation: Findings from the Population Assessment of Tobacco and Health Study. *LGBT health*, *5*(1), 33–44. doi.org/10.1089/lgbt.2017.0175

[103] World Health Statistics. (2017). *Monitoring health for the SDGs, Sustainable Development Goals*. Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO. Retrieved from https://apps.who.int/iris/handle/10665/332070.

[104] Aguayo-Romero R. A. (2021). (Re)centering Black Feminism Into Intersectionality Research. *American journal of public health*, *111*(1), 101–103. doi.org/10.2105/AJPH.2020.306005

[105] Bowleg, L. (2020, December 16). Evolving intersectionality within public health: From analysis to action. *American Journal of Public Health, 111*(1), 88–90. doi:10.2105/AJPH.2020.306031

[106] Brandon, T., & Pritchard, G. (2011). 'Being fat': A conceptual analysis using three models of disability. *Disability & Society*, *26*(1), 79–92. doi:10.1080/09687599.2011.529669

[107] See Note 103.

[108] Centers for Disease Control and Prevention. *Behavioral Risk Factor Surveillance System Survey data*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

[109] Fingerhut, A.W., & Abdou, C. M. (2017). The role of healthcare stereotype threat and social identity threat in LGB health disparities. *Journal of Social Issues*, *73*(3), 493-507. doi.org/10.1111/josi.12228

[110] SisterSong Women of Color Reproductive Health Collective. Retrieved from https://www.sistersong.net/reproductive-justice. Accessed February 2020, January 8, 2021.

[111] Ross, Loretta J. (2017) Reproductive justice as intersectional feminist activism. *Souls, 19*:(3), 286–314. doi:10.1080/10999949.2017.1389634

[112] Goodenow, C., Szalacha,, L.A., Robin, L.E. & Westheimer,K., (2008). Dimensions of Sexual Orientation and HIV-Related Risk Among Adolescent Females: Evidence From a Statewide Survey. *American Journal of Public Health* 98, 1051_1058. doi.org/10.2105/AJPH.2005.080531

[113] London, S. (2006). Lesbians bisexual women: misperceptions of risk jeopardize sexual health. *Perspectives on Sexual and Reproductive Health, 38*.

[114] Women's Institute at Gay Men's Health Crisis (2009). HIV Risk for Lesbians, Bisexuals & Other Women Who Have Sex With Women Crisis. Retrieved at https://www.lgbtagingcenter.org/resources/pdfs/GMHC_lap_whitepaper_06091.pdf

[115] Goldberg, S. K., Reese, B. M., & Halpern, C. T. (2016). Teen Pregnancy Among Sexual Minority Women: Results From the National Longitudinal Study of Adolescent to Adult Health. *The Journal of adolescent health: Official publication of the Society for Adolescent Medicine*, *59*(4), 429–437. doi.org/10.1016/j.jadohealth.2016.05.009

[116] Stoffel, C., Carpenter, E., Everett, B., Higgins, J., & Haider, S. (2017). Family Planning for Sexual Minority Women. *Seminars in reproductive medicine*, *35*(5), 460–468. doi.org/10.1055/s-0037-1604456

[117] See Note 2.

[118] Bowen, D. J., Bradford, J. B., Powers, D., McMorrow, P., Linde, R., Murphy, B. C., Han, J., & Ellis, J. (2004). Comparing women of differing sexual orientations using population-based sampling. *Women & health*, *40*(3), 19–34. doi.org/10.1300/j013v40n03_02

[119] Mark Assink, Esther D. Rothblum, Bianca D. M. Wilson, Nanette Gartrell & Henny M. W. Bos (2021) Mental Health of Lesbian, Bisexual, and Other-Identified Parents and Non-Parents from a Population-Based Study. *Journal of Homosexuality*. DOI:10.1080/00918369.2021.1892401

[120] Carone N, Rothblum ED, Bos HMW, Gartrell NK, Herman JL. (2020) Demographics and health outcomes in a U.S. probability sample of transgender parents. *Journal of Family Psychology*. doi:10.1037/fam0000776. Epub ahead of print. PMID: 33001675.

