# Reclaiming Our Voices: Two Spirit Health & Human Service Needs in New York State

*Suggested Citation: Frazer, M. Somjen and Pruden, Harlan. (2010). Reclaiming Our Voice :Two Spirit Health & Human Service Needs in New York State. NYS DOH AIDS Institute: Albany, NY.*

## Introduction

American Indians, Alaska Natives and other Native peoples (called in this report 'Natives' or 'Native people', by request of participants, except when quoting or from research specifying 'Indian' or another demographic designation) are at greater risk for many serious health problems, including diabetes, heart disease, and alcoholism.[1] They are also more likely to smoke and to be obese and less likely to engage in leisure time physical activity. Furthermore, they are less likely to have had age- and gender- appropriate cancer screening.[2]

Lesbian, gay, bisexual, and transgender (LGBT) people are more likely to have mental health issues related to stress. Research suggests that when minorities are exposed to prejudice, they have negative mental health outcomes, including depression and anxiety, and this phenomenon is well-documented in the LGBT community.[3] Stress also contributes to substance abuse issues, and both Native people and LGBT people are more likely to smoke and drink.[4]

Both groups suffer from stigma and are disproportionately likely to be victims of violence.[5]

However, very little is known about LGBT Native people and their specific experiences of health and human services disparities. New research using a large national study of LGBT American Indians found a high rate of HIV prevalence and partner concurrency[6] and strong relationships between discrimination and physical pain, impairment, and poor health.[7] Smaller studies of LGBT American Indians have found

[1] Holm, J. E., Vogeltanz-Holm, N., Poltavski, D., & McDonald, L. (2010). Assessing health status, behavioral risks, and health disparities in American Indians living on the northern plains of the U.S. Public Health Reports, 125(1), 68-78.
[2] Ibid.
[3] Meyer, I. H., Schwarz, S., & Frost, D. M. (2008). Social patterning of stress and coping: Does disadvantaged social statuses confer more stress and fewer coping resources? Social Science and Medicine, *67*(6), 368-379.
[4] Mayer, K. H., Bradford, J. B., Makadon, H. J., Stall, R., Goldhammer, H., & Landers, S. (2008). Sexual and gender minority health: What we know and what needs to be done. American Journal of Public Health, 98(6), 989-995.
[5] Mayer, Ibid. Oetzel, J., & Duran, B. (2004). Intimate partner violence in American Indian and/or Alaska Native communities: A social-ecological framework of determinants and interventions. American Indian and Alaska Native Mental Health Research, 11(3), 49-68.
[6] Cassels, S., Pearson, C. R., Karina, W., Simoni, J. M., & Morris, M. (2010). Sexual partner concurrency and sexual risk among gay, lesbian, bisexual, and transgender American Indian/Alaska Natives. Sexually Transmitted Diseases, 37(4), epub ahead of print.
[7] Chae, D. H., & Walters, K. (2009). Racial discrimination and racial identity attitudes in relation to self-rated health and physical pain and impairment among two-spirit American Indians/Alaska Natives. American Journal of Public Health, 99(Suppl 1), S144-151.

high rates of victimization, child abuse and historical trauma. These studies have also revealed problems with mental health and HIV risk behaviors.[8]

Many contemporary Native people who have same-sex attractions and/or non-normative gender identities and/or identify as LGBT also identify as two-spirit. Dating back before European colonization, many indigenous peoples used a specific word(s) in their language to refer to people with alternative gender roles (and specific cultural roles) and/or people who entered into same-sex relationships (for example, the Lakota had *winkte* or Dinè had *nadleeh*).[9] "Two-spirit" is a more recent nomenclature, chosen as an umbrella term in the 1990s by Native people who felt themselves to be contemporary inheritors of these traditional roles and set their community apart from white-dominated LGBT communities.

Because of these key differences in LGBT and two-spirit experiences, health and human services designed for the wider LGBT population may not serve two-spirit needs: either because of outright experiences of racism or a failure to provide culturally sensitive services owing to lack of knowledge or experience with this population. Because some Native communities may hold homophobic and/or transphobic attitudes toward two-spirit and LGBT people, they also do not provide all needed services for this population. This needs assessment is designed to help illuminate these gaps.

