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Brief Report: The Relationship between Multiple Forms of Oppression and Subjective Health among Black Lesbian and Bisexual Women

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This study was designed to explore the relationships between multiple forms of oppression and subjective physical health among a community sample of 85 Black lesbian and bisexual women. Self-report surveys assessing health behaviors, physical and mental health status, and experiences with discrimination were administered during a weekend retreat of a community-based organization serving this population. Structural equation modeling showed there were significant, but different, relationships between subjective health and two types of oppression, heterosexism and weight-based discrimination. Further research on the independent and intersectional effects of multiple forms of oppression on health is needed.

KEYWORDS oppression, heterosexism, weight-bias, lesbians, Black populations

INTRODUCTION

While the idea that “oppression is bad for your health” is neither novel nor the intellectual brain child of academia, the scientific examination of
the relationship between oppression and health helps to “generate valid knowledge to guide actions designed to improve public health” (Krieger, 2008, p. 4). In the effort to inform health policy and promotion efforts, the current study is focused on examining the relationship between oppression and health among a group that is socially located at the intersection of multiple systems of oppression, Black lesbian and bisexual women (Combahee River Collective Statement, 1977; Greene, Miville, & Ferguson, 2008).

Studies examining the relationship between oppression and physical health among African Americans have found that experiences with racism are associated with increased levels of physical health problems, such as high blood pressure (see, e.g., Bowen-Reid & Harrell, 2002; Krieger, 2008) and similar relationships were found between heterosexism and illness among a sample of gays and lesbians (Huebner & Davis, 2007). In addition to physical health, some scholars have examined relationships between forms of oppression, such as sexism and heterosexism, and mental health, finding similarly deleterious associations (Klonoff, Landrine, & Campbell, 2000; Mays & Cochran, 2001). Szymanski and Meyer (2008) extended this line of research by explicitly testing the multiplicative effects of two forms of oppression, racism and heterosexism, on the mental health of Black same-gender loving women and found that experiencing both forms independently, but not interactively, predicted poorer mental health.

In the current study, we aimed to further expand this area of inquiry by exploring the relationships between multiple forms of oppression, mental health, and physical health. We also aimed to broaden the conversation about oppression by assessing the relationship between physical health and forms of oppression that are less talked about and beyond the classic three types expected to be relevant to Black lesbian and bisexual women (racism, sexism, and heterosexism). Given previous research on oppression and health, we hypothesized that experiences with oppression would be negatively correlated with physical health. Further, we sought to explore whether a model of multiple forms of oppression would significantly predict health, including a measure of depression as a possible mediating variable, given that prior research has proposed mental health status as a potential mechanism connecting oppression and physical health (see, Meyer, 2003, for heterosexism and health; Okazaki, 2009, for racism and health; Zucker & Landry, 2007, sexism and health).

METHOD

To explore these questions, we used data collected at an event held by an organization for lesbians of African descent in California. This group holds annual gatherings and these data were collected at the 2007 event. One
of the major goals of these events is to create a space that is affirming of the participants’ ethnic, sexual, and gender identities. This provided us with a great case to test Black feminist and psychological theory regarding the multiplicative effects of oppression in the context of an intentional and supportive network of women.

Participants
Survey participants (n = 85) were on average 48 years old (SD = 9), ranging from 25–68 years. With regard to ethnic identity, a large majority identified as Black or African American (84%), and smaller percentages identified as Caribbean/West Indian, (2.5%), African (2.5%), Black biracial/multiracial (4.9%), or other (6.2%). Approximately 67% identified as lesbian or gay, 12% chose no labels, 9% as same-gender loving, 5% as bisexual, and the remaining chose some other term, like queer. With regard to lesbian gender, some participants chose the labels to describe their gender expression: androgynous (33%), femme (18%), all/mix gender (18%), stud/butch (13%). The sample was primarily middle class economically, with 80% earning $50,000 or more a year.

Procedures
We used a convenience sampling method by making announcements to the participants throughout the weekend events. Participants completed an anonymous paper and pencil questionnaire and dropped them off in a marked secure box. The response rate was approximately 60% of attendees. The organization’s Board of Directors gave permission for analysis of data and presentation and the study was approved by California State University, Long Beach Institutional Review Board.