[121] Goldberg, A.E., Gartrell, N.K., & Gates, G. (2014). *Research report on LGB-parent families*. Los Angeles: The Williams Institute. Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGB-Parent-Families-Jul-2014.pdf

[122] National Center for Health Statistics. (2021, February 15). *Maternal Mortality*. Washington, DC: Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/nchs/maternal-mortality/index.htm

[123] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality.

[124] Gartrell, N., Rothblum, E. D., Koh, A. S., van Beusekom, G., & Bos, H. (2019). "We Were Among the First Non-traditional Families": Thematic Perceptions of Lesbian Parenting After 25 Years. *Frontiers in Psychology*. 10(OCT), 2414. https://doi.org/10.3389/fpsyg.2019.02414

[125] Wilson, B. D. M., Kreuger, E., Politt, A., & Bostwick, W. (in press). Partnership status and mental health in a nationally representative sample of sexual minorities. *Psychology of Sexual Orientation and Gender Diversity*.

[126] Hatzenbuehler, M. L. (2016). Structural stigma: Research evidence and implications for psychological science. American Psychologist. 71(8), 742–751. doi:10.1037/amp0000068. Institute of Medicine. (2011). The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding 18, 32 ("LGBT people . . . face a profound and poorly understood set of . . . health risks due largely to social stigma . . . . ." and "[c]ontemporary health disparities based on sexual orientation and gender identity are rooted in and reflect the historical stigmatization of LGBT people.") Office of Disease Prevention and Health Promotion. .");*Lesbian, gay, bisexual, and transgender health*. Retrieved February 26, 2021 from, https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health ("Research suggests that LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights . . . . Social determinants affecting the health of LGBT individuals largely relate to oppression and discrimination. Examples include: . . . [l]ack of laws protecting against bullying in schools.").

[127] Hatzenbuehler, M. L., Keyes, K. M., & Hasin, D. S. (2009). State-level policies and psychiatric morbidity in lesbian, gay, and bisexual populations. American Journal of Public Health. 99(12), 2275–2281.

[128] Hatzenbuehler, M. L., McLaughlin, K. A., Keyes, K. M., & Deborah S. Hasin, D. S. (2010). The impact of institutional

discrimination on psychiatric disorders in lesbian, gay, and bisexual populations: A prospective study. *American Journal of Public Health, 100*(3), 452–459.

[129] Mallory, C., Vasquez, L. A., & Meredith, C. (2020). Legal protections for LGBT people after Bostock v. Clayton County. Los Angeles: The Williams Institute. Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/Bostock-State-Laws-Jul-2020.pdf; Conron K. J., & Goldberg, S. K. (2020). LGBT people in the U.S. not protected by state non-Discrimination statutes. Los Angeles: The Williams Institute. Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-ND-Protections-Update-Apr-2020.pdf

[130] Mallory, C., & Tentindo, W. (2019). Medicaid coverage for gender-affirming care. Los Angeles: The Williams Institute. Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/Medicaid-Gender-Care-Oct-2019.pdf

[131] Herman, J. L., Brown, T. N. T., & Hass, A. P. (2019) Suicide thoughts and attempts among transgender adults: Findings from the 2015 U.S. Transgender Survey 16. Los Angeles: The Williams Institute. Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/Suicidality-Transgender-Sep-2019.pdf

[132] Centers for Disease Control and Prevention (2019, November 12). *HIV and transgender people*. Retrieved from https://www.cdc.gov/hiv/group/gender/transgender/index.html

[133] HIV.gov. (2021, February 23). *What is 'Ending the HIV Epidemic: A Plan for America'?* Retrieved from https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview.