The needs assessment focuses on New York State. Although New York is less associated with Native populations than are some Western states, it is important to note that NYS ranks in the top ten states with the largest Native populations – the top 10 each have populations over 100K.[10] With the majority of Native Peoples in the United States now living outside of tribal areas, a focus on these areas can inform outreach work not only in New York State but also other states with a large number of Native people living outside of reservations.[11]For example, New York City, where two focus groups were conducted, includes the largest number of Indians living in an US city.[12]

---

[8] Simoni, J. M., Walters, K., Balsam, K. F., & Meyers, S. B. (2006). Victimization, substance use, and HIV risk behaviors among gay/bisexual/two-spirit and heterosexual American Indian men in New York City. American Journal of Public Health, 96(12), 2240-2245. Balsam, K. F., Huang, B., Fieland, K., C., Simoni, J. M., & Walters, K. (2004). Culture, trauma, and wellness: A comparison of heterosexual and lesbian, gay, bisexual, and two-spirit Native Americans. Cultural Diversity and Ethnic Minority Psychology, 10(3), 287-301.

[9] Adams, H. L., & Phillips, L. (2009). Ethnic related variations from the Cass model of homosexual identity formation: The experiences of two-spirit, lesbian and gay Native Americans. Journal of Homosexuality, 56(7), 959-976.

[10] U.S. Census Bureau, ''Annual Estimates of the Population by Race Alone and Hispanic or Latino Origin for the United States and States: July 1, 2003 (SC-EST2003-04);'' published 30 September 2004; http://www.census.gov/popest/states/asrh/tables/SC-EST2003-04.pdf

[11] U.S. Census Bureau, "We the People: American Indians and Alaskan Natives in the Untied States: Issued February 2006" (CENSR-28) Page 14. http://www.census.gov/prod/2006pubs/censr-28.pdf.

[12] Urban Indian Health Issue Brief. By Ralph Forquera for the Henry J. Kaiser Foundation, November 2001; Ogunwole SU. The American Indian and Alaska Native Population: 2000. Census 2000 Brief C2KBR/01-15. Washington, DC: U.S. Census Bureau; 2002.

## Methods

This project was originally conceived as a series of focus groups with two-sprit and LGBT Native people in cities across New York State. The goal of the focus groups was to investigate risk and protective factors, sources of health care and healing, issues of historical trauma, and other culturally specific issues that affect the health and well-being of this community. The focus group participants were recruited through social networks and advertising on the NorthEast Two-spirit Society's (NE2SS, the only two spirit organization operating in New York State) mailing lists. Two focus groups, in New York City and in Buffalo, were very successful at attracting participants. The remaining four, however, had one or two respondents — despite extensive recruiting efforts. There were a total of 20 participants across the 6 focus groups.

Also included in this report is an analysis of quantitative data collected for a larger project on LGBT health and human service needs in New York State.[13] Nearly 3,500 valid responses were included in this survey project, allowing racial and ethnic comparisons in health and human services disparities within the LGBT community. Just under 100 responses were from American Indians/Native people.

The racial/ethnic distribution of the LGBT survey sample is portrayed in Table 1. Over three quarters of the sample (75.2%) were classified as White, followed by Hispanic (9.1%), Black (7.6%) and Asian (3.9%). As noted, nearly 100 individuals identified and were classified as American Indian (2.7%). Please note that the survey used the term 'American Indian' to identify Native people, as well as self-identified American Indian people.

**Table 1: Racial/Ethnic Distribution of LGBT Survey Data**

| | Number of Cases | % of Sample |
|---|---|---|
| American Indian | 92 | 2.7% |
| Hispanic | 314 | 9.1% |
| Black | 260 | 7.6% |
| Asian | 133 | 3.9% |
| White | 2586 | 75.2% |
| Other** | 56 | 1.6% |

* Race/ethnicity based on the following categorization scheme: American Indian; Hispanic not American Indian; Black, not Hispanic or American Indian; Asian, not Black, Hispanic, or American Indian; White, not Asian, Black, Hispanic or American Indian; Other, not White, Asian, Black, Hispanic or American Indian. ** Includes Arab American.

[13] The full report is available at: http://www.prideagenda.org/Portals/0/pdfs/LGBT%20Health%20and%20Human%20Services%20Needs%20in%20New%20York%20State.pdf

## Findings

*Diversity among Two-spirit People*

The LGBT Native and two-spirit people who participated in these focus groups varied in several important ways that affected their answers to the questions they were asked about health disparities, health and human services utilization, and cultural experiences. Some were officially enrolled in a specific Nation, allowing access to Indian Health Service benefits and other entitlements. Others were not. Two had been adopted by non-Native families and three did not know of their Native ancestry until they were well into adulthood, while others were raised within Native communities and with regular access to their own traditions. Some lived on reservations, others nearby, and still others in cities far from reservations. Some were regularly involved in Native cultural events, while others were never engaged in these events. Because of the recruitment methods, several were leaders in their communities (two-spirit and/or local Native groups). Finally, female-assigned and male-assigned two-spirit people had different experiences in their communities.[14]

