

Cultural Sensitivity and Research Involving Sexual Minorities

It is only reasonable to assume that public health research studies and interventions should be considered appropriate and relevant by their participants. Such appropriateness and relevance is, moreover, a prerequisite to having participants. Yet, if this is a key to participation, why do researchers and program planners know so little about what issues determine whether sexual minorities deem given projects to be safe, appropriate and relevant?

In this issue of *Perspectives on Sexual and Reproductive Health* (page 6), Marrazzo, Coffey and Bingham offer results of a qualitative study of young lesbian and bisexual women, reporting their thoughts and experiences about sexual practices and sexually transmitted diseases (STDs). This study is one of only a handful to collect the cultural information necessary to plan effective sexual health interventions for sexual minority populations, other than HIV prevention studies involving gay or bisexual men. Women in this study perceived themselves to be at low risk for STDs, which they considered a heterosexual issue. Not surprisingly, they did not have accurate or extensive knowledge of bacterial vaginosis or STDs. Women expressed both a desire to talk openly with their health care providers about sexual health and a reluctance to do so. STD interventions, they maintained, need to emphasize healthy sexuality and respect for one's body and one's partner, and to avoid negative messages regarding sexual practices or female genitalia.

Such cultural knowledge is critical for sexual health research or interventions in sexual minority populations because a project that inadvertently sends the message "We don't understand you" could alienate the very people it seeks to reach. The questions required to gain sexual health knowledge may be touchy for research participants of any sexual orientation or gender identity; however, for those who are transgender, lesbian, bisexual or gay, such questions can reach to the heart of personal identity and group affiliation. Moreover, they can evoke a history of oppression that has involved the health professions. To effectively work to improve sexual health in these communities, health professionals need to understand both the way in which sexual information historically has been guarded by individuals and misused by researchers, and the potential of culturally sensitive approaches to overcome the barriers imposed by this history.

HISTORY OF PROBLEMATIC RELATIONS

Trusting relationships with health professionals may be more difficult to establish for sexual minorities than for other people. Their suspicion of researchers extends back to the

earliest scientific research on sexuality by Richard von Krafft-Ebing, whose groundbreaking 1886 book, *Psychopathia Sexualis*, was composed of case studies of and interviews with "sexual deviants." Krafft-Ebing's reputation had led sexual minority individuals to send him personal information, with the hope that it would benefit others.¹ Despite their voluntary and altruistic participation, some homosexual men later wrote letters to Krafft-Ebing objecting to their vulgar characterization in his work and indicating that they had been unaware of the researcher's negative assessment of them.² As a result of the work of Krafft-Ebing and others, variations from heterosexuality were medicalized as pathological by the turn of the century.³ In the United States, pathologizing categories became linked to the policing of "sex offenders" at the municipal level, which by the 1930s led to widespread arrest, harassment, police abuse, beatings and rapes.⁴

Although homosexuality was dropped from the *Diagnostic and Statistical Manual of Mental Disorders* in 1973 and prosecution of attacks against sexual minorities has improved, ongoing arguments over issues such as "reparative therapy," the social and legal status of same-sex relationships, and nondiscrimination protections for gay, lesbian, bisexual and transgender persons reinforce a level of justifiable suspicion. In addition, there is ongoing evidence of homophobia within health care professions.⁵ Perhaps this is why lesbians report greater reluctance than other women to seek care, particularly preventive services,⁶ and may be less likely than other women to seek testing for STDs, even when their risk history warrants it.⁷ Thus, it is reasonable to assume a level of distrust on the part of sexual minorities regarding the intentions and degree of cultural sensitivity of those who wish to study or improve the sexual health of their communities.

RESPONSES TO HOMOPHOBIA

In addition to being wary of health professionals, sexual minority individuals may choose to protect the privacy of their sexual health information and even their orientation or gender identity, thereby limiting research and intervention projects' access to the population. Historically, secrecy and respect for privacy have played a vital role in the protection of sexual minority individuals' ability to work and live without experiencing negative consequences resulting from homophobia. Public tolerance of gay men and lesbians has increased since the gay and lesbian rights movement started in the late 1960s; however, bisexuals have attained less public visibility, and transgender people have yet to

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gain broad social acceptance. For many sexual minority individuals, privacy is still critical to maintaining employment, family relations, ties to ethnic cultural groups or membership in religious institutions, and respect for privacy has become part of sexual minority cultures.

In light of the dearth of research available on how sexual minorities negotiate homophobia in day-to-day interactions, it may be reasonable to refer to some aspects of Philomena Essed's work on "everyday racism."⁸ Essed describes how a sample consisting primarily of well-educated black women in the United States and the Netherlands continuously assessed interactions as acceptable or not, and then evaluated unacceptable interactions to determine the likelihood that the bias was intentional and the degree of social significance.

Although a person's race is usually more apparent than his or her sexual orientation or transgender status, the negotiation of privacy and release of information about sexual minority identity similarly require that individuals continuously interpret their interactions. Also, the more hidden nature of sexual orientation sometimes allows for assessment of bias before disclosure of membership in a minority group. Even when individuals are unable to articulate precisely how a situation is problematic, they know at a deeper level, red flags are raised and they act accordingly. In Essed's work, such actions included confrontation and attempts to remedy the problem, but frequently involved individuals' simply pulling away from a situation, especially if the action was not egregious or the perceived social significance was small.