[134] Blosnich, J. R., Henderson, E. R., Coulter, R. W. S., Goldbach, J. T., & Meyer, I. H. (2020) *Sexual Orientation Change Efforts, Adverse Childhood Experiences, and Suicide Ideation and Attempt Among Sexual Minority Adults, United States, 2016–2018*. American Journal of Public Health 110(7), 1024–130. Retrieved from https://ajph.aphapublications.org/doi/10.2105/AJPH.2020.305637

[135] Mallory, C., Brown, T. N. T., & Conron, K. J. (2019) Conversion therapy and LGBT youth. Los Angeles: The Williams Institute. Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-Update-Jun-2019.pdf

[136] Meyer, I. H., Luo, F., Wilson, B. D. M., & Stone, D. M. (2019).,

Sexual orientation enumeration in state antibullying statutes in the United States. Los Angeles: The Williams Institute. Retrieved from https://williamsinstitute.law.ucla.edu/publications/lgbt-antibullying-laws-youth/.

[137] Kann, L., McManus, T., Harris, W. A., Shanklin, S. L., Flint, K. H., Queen, B. ... Ethier, K. E. (2018).., Youth Risk Behavior Surveillance—United States, 2017. Morbidity and Mortality World Report *Surveillance Summary 67*(8) .1, 11 Retrieved from https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2017/ss6708.pdf; Hatzenbuehler, M. L., Jun, H. J., Corliss, H. L., & Austin, S. B. (2014). Structural stigma and cigarette smoking in a prospective cohort study of sexual minority and heterosexual youth. *Annals of behavioral medicine : a publication of the Society of Behavioral Medicine*, *47*(1), 48–56. doi.org/10.1007/s12160-013-9548-9; Bontempo, D. E., & D'Augelli, A. R. (2002). Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behavior. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine*, *30*(5), 364–374. doi.org/10.1016/s1054-139x(01)00415-3

[138] Raifman J, Moscoe E, Austin SB, McConnell M. Difference-in-Differences Analysis of the Association Between State Same-Sex Marriage Policies and Adolescent Suicide Attempts. JAMA Pediatr. 2017;171(4):350–356. doi:10.1001/jamapediatrics.2016.4529

[139] Hatzenbuehler M. L. (2011). The social environment and suicide attempts in lesbian, gay, and bisexual youth. *Pediatrics*, *127*(5), 896–903. https://doi.org/10.1542/peds.2010-3020

[140] *Compliance with Statutory Program Integrity Requirements*, 84 Fed. Reg. 7714 (Mar. 4, 2019).

[140] Salganicoff, A., Laurie Sobel, L., & Ramaswamy, A. (2019, June 24). *Coverage for abortion Services in Medicaid, Marketplace Plans and Private Plans*. San Francisco: Kaiser Family Foundation. Retrieved from https://www.kff.org/womens-health-policy/issue-brief/coverage-for-abortion-services-in-medicaid-marketplace-plans-and-private-plans

[141] Movement Advancement Project. (2021, February 26). *Foster and adoption laws second/stepparent*. Retrieved from https://www.lgbtmap.org/equality-maps/foster_and_adoption_laws

[142] *Other Parental Recognition Laws – Assisted Reproduction*, Movement Advancement Project. (2021, February 26). *Other parental recognition laws—assisted reproduction*. Retrieved from, https://www.lgbtmap.org/equality-maps/other_parenting_laws

[143] Movement Advancement Project. (2021, February 26). *Foster and adoption laws – adoption*. Retrieved from https://www.lgbtmap.org/equality-maps/foster_and_adoption_laws/adoption

[144] Movement Advancement Project. (2020) Religious exemption laws. Retrieved from https://www.lgbtmap.org/img/maps/citations-religious-exemption.pdf

[145] Fulton v. City of Philadelphia, 922 F.3d 140 (3d Cir. 2019), *cert. granted sub nom.* Fulton v. City of Philadelphia, 140 S. Ct. 1104, 206 L. Ed. 2d 177 (2020).

[146] Rossin-Slater, M., & Uniat, L. (2019, March 28) "Paid Family Leave Policies And Population Health, " Health Affairs Health Policy Brief, March 28, 2019.DOI: 10.1377/hpb20190301.484936

[147] Boyd, R. (2014). African American disproportionality and disparity in child welfare: Toward a comprehensive conceptual framework. *Children and Youth Services Review*, 37, 15–27. doi:10.1016/j.childyouth.2013.11.013

[148] Roberts, D.E. (2002). *Shattered bonds: The color of child welfare*. New York: Basic Books.