Another area in which the participants varied was their attitude towards the use of the word 'two-spirit'. Although most were comfortable with it, one said specifically that he does not identify as two-spirit and others asked what the facilitators meant when they used the word, acknowledging that the identity is not one with a settled consensus on how it is defined. One who felt strongly positive about the identity said: "So that stigma of not only being gay, lesbian, bisexual, or transgender, needs to be recaptured and put that positive spin on it with the two-spirit title. And that this is our word, this is our term. We need to go back into our history and our communities to find out where are those traditional words, what do they mean to us as individuals as gay men, lesbian, bisexual, and transgender people. What does that term two-spirit mean to us? We have to answer that question not only for ourselves but for the rest of the community as well. We need to find those traditional words and bring those back out into the community and stand and say them in front of the community." The word, for him, functions in an anti-stigma capacity as well as an umbrella to hold many identities from different nations and tribes.

Another who was less comfortable with the term explained that he felt all people have male and female inside and two-spirit was not a specific term for him in the way that 'gay' is: "I heard a Navajo elder talk about the Navajo way…but what he was saying is that all people have male and female spirits, whether or not they are attracted to members of their own sex, both or the opposite. And it wasn't so much an issue of sexual orientation it was more that everybody has the male and the female inside them... I am okay with saying two-spirit but it might have other meanings for other community members as well. I know that a lot of Navajo people mix up the term..."

*Differences between Native people and other Racial and Ethnic Groups in the LGBT Community*

Table 2 reveals that Native respondents were more likely to identify as transgender than as male (non-transgender) or female (non-transgender). This is likely related to the close relationship between non-

[14] 'Female' and 'male' are assignments made at birth. For two-spirit people, gender may be far more complicated, however, the original assignments (and subsequent gendered upbringing) are also salient.

normative gender identity and same-sex attraction implied in the word 'two-spirit', rather than a difference in underlying distributions of gender identity.

**Table 2: Gender Identity by Race/Ethnicity in the LGBT Survey**

| Race/Ethnicity | Gender Identity* | | | | | |
|---|---|---|---|---|---|---|
| | Male | | Female | | Transgender | |
| | # | % | # | % | # | % |
| American Indian (n=91) | 40 | 44.0% | 30 | 33.0% | 21 | 23.1% |
| Hispanic (n=311) | 169 | 54.3% | 114 | 36.7% | 28 | 9.0% |
| Black (n=258) | 97 | 37.6% | 136 | 52.7% | 25 | 9.7% |
| Asian (n=133) | 59 | 44.4% | 63 | 47.4% | 11 | 8.3% |
| White (n=2577) | 1173 | 45.5% | 1222 | 47.4% | 182 | 7.1% |
| Other (n=50) | 24 | 48.0% | 21 | 42.0% | 5 | 10.0% |

* Excludes 21 cases with missing data on gender identity. p<.001.

Native people were also more likely to have experienced poverty and unemployment. Table 3 displays the relationship between race/ethnicity and four separate economic indicators.

American Indian respondents reported the lowest rate of full-time employment at 37%. This rate was significantly lower than the rate reported by white (60.0%) and Asian (60.2%) respondents. American Indians also reported the highest rate of unemployment at 26.1%. This rate was significantly higher than the unemployment rates of white (13.0%), Asian (4.5%), and Hispanic (13.7%) respondents. Table 3 also reveals that 22.8% of American Indian respondents reported household incomes of less than $10,000, second only to Black respondents (23.5%), and significantly higher than white respondents (8.5%). Finally, over one-in-three American Indian respondents (34.8%) reported that their income did not cover their basic living expenses. This was significantly higher than the percentage of white (16.9%) and Asian (15.0%) respondents making the same assertion.

**Table 3: Employment and Income by Race/Ethnicity in the LGBT Survey**

| Race/Ethnicity | % employed full time | % unemployed | % with pre-tax household income < $10,000 | % with income not covering basic living expenses |
|---|---|---|---|---|
| American Indian (n ≈ 92) | 37.0% | 26.1% | 22.8% | 34.8% |
| Hispanic (n≈314) | 53.2% | 13.7% | 21.7% | 27.7% |
| Black (n≈260) | 51.2% | 18.5% | 23.5% | 27.7% |
| Asian (n≈133) | 60.2% | 4.5% | 18.0% | 15.0% |
| White (n≈2586) | 60.0% | 13.0% | 8.5% | 16.9% |
| Other (n≈56) | 37.5% | 8.9% | 19.6% | 26.8% |
| Significance* | p<.001 | p<.001 | p<.001 | p<.001 |

* Based on one way analysis of variance (ANOVA) test. Additional analyses (Tukey HSD) revealed that the differences between American Indians and the following sub-groups were statistically significant at or below p<.05: % employed full time (White, Asian); % unemployed (White, Asian, Hispanic); % with pre-tax household income < 10,000 (White); % with income not covering basic living expenses (White, Asian).