The implication, from a researcher or intervention worker's point of view, is that inadvertent bias or cultural insensitivity will likely result not in confrontation, but in a quiet ending of interaction. Such pulling away can limit the effectiveness of community interventions and the validity of research. In research, it is reflected in incomplete data, low participation rates or high loss to follow-up, producing biased results. Community-based service organizations are aware of similar issues in service provision: In a study of representatives of HIV and AIDS community-based organizations, participants cited specific social and cultural factors that facilitate the delivery of prevention interventions, including "knowledge of cultural norms" and "credibility of staff members."⁹ The identification of these factors reveals a clear awareness by community-based organizations that potential clients assess their interactions with staff, and such assessments can facilitate or impede service delivery. Study participants also mentioned cultural barriers, including "shame about sexuality," "conservative political environments" and distrust of social service providers, the system or the dominant culture. Given these concerns, how can distrust and lack of credibility be overcome?

DEVELOPING CULTURAL SENSITIVITY

Cultural sensitivity can provide a means to overcome initial distrust or concerns, allowing for participation and open information exchange. Existing approaches to cultural

sensitivity can readily be extended to sexual minority populations.

Resnicow et al. define cultural sensitivity as "the extent to which ethnic/cultural characteristics, experiences, norms, values, behavioral patterns and beliefs of a target population as well as relevant historical, environmental, and social forces are incorporated in the design, delivery, and evaluation of targeted health promotion materials and programs."¹⁰ They present a model for understanding cultural sensitivity within a context of public health programming by differentiating "surface structure" from "deep structure." Surface structure includes factors affecting the interface between the study or intervention and the target audience, such as characteristics of staff, appropriateness of locations and familiarity of images used. Appropriate surface structure increases the acceptability of the project by eliminating images, language and interactions that could be perceived as problematic, while incorporating those that signal community membership or knowledge. As such, thoughtful shaping of surface structure alleviates situations that would trigger participants' assessment for bias, allowing them to perceive the environment as safe and acceptable.

Examples of appropriate surface structure in work among sexual minority populations include having sexual minority individuals on staff, using pictures of same-sex couples or transgender individuals in program materials, and locating the project in an area frequented by community members. Marrazzo et al.'s identification of prevalent sexual behaviors among women who have sex with women—such as digital-vaginal penetration and use of penetrative toys—allows for construction of an intervention that displays knowledge of the community and avoids incorrect assumptions.

Deep structure goes further, incorporating "the cultural, social, historical, environmental and psychological forces that influence the target health behavior in the proposed target population."¹¹ It involves the factors that make studies seem critical to participants, cause interventions to resonate and encourage communities to claim and sustain projects as their own. Marrazzo et al.'s conclusion that messages should be expressed with an emphasis on health can be viewed as a deep structural element. An emphasis on healthy sexuality by a population once characterized as sexually pathological represents a positive response to the historical, social and psychological forces that have maintained that homosexuality is, at the very least, an unhealthy behavior.

Marrazzo et al.'s study also demonstrates that identification of a lack of cultural relevance may be critical. Lesbian and bisexual women in this study connected STD prevention with heterosexuality, and did not perceive themselves to be at high risk of STD. This finding indicates that to create an intervention to reduce fluid exchange among women—the ultimate goal of the Marrazzo et al. study—one would need to include an educational component, as an STD prevention program would not have immediate cultural resonance within this community. This need is reinforced by a study that found that only about

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30% of lesbians considered themselves “fundamentally vulnerable” to STDs.¹²

The contrast between surface and deep structure highlights the potential need to go beyond simple measures to improve acceptability, such as choosing culturally appropriate images for a brochure. A broad understanding of both surface and deep structure could produce projects with true cultural relevance. Cultural sensitivity must become more than just a buzzword, more than something that is nice to attend to if possible. In addition, it must be understood as a practical necessity worthy of time, effort and funding. The outcomes of cultural sensitivity in public health—including participation in intervention or research projects, completeness and validity of data in research, and effectiveness of interventions—merit increased effort to obtain cultural knowledge. Ultimately, improvements in public health depend on it.

Barriers to the production of cultural knowledge on sexuality exist, including institutional review board underapproval of socially and politically sensitive studies,¹³ lack of federal funding for a nationally representative study of sexuality and underfunding of all areas of sexual health research outside HIV prevention in identified high-risk groups. Despite these barriers, work can be undertaken within the current context to improve cultural knowledge regarding sexual health.

What little we know about lesbian and bisexual health is frequently grounded in an idea of a homogenous subculture, and cannot detail the particularities and nuances that affect deep structure in local interventions. The cultural knowledge detailed by Marrazzo et al. provides important information on beliefs and knowledge among young urban lesbian and bisexual women; however, these results may not apply to other groups, such as older lesbians or those living in rural areas. Constructing a complete cultural picture will require the conduct of similar studies in varying subgroups within broader sexual minority communities.

The information necessary to construct culturally relevant structure is best obtained through qualitative research like that done by Marrazzo et al.—studies that are, by design, fairly small and can be tailored to represent the specific pop-

ulation targeted for an intervention. Ultimately, the culturally detailed information gathered increases the likelihood that the intervention is successful. At the same time, the process itself adds to the wider understanding of cultural knowledge on sexuality, and helps repair and build trust between sexual minority communities and the health professions.

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