Measures
The questionnaire had five main sections: (1) Health Status, which included questions assessing current physical and mental health/disease; (2) Health Behavior, which included questions about routine medical exams, subjective assessments about current healthiness, tests for health conditions, and other health behaviors; (3) Health Beliefs; (4) Health Care Access, which included questions about experiences with discrimination and health insurance coverage; and (5) Demographics. The current study used responses to items from several of these five sections. Subjective physical health was measured by one question, “How would you describe your overall health?” (1 = Poor, 2 = Fair, 3 = Good, 4 = Excellent). Lifetime experiences with oppression were measured by one question, “In your lifetime, have you
TABLE 1 Descriptive Statistics for Health and Oppression Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>%</th>
<th>M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective Physical Health</td>
<td></td>
<td>3.16 (.35)</td>
</tr>
<tr>
<td>Excellent</td>
<td>29.1</td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>59.3</td>
<td></td>
</tr>
<tr>
<td>Fair</td>
<td>10.5</td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td>Depression (CES-D sum score)</td>
<td></td>
<td>11.54 (14.53)</td>
</tr>
<tr>
<td>Types of Oppression based on:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td>85.2</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>51.9</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>46.9</td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td>36.8</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>30.9</td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>24.7</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>23.5</td>
<td></td>
</tr>
<tr>
<td>Butch identity</td>
<td>18.5</td>
<td></td>
</tr>
<tr>
<td>Insurance status</td>
<td>11.1</td>
<td></td>
</tr>
<tr>
<td>Femme identity</td>
<td>7.4</td>
<td></td>
</tr>
<tr>
<td>Literacy level</td>
<td>3.7</td>
<td></td>
</tr>
</tbody>
</table>

n = 85.

ever experienced discrimination or unfair treatment because of your. . .” and participants were asked to place a check mark next to as many statuses or identities that applied to this question for them. We coded each status in which participants could experience discrimination as its own variable, measured dichotomously (yes/no). Respondents’ weight (entered as a covariate as discussed below) was measured combining self-reported weight and height into the Body Mass Index (BMI). Depression was measured using a 12-item short form of the Center for Epidemiologic Studies Depression Scale (CES-D) (Radloff, 1977). The 12-item scale asks respondents how many days they experienced various symptoms or feelings; we used all but one item (regarding experiencing a “poor appetite”) because Confirmatory Factory Analysis showed that it did not load significantly on to the scale. The 11-item revised CES-D scale reliability for this sample was high, alpha = .92.

RESULTS

Descriptive

Descriptive Statistics are reported in Table 1. Particularly notable, many forms of discrimination that are typically not considered in discussions of oppression among Black same-gender loving women were reported at relatively high rates, including weight-based oppression.
Analysis Overview

The inferential analyses were conducted in two phases. Given the relatively small sample size, the first phase involved conducting a series of bivariate analyses using Pearson r correlation tests to narrow the list of predictors included in the final model. The objective was to maintain the theoretical grounding of the study and simultaneously reduce variables to test, thereby increasing statistical power. This phase yielded two significant oppression-related predictors of subjective health, one of which was correlated in the expected negative direction (Weight-based oppression: $r = -0.21$, $p < .05$) and the other was surprisingly positively correlated (Heterosexism: $r = 0.30$, $p < .01$), suggesting that those who reported experiences with heterosexism reported higher levels of subjective physical health.

In the next phase, we used structural equation modeling to examine the hypothesized relationships between oppression, depression, and subjective physical health, controlling for BMI (see Figure 1 for hypothesized model structure). After testing assumptions, we conducted a full structural equation model that simultaneously confirmed the factor model of the latent variable, depression, and tested the hypothesized structure of the entire model (see Figure 1). A good model fit is indicated by a nonsignificant Satorra-Bentler scaled chi-square, values greater than .95 on the CFI, and a value less than .06 on the RMSEA (Ullman, 2006). We evaluated the significance of the intervening variables using tests of indirect effects through EQS. This method of examining intervening variables has more power than the mediating variable approach (MacKinnon, Lockwood, Hoffman, West, & Sheets, 2002).
Assumptions and Missing Data

There were a total of 85 women in this study and, of those, 72 (85%) had complete data for all variables. Four participants did not answer any of the depression measure items and six participants did not respond to all BMI-related items and, therefore, their data were deleted from the dataset. We screened remaining cases, which had minimal missing data points, to test for missing data patterns and identified none; therefore, we used the maximum likelihood (ML) estimation with the EM algorithm to impute data based on the assumption that data were missing at random (MAR; Ullman, 2006). Given the nonnormality of the data, assessed with Mardia’s normalized coefficient (normalized estimate = 29.74, \( p < .05 \)), we estimated the models using ML estimation and evaluated fit with the Robust indices.

Model Test and Indirect Effects

Analyses indicate that the hypothesized model fit the data, Robust Satorra–Bentler scaled \( \chi^2(N = 79, df = 65) = 45.11, p > .05 \), Robust CFI = 1.00, Robust RMSEA = .00. Although the hypothesized direct effects model significantly explained the variability in subjective physical health (\( R^2 = 29.3\% \)), weight-based oppression (16.7\%), and depression (8.7\%), not all individual predictors were significantly predictive (see Figure 2 for significant path coefficients). The findings demonstrate that experiencing heterosexism significantly predicts higher levels of perceived physical health, but does not predict depression scores. Higher BMI directly predicted experiencing weight-based oppression and lower levels of perceived physical health; experiencing weight-based oppression directly predicted higher levels of depression and higher levels of depression directly predicted lower levels of perceived physical health. As noted in the introduction, the known

FIGURE 2
Final structural equation model with significant standardized regression coefficients. Significance tests were performed on unstandardized coefficients. Paths and arrows indicate the significant relationships we found. \( *p < .05 \). Note: dashed pathway represents indirect effect of weight-based oppression on subjective health through depression.
relationships between oppression and mental health, as well as between mental health and physical health, led us to hypothesize indirect effects between these forms of oppression and subjective physical health. The indirect pathway between weight-based oppression and perceived physical health through depression was significant.