*Pressing Health Issues*

Mental health and substance abuse were by far the most common answers to our questions about the most pressing health needs of two-spirit people. Nearly every focus group participant mentioned them or agreed that they were one of the most pressing health issues for two-spirit people. Physical health conditions were also mentioned, including diabetes, heart disease and cancer, as was violence. It was striking that the mental health and substance abuse were more prominent, however, and also that the empirical literature and the participants' perceptions of problems are similar.

For example, one person who participated in a focus group because she works in the Native community (although she is not two-spirit herself) mentioned: "a high rate of alcoholism, drug abuse, not saying that they are all alcoholics or drug addicts or that kinda stuff, but that's a definitely a health concern. Diabetes is rampant across the board, not just lesbian or gay. Heart disease, more prevalent recently has been cancer, cervical cancer as well as liver cancer, kidney cancer…"

More than half of the participants in the focus groups revealed that they were recovered alcoholics, suggesting not only the prevalence of alcoholism in the community, which is well-known, but also the success of the recovery model for at least some people with addiction problems. One person in recovery explained that he had trouble coming to terms with his sexuality as someone who had been adopted and raised Catholic and "I feel better about myself because I've been in recovery."

There was also an understanding of the intersectional challenges of being gay and Native for mental health and self-esteem. One participant explained: "On a reservation, I find the lack of self-confidence in our people, that people can intimidate them, people can use them and they won't say anything, they won't do anything. They'll just put up with it. And I thought, 'Well maybe that's how we survived for 500 years. Maybe we have survived because we have put up with that.' We don't seem to revolt or get pissed off and demonstrate whatever. So I think generally speaking for our people we have low self-esteem and then for gay people, there's just no chance. How do you get self-confidence as a gay person? It's double hard."

The same focus group participant contextualized his struggle in both religion/spirituality and mental health, a common theme in coming out narratives in the focus groups: "…I was brought up Christian but when I came to the conclusion as a Christian that if I am going to stay a Christian I am supposed to commit suicide because God ain't changing me. I thought, God, he could do anything, he can change you, and I prayed and prayed for that and it didn't work, and I gave up on Christianity, and because I had spirituality and I needed spirituality so I went more traditional, I thought, that's the only way I can go."

Health care access was also an issue for Native people. Survey responses revealed that American Indian respondents were much more likely to not have a regular source of care or use the emergency room, and were much more likely not to have health coverage (Table 4).

**Table 4: Health Care Access by Race/Ethnicity**

| Race/Ethnicity | % emergency room/no care as usual care source | % without health care coverage |
|---|---|---|
| American Indian (n ≈ 92) | 16.3% | 20.7% |
| Hispanic (n≈314) | 9.5% | 11.4% |
| Black (n≈260) | 6.0% | 9.5% |
| Asian (n≈133) | 4.7% | 9.7% |
| White (n≈2586) | 3.6% | 6.9% |
| Other (n≈56) | 12.2% | 20.4% |
| Significance* | p<.001 | p<.001 |

* Based on one way analysis of variance (ANOVA) test. Additional analyses (Tukey HSD) revealed that the differences between American Indians and the following sub-groups were statistically significant at or below p<.05: % emergency room/no care as usual source of care (White, Asian, Black); % without health care coverage (White, Asian, Black).