[149] Crenshaw, K. W. (2013). From private violence to mass incarceration: Thinking intersectionally about women, race, and social control. *Journal of Scholarly Perspectives*, *9*(01), 21–50. https://www.uclalawreview.org/pdf/59-6-1.pdf

[150] Morris, M. W. (2012). *Race, gender, and the school-to-prison pipeline: Expanding our discussion to include Black girls.* New York and Los Angeles: African American Policy Forum.

[151] Richie, B. (2012). *Arrested justice: Black women, violence, and America's prison nation*. New York: NYU Press.

[152] Wilson, B., Jordan, S. P., Meyer, I. H., Flores, A. R., Stemple, L., & Herman, J. L. (2017). Disproportionality and disparities among sexual minority youth in custody. *Journal of Youth and Adolescence*, *46*(7), 1547–1561. doi:10.1007/s10964-017-0632-5

[153] Meyer, I. H., Flores, A. R., Stemple, L., Romero, A. P., Wilson, B. D., & Herman, J. L. (2017). Incarceration rates and traits of sexual minorities in the United States: National Inmate Survey, 2011–2012. *American Journal of Public Health*, *107*(2), 267–273. doi:10.2105/AJPH.2016.303576

[154] Wilson, B., Jordan, S. P., Meyer, I. H., Flores, A. R., Stemple, L., & Herman, J. L. (2017). Disproportionality and Disparities among Sexual Minority Youth in Custody. *Journal of youth and adolescence*, *46*(7), 1547–1561. https://doi.org/10.1007/s10964-017-0632-5

[155] Irvine-Baker, A., Jones, N., and Canfield, A. (2019). Taking the 'girl' out of gender-specific programming in the juvenile justice system. American Review of Criminology, 2, 321–336. doi.org/10.1146/annurev-criminol-032317-091922

[156] See Note 154.

[157] Meyer, I. H., Flores, A. R., Stemple, L., Romero, A. P., Wilson, B. D., & Herman, J. L. (2017). Incarceration Rates and Traits of Sexual Minorities in the United States: National Inmate Survey, 2011-2012. *American journal of public health*, *107*(2), 267–273. doi.org/10.2105/AJPH.2016.303576

[158] Conron, K. J. & Wilson, B. D. M. (Eds.) (2019). A Research Agenda to Reduce System Involvement and Promote Positive Outcomes with LGBTQ Youth of Color Impacted by the Child Welfare and Juvenile Justice Systems. Los Angeles, CA: The Williams Institute.

[159] Baams, L., Wilson, B. D. M., & Russell, S. T. (2019). LGBTQ Youth in unstable housing and foster care. *Pediatrics*, *143*(3), e20174211 doi:10.1542/peds.2017-4211

[160] Wilson, B. D, M., & BDM, Kastanis A. AAA. (2015). Sexual and gender minority disproportionality and disparities in child welfare: A population-based study. *Child Youth Services Review*, *58*, 11–17. doi:10.1016/j.childyouth.2015.08.016

[161] Dettlaff, A. J., Washburn, M., Carr, L. "Christian," & Vogel, A. "Nikki." (2018). Lesbian, gay, and bisexual (LGB) youth within in welfare: Prevalence, risk and outcomes. *Child Abuse & Neglect*, *80*, 183–193. doi:10.1016/J.CHIABU.2018.03.009

[162] Fish, J. N., & Baams, L. (2018). Trends in alcohol-related disparities between heterosexual and sexual minority youth from 2007 to 2015: Findings from the Youth Risk Behavior Surveillance Survey. *LGBT Health*, *5*(6), 359–367.

[163] "Racial/Ethnic Composition Cities & Communities Los Angeles County." Los Angeles Almanac. © 1998-2021 Given Place Media, publishing as Los Angeles Almanac. Jan. 2021 < http://www.laalmanac.com/population/po38.php >.