**DISCUSSION**

Our study demonstrated that in addition to the expected forms of oppression (racism, heterosexism, and sexism), many Black same-gender loving women in this sample experienced a number of other forms of discrimination, such as ageism, weight-based oppression, and discrimination based on lesbian gender expression. These findings highlight the importance of maintaining a broad framework for understanding the ways oppression affects the lives of any group given that many of us are located at the intersection of both privileged and subjugated statuses.

With regard to the model tests, the analyses above showed that we found significant, but different, relationships between subjective health and two types of oppression. Surprisingly, those who experienced heterosexism tended to report higher levels of health. As expected, those that experienced weight-based oppression tended to report worse health. The model we hypothesized (Figure 1) was only partially supported (see, Figure 2 for final model). In short, once we controlled for the influence of all other variables in the model, heterosexism was a significant direct predictor of subjective physical health, but weight-based oppression was not. However, weight-based oppression was a significant indirect predictor, suggesting that experiencing weight-based oppression was indirectly related to poorer health because it decreased mental health which in turn decreases perceived physical health.

**Limitations and Future Research**

While the theoretical basis for the direction of relationships we predicted is in line with contemporary theory on the effects of oppression, it is important to keep in mind that this study used a cross-sectional design. It is possible that the directions of the paths are reversed and it would be useful if future research employed a longitudinal design to rule out this possibility. Further, some areas of future research that we are pursuing include expanding how oppression is measured. Because it was important to describe the multiple forms of oppression that this community experienced in a relatively short survey, our measure was not sensitive enough to capture both perceived and observed experiences, as well as at individual and systemic levels of oppression. Additionally, we were not able to test the types of truly
intersectional research questions that are rooted in some Black feminist, critical race, and fat studies theories, such as the ways in which systems of oppression based on size, race, sexuality and gender intersect in specific spaces to affect health (see, Bowleg, 2008, for comprehensive review on challenges to testing additive and intersectional oppression-related hypotheses).

We are likely to obtain different kinds of information about the health effects of experienced oppression with different measures (Krieger, 2008; Szymanski & Meyer, 2008). One question we are still wrestling with is why we failed to find a relationship between racism or sexism and health. This may be due to the very simplistic way we measured these constructs or because there was too little variability in response to those forms of oppression (i.e., most participants experienced them) to allow for statistical testing. A useful next step may be to employ a mixed methods approach that qualitatively explores how multiple forms and levels of oppression are understood and experienced among Black same-gender loving women, and then quantitatively examine independent and intersecting pathways between oppression and health.

Implications

We see several interesting implications from this small exploratory quantitative study. First, we take note that there were differential relationships between health and the two forms of oppression tested in the model, heterosexism and weight-bias. One possible reason is that research has shown that having an awareness of one’s vulnerability to oppression is ideal for health in that critical consciousness creates a potential psychological buffer and may lead to seeking out social support for managing oppression (Huebner & Davis, 2007). Given the population studied and the setting in which the study was conducted (a weekend retreat designed for social support and activism around issues connected to race, sexuality, and gender), we would expect that the levels of awareness and support for various types of oppression differed. That is, heterosexism is likely to be better understood by our participants than weight-bias, and as such experiencing these two forms of discrimination may be interpreted and internalized at varying levels.

Therefore, it is also likely that differing levels of social support available for different forms of oppression may explain the findings. Specifically, some forms of oppression were consistently and directly acknowledged and addressed through workshops, such as heterosexism and racism, but other forms were not. This may have in turn created a very different context for how less-talked about forms of oppression are experienced, such as weight-bias; in these cases, there tends to be less validation and, thus, less support.
for resistance strategies. Given the potential for different forms of oppression to be related to health in different ways, it also makes sense that depression and mental health may be a mediating variable for some forms but not others, as we found in this study. The findings generally highlight the importance of considering the relationships between oppression and health in the context of the level of available psychological, social, and political support for resisting that form of oppression.

REFERENCES


**CONTRIBUTORS**

**Bianca D.M. Wilson**, Ph.D., is a community psychologist and Assistant Professor of Psychology at California State University, Long Beach. Her research focuses on the relationships between culture, oppression, and sexual health among African-American same-gender loving people.

**Chiamaka Okwu**, received her Bachelor of Arts, Magna Cum Laude at California State University, Long Beach 2009. As a scholar in the National Institute of Mental Health (NIMH) Career Opportunities in Research (COR) program