**Table 5: Barriers to Health Care Services by Race/Ethnicity**

| % of respondents indicating that the factor is "somewhat" or a "major" problem | 1. Long distance to LGBT sensitive medical facilities | 2. Health care workers who refuse to provide services to LGBT people | 3. Fear that they will be treated differently by medical staff because they are LGBT | 4. Not enough health providers trained to care for LGBT people | 5. Not enough mental health specialists |
|---|---|---|---|---|---|
| American Indian (n ≈ 92) | 27.8% | 14.4% | 31.1% | 37.1% | 48.3% |
| Hispanic (n≈314) | 29.0% | 21.5% | 33.0% | 49.0% | 45.1% |
| Black (n≈260) | 18.7% | 16.8% | 29.1% | 46.4% | 39.2% |
| Asian (n≈133) | 20.3% | 12.0% | 35.1% | 53.4% | 39.8% |
| White (n≈2586) | 17.1% | 7.7% | 25.4% | 37.0% | 33.0% |
| Other (n≈56) | 28.0% | 15.7% | 27.0% | 58.0% | 41.2% |
| Significance* | p<.001 | p<.001 | P=.006 | p<.001 | p<.001 |
| **% of respondents indicating that the factor is "somewhat" or a "major" problem** | **6. Not enough psychological support groups for LGBT people** | **7. Community fear or dislike for LGBT people** | **8. My personal financial resources** | **9. Don't have adequate and affordable housing** | **10. Lack of transport to get to needed services** |
| American Indian (n ≈ 92) | 50.6% | 46.7% | 60.7% | 30.0% | 24.4% |
| Hispanic (n≈314) | 49.0% | 49.5% | 50.8% | 29.8% | 20.2% |
| Black (n≈260) | 46.6% | 45.8% | 48.8% | 30.7% | 18.6% |
| Asian (n≈133) | 39.4% | 53.0% | 44.3% | 19.7% | 6.1% |
| White (n≈2586) | 36.6% | 39.5% | 40.7% | 15.8% | 7.2% |
| Other (n≈56) | 50.0% | 48.1% | 59.6% | 27.5% | 17.3% |
| Significance* | p<.001 | p<.001 | p<.001 | p<.001 | p<.001 |

* Based on one way analysis of variance (ANOVA) test. Additional analyses (Tukey HSD) revealed that the differences between American Indians and the following sub-groups were statistically significant at or below p<.05 for the following models: Not enough mental health specialists (White); My personal financial resources (White); Don't' have adequate and affordable housing (White); Lack of transport to get to needed services (White, Asian).

American Indian survey respondents identified multiple barriers to health care at significantly higher rates than other survey respondents. American Indians were more likely to cite lack of transportation, insufficient access to mental health specialists, insufficient access to LGBT psychological support groups, and personal financial barriers to health care access (Table 5).

American Indian survey respondents also reported mental health disparities; Native LGBT people were significantly more likely to experience depression compared to other racial/ethnic groups (Table 6).

**Table 6: Depression and Loneliness by Race/Ethnicity in the Survey**

| | % with probable depression | Loneliness scale |
|---|---|---|
| American Indian (n ≈ 92) | 33.0% | 5.74 |
| Hispanic (n≈314) | 22.4% | 5.64 |
| Black (n≈260) | 23.0% | 5.66 |
| Asian (n≈133) | 15.9% | 5.64 |
| White (n≈2586) | 14.9% | 5.26 |
| Other (n≈56) | 26.0% | 5.51 |
| Significance* | p<.001 | p<.001 |
| * Based on one way analysis of variance (ANOVA) test. Additional analyses (Tukey HSD) revealed that the differences between American Indians and the following sub-groups were statistically significant at or below p<.05: % with probable depression (White, Asian). | | |

*Homophobia*

Indirectly or directly, for those who were on reservations or had close ties to Native communities, homophobia within those communities affected both their mental health and access to services. These communities are important resources to Native people who experience racism and lack of cultural sensitivity in the broader world. Homophobia within the communities has a disproportionate effect (compared with homophobia in the non-Native community) on gay and two-spirit members, because they rely on cultural support.

Reservations are small and intimate places: "I think to answer it we have to look at the community specifically, city native or reservation native. The city native GLBT [gay, lesbian, bisexual, and transgender] community has a lot more access to resources as far as education, even just a social circle. They are able relate to other gay and lesbian men and women but coming from a reservation you basically feel like you're alone. Growing up, you already know in your head, when I grow up I know I am going to be with a man but I do have to follow the community standard because if I don't I will get my ass kicked every day and if you do you'll still get beat up anyway…reservations we are so cut off from everybody, it's just us, your family, and everybody pretty much knows you or your relatives. With city even though the community is still small and tight knit is not as small as a reservation is. There is still people here in the city that when they meet you don't know. So there's a small notion of anonymity. Where as if I go home, I'm [father's name]'s gay kid. I don't have a name but I am [father's name]'s fag kid."

In a different focus group, another participant spoke clearly about a theme that underlay several of the focus groups' discussions of homophobia: people who were considered male by their communities of origin who had sex with other men had particularly negative experiences. In an answer to a question about why this is, the participant said: "I believe it's the way they are brought up, as a man you are supposed to be a caretaker and this and that, the one that is supposed to take care of your house. You can still do that no matter what. That's the way that they think."