[164] Wilson, B.D.M., Cooper, K., Kastanis, A., & Nezhad, S. (2014). *Sexual and gender minority youth in foster care: Assessing disproportionality and disparities in Los Angeles.* Los Angeles: The Williams Institute. Retrieved from: https://williamsinstitute.law.ucla.edu/wp-content/uploads/SGM-Youth-in-Foster-Care-Aug-2014.pdf

[165] Nugent, C. N. CN, Ugwu, C., Jones, J., Newburg-Rinn, S., White, T. (2020). Demographic, health care, and fertility-related characteristics of adults aged 18–44 who have ever been in foster care: United States, 2011–2017 (138). Hyattsville, MD: National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/data/nhsr/nhsr138-508.pdf

[166] Wilson, B.D.M., Cooper, K., Kastanis, A., & Nezhad, S. (2014). *Sexual and gender minority youth in foster care: Assessing disproportionality and disparities in Los Angeles.* Los Angeles: The Williams Institute. Retrieved from: https://williamsinstitute.law.ucla.edu/wp-content/uploads/SGM-Youth-in-Foster-Care-Aug-2014.pdf

[167] Cooper, K.C., Wilson, B.D. M., Choi, S.K. (2017). Los Angeles County LGBTQ Youth Preparedness Scan. Submitted to the Los Angeles Board of Supervisors. https://williamsinstitute.law.ucla.edu/wp-content/uploads/LACo-Youth-Prepare-Scan-Feb-2017.pdf

[168] Irvine, Angela, and Aisha Canfield. 2016. "The Overrepresentation of Lesbian, Gay, Bisexual, Questioning, Gender Nonconforming, and Transgender Youth Within the Child Welfare to Juvenile Justice Crossover Population." *Journal on Gender, Social Policy, and the Law*, *24*(2): 243-261.

[169] Herz, D.C., Dierkhising, C.B., Raithel, J. et al. Dual System Youth and their Pathways: A Comparison of Incidence, Characteristics and System Experiences using Linked Administrative Data. *J Youth Adolescence 48*, 2432–2450 (2019). https://doi.org/10.1007/s10964-019-01090-3

[170] Meyer, I. H. (2015). Resilience in the study of minority stress and health of sexual and gender minorities. *Psychology of Sexual Orientation and Gender Diversity*, *2*(3), 209–213. doi:10.1037/sgd0000132

[171] Phinney, J.S. & Ong, A.D. (2007). Conceptualization and measurement of ethnic identity: Current status and future

directions. *Journal of Counseling Psychology*, 54 (3) 54(3), 271–281. https://doi.org/10.1037/0022-0167.54.3.271

[172] Keyes, C.L. (1998). Social well-being. *Social Psychology Quarterly*, *61*(2), 121–140.

[173] Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The Multidimensional Scale of Perceived Social Support. Journal of Personality Assessment, 52(1), 30–41. https://doi.org/10.1207/s15327752jpa5201_2

[174] Keyes, C.L. (1998). Social well-being. *Social Psychology Quarterly*, *61*(2), 121–140.

[175] Porter, T.J. (2013). Moral and political identity and civic involvement in adolescents. *Journal of Moral Education*, 42(2), 239–255. doi:10.1080/03057240.2012.76113; Pancer, M. (2015). The psychology of citizenship and civic engagement. Oxford, UK: Oxford University Press.

[176] Eliason, M. J., Streed, C., Jr, & Henne, M. (2018). Coping with stress as an LGBTQ+ health care professional. *Journal of Homosexuality*, *65*(5), 561–578. doi:10.1080/00918369.2017.1328224

[177] Barsigian, L. L., Hammack, P. L., Morrow, Q. J., Wilson, B. D. M., & Russell, S. T. (2020). Narratives of gender, sexuality, and community in three generations of genderqueer sexual minorities. *Psychology of Sexual Orientation and Gender Diversity*, *7*(3), 276–292. doi:10.1037/sgd0000384

[178] Goldberg, S. K., Rothblum, E. D., Russell, S. T., & Meyer, I. H. (2020). Exploring the Q in LGBTQ: Demographic characteristic and sexuality of queer people in a U.S. representative sample of sexual minorities. *Psychology of Sexual Orientation and Gender Diversity*, *7*(1), 101–112. doi:10.1037/sgd0000359