For many Native people, men having sex with other men is a violation of that masculine role. The same participant recounted his early experiences with homophobia "I used to get discriminated against a lot—I used to live across the street from the school and kids would yell out the window—'faggot!'…My uncle is one of them [a homophobic person] and he's a chief...[another homophobic person] used to come to our house and spray paint the house…" This was borne out indirectly in another focus group in a discussion of a female participants' recent marriage to her female partner: "I just got married. We are going on a honeymoon in two weeks...We have very supportive families, both sides of our family are supportive, so we are very fortunate that we have that. Because we do have quite a few of our friends don't have supportive families, and think they did something wrong in raising them. One of our friends her mother is still trying to hook her up with men. One of our other friends, her mother says if she hadn't played softball, she won't be a lesbian." Women did not have a universally easy time, but they were more likely to be accepted.

Another spoke about homophobia as invisibility, rather than outward hostility: "I went to the University of Buffalo and they had a conference on…Iroquois women [who came] in from the different reservations to speak. One of the questions somebody asked was about gay people in [Iroquois] our culture. I remember one of the women who I have a lot of respect for said, 'Oh, we don't have any of those kind of people, that's a white problem.' And you know, I was in the process of coming out and I thought…of course everybody has gay people, two-spirit people in their culture but for her to say no, that it was a white man's thing. I didn't know whether to come out and correct her, in front of everybody…"

The LGBT survey data supported the conclusion that Native LGBT and two-spirit people are more likely to experience violent homophobia and transphobia than are other LGBT people. Table 7 highlights this disparity, with nearly 1 in 3 American Indian respondents (29.3%) experiencing hate violence, compared to just over 1 in 10 white respondents (11.3%).

**Table 7: Safety and Violence by Race/Ethnicity**

| | **% not feeling safe in their community** | **% experiencing hate violence** |
|---|---|---|
| American Indian (n ≈ 92) | 22.8% | 29.3% |
| Hispanic (n≈314) | 23.5% | 20.1% |
| Black (n≈260) | 18.3% | 18.4% |
| Asian (n≈133) | 12.0% | 10.9% |
| White (n≈2586) | 13.2% | 11.3% |
| Other (n≈56) | 28.0% | 23.1% |
| Significance* | p<.001 | p<.001 |
| * Based on one way analysis of variance (ANOVA) test. Additional analyses (Tukey HSD) revealed that the differences between American Indians and the following sub-groups were statistically significant at or below p<.05: % experiencing hate violence (White, Asian). | | |

As victims of violence, invisibility and stigma, two-spirit people, particularly those who experienced homophobia on tight-knit reservation communities, had additional mental health challenges.

*Experiences of Stereotyping within the LGBT Community*

Many participants were comfortable seeking services and social opportunities within the LGBT community. However, others were uncomfortable because they experienced stereotyping and fetishization. One male participant explained that a man at a bar tried to pick him up by saying 'How' as a greeting. A young woman recounted a recent incident at the university she attends: "A couple of weeks ago I went to a minority dinner for grad students. There was this girl who asked me, do you have a feather, dance around a fire I was like [puts head in hands] she was serious, I didn't even know how to talk to her, so offensive, I had no other choice but to laugh it off." However, most people recounting this type of story would rather not have to make the choice to laugh it off.

The lack of specific programming in the mainstream LGBT community and the experiences of stereotyping are evidence that two-spirit people have a different set of needs. Tellingly, American Indian respondents to the survey were less likely to say that they had visited an LGBT-specific venue for health and human services in the past year than were respondents of other races and ethnicities, although these differences did not reach the level of statistical significance (Table 8).

**Table 8: Utilization of LGBT Specific Services by Race/Ethnicity**

| | **% gong to event at LGBT center or other LGBT specific place in past year** | **% using health or human services specifically targeted to LGBT in past year** |
|---|---|---|
| American Indian (n ≈ 92) | 84.8% | 52.7% |
| Hispanic (n≈314) | 87.5% | 59.6% |
| Black (n≈260) | 91.8% | 59.1% |
| Asian (n≈133) | 91.7% | 60.2% |
| White (n≈2586) | 89.0% | 46.3% |
| Other (n≈56) | 94.1% | 52.9% |
| Significance* | p=.233 (NS) | p<.001 |
| * Based on one way analysis of variance (ANOVA) test. Additional analyses (Tukey HSD) revealed no statistically significant differences between American Indians and any other subgroup for either service utilization variable. | | |

*Health Care Access*

Participants who had insurance through school or work were much less concerned about their healthcare than those who had access to health care only through the Indian Health Service or had no health care at all. Focus group participants who had used the Indian Health Service repeatedly explained that the clinics do not respect privacy.

One participant, for example, told a story illustrating this and his resulting decision not to access services: “I don’t access services, I’m bad. I used to. If I were to access any type of services I would have to go back to my reservation, which is six hours away from here. I have since stopped using them because my sister went for a pregnancy test and before she got home, the receptionist had called my mother to congratulate her, that my sister was pregnant. Those are the reservation clinics, you know people...In that scenario, I felt reservation clinic is not safe, any type of reservation clinic is not going to be safe because there is going to be a breach of confidentiality somewhere. I have health insurance at work just so I would have it. Even if I caught a virus or something, I guess it’s just an inborn distrust of medical care, I’d wait until on my deathbed before I’d go to a doctor and even then I would just go to the ER. And that's what I'm finding, a lot of the community are doing that, there are not accessing general health care, they're waiting until deathly ill and going to the ER. I think it’s just a common thread.” Others in this and other focus groups echoed his concerns.

However, some of the participants were happy with their Indian Health Service care. Many who were insured had selected private doctors who were culturally competent enough to provide health care without any serious barriers. To stay healthy, others used a combination of traditional healing and spiritual practice, Indian Health Service and other medical providers to stay healthy. Integration of spirituality was a key component of several stories .”...VA hospital has a chaplain system, that has a traditional Native American on call. So if you are Native American in the Bronx VA Hospital and you want ceremony, they bring in someone to do ceremony for you. I think that is a model that should be replicated, And it’s not just…if you are Cayuga they will find someone who is spiritual healer from the Cayuga Nation, so they developed network of service providers, that's one thing.” However, this was an unusually positive experience for both veterans and others with health care.

*Multiple Identities*

Different participants emphasized different parts of their identity when talking about challenges in accessing sensitive health care. For example, one middle-aged man who has a longtime male partner and an adolescent son said: “I started a new job and went to the HR specialist and she was very insensitive and I didn’t call her on it, [she said] your wife will have two doctors, her gyn[ecologist] and her primary care provider. How do I respond to say, ‘I don’t have a wife, I have a spouse who is not a woman.’ Those are more the problems that we face, as opposed to native identity.”

In the same focus group, however, several participants mentioned incidents where people assumed they did not speak English as a first language, assumed they were Asian or another race or ethnicity. Even medical providers sometimes made this mistake. In describing an ideal encounter with a medical provider, one person specified “He would know that I’m native, not misclassified as Asian or Puerto Rican...I’ve seen doctor files when I’ve had access to them where they never asked me, and they documented me as an Asian Pacific Islander or Latino Puerto Rican. It just baffles me that health care providers will just go through their list and not ask me a damn thing.”

*Historical and Intergenerational Trauma*

Several members of focus groups directly or indirectly mentioned legacies of colonialism for their immediate, current quality of life. For example, in explaining experiences with prejudice and invisibility on the reservation, one focus group participant said: "I think after 500 years of Christianity we have all of their biases. Like a lot of people on my reservation don't like black people. I am thinking, 'How can you not, you don't even know any black people, this is the worst prejudice you can have. What have black people done to you?' [Not to] say anything about two-spirit people, they wouldn't even know what I was talking about. I think it has to do with both Christianity and to more traditional ways as far as talking about this cause we have lost so much of that understanding that I think we had even up to three hundred years ago." Another, who was adopted by a white family, said explicitly: "I'm mixed, I view myself as the product of colonialism, frankly. I'm Lakota and Cherokee and Welsh."

Another person linked health problems directly to historical trauma, "Alcoholism and drug addiction are one symptom of many. Incest, boarding schools, religion, cultures, traditions, values…that's what hit me, historical trauma." Several also mentioned the sadness of losing traditional two-spirit roles in the process of colonialism. For example, one two-spirit person who had grown up on a reservation explained that his mentor couldn't remember the traditional name for an LGBT or two-spirit person, only that they had been revered in pre-colonial times.

Although it was rarely mentioned in these particular focus groups, an important legacy of colonialism in recent memory for many Natives was forcible relocation to boarding schools. However a related legacy of colonial oppression was military service. Because of the tradition of boarding schools (which are run on a military model) and poverty in Native communities, Native people are disproportionately represented in the military. Several of the focus group participants had served in the military. Because of the military's institutionalized homophobia, this was rarely a good experience.

## Recommendations

*Infrastructure*

The challenges in recruiting participants for this research indicate some of the challenges in reaching two-spirit people and LGBT Native people. These challenges were also explicated when discussing the need for and the challenges for interventions such as cultural programming (see below). In New York City, where the NorthEast Two-Spirit Society (NE2SS) is active and in Buffalo, where the Native American Community Services of Erie & Niagara Counties (NACS) is active, the focus groups were very well-attended and participants were active and engaged. In other communities, such as Rochester and Syracuse, where there is less infrastructure, the groups were underattended. This suggests that the creation of infrastructure for two-spirit people is important to reaching them.

*Culturally Relevant Mental Health and Substance Abuse Services*

Participants in these focus groups echoed previous studies in identifying the increased risk of mental health and substance abuse issues for LGBT, Native, and particularly, two-spirit people. There are

currently no mental health or substance abuse programs tailored to this community. Given the importance of cultural relevance and sensitivity to effective delivery of services, this is an important intervention.

*Cultural programming*

Perhaps because of the many ways that two-spirit people confront identity challenges, several participants in the focus groups identified cultural programming as important to their health and well-being. Several participants mentioned that they would appreciate the ability to learn or speak the languages of their nations; however, these languages varied widely and thus this presents challenges in implementation.

One young two-spirit man said that it was a pressing need to have cultural programming to enhance health and well-being, for example: "A Pow Wow where it would be [okay to be] both native and gay, where I don't feel pressured, a gathering of Nations." Another participant from a different focus group said: "[In order to prevent drug and alcohol abuse on reservations] get basketball teams going or volleyball, recreational things. Get them so tired they don't want to go out," Someone else from the same focus group mentioned: " It brings the community together to go to lacrosse games. We don't have powwows here, we have festivals. There's dancing there's social singing, we have our local artists and crafts people at the school, or once in a blue moon, at the arena. Two years ago we had a green corn festival, green corn dance, a lot of alcoholism there. It was always held outdoors where the kids play lacrosse. Those are pretty popular. We've got one coming up April 11. It brings people together, local artists; people can just visit. It's a time when Native people come together and just visit. We have Native people who come down from up north, Six Nations, and sell crafts and catch up with people."

Having cultural events with no alcohol was particularly important to all three of these participants. One also suggested that since there is little for gay people to do to socialize other than go to bars, Native gay people, with their greater propensity for alcoholism, particularly need other options. This is an important context to recommendations about culturally relevant treatment for substance abuse, as treatment needs to exist in a supportive social context.

In addition to talking about existing or ideal programs, in the process of the focus group, participants shared with one another what they had learned about their Nation's histories of having a social role for gender non-conforming or same-sex attracted people. Twice they mentioned the importance of knowing a word from their own language to identify their role, above and beyond identifying as two-spirit. Cultural programming for two-spirit people could fulfill this type of role, helping two-spirit people learn about and share what they know about the existence of pre-colonial identities.

## Conclusions

These focus groups provide one particular perspective on the health and human services experiences of two-spirit and LGBT Native people in New York State. Although somewhat limited in number and diversity, the groups provide insight on a wide variety of issues. As a minority group, two-spirit and LGBT Native people in New York State experience a wide variety of forms of oppression — in the LGBT

community, in Native communities and in the wider world. Oppression can take the form of homophobia, racism, or invisibility, and it can also mean inadequate access to health care in the context of greater health needs. Further research is needed on this important topic; however, programs should not wait for further research but rather begin by addressing known needs.

**ACKNOWLEDGMENTS**

Cissy Elm, Director, HIV/AIDS Programs, American Indian Community House

Kevin Garrity, Director of Outreach and Development, Rainbow Heights Club

Pete Hill, Health & Wellness Director, Native American Community Services of Erie & Niagara Counties, Inc. (NACS)

Christian Huygen, Executive Director, Rainbow Heights Club

Ryan King, Referral Specialist, Pride Center of Western New York

Carolyn Melenani Kuali`i, Director, Kua`âina Associates

Cara Thunder, Health Director, American Indian Community House

Brian Toledo, Council Member, NorthEast Two-Spirit Society

Gregg Martello, Member, NorthEast Two-Spirit Society

Harlan Pruden Council Member, NorthEast Two-Spirit Society

Barbara E. Warren, Director, Hunter College Institute for LGBT Social Science and Public Policy

## Authorship

**Somjen Frazer Consulting**

Somjen Frazer has been providing affordable research and evaluation services to nonprofits and universities since 2003. With a specific focus on LGBT communities, Somjen Frazer worked on projects in a variety of relevant fields, such as criminal justice and political participation. Current and recent clients include Lambda Legal, the National Council for Research on Women, the New York State LGBT Health and Human Services Network and Public Agenda. To date, twenty percent of the firm's work has been pro bono for small LGBT organizations that could not otherwise afford such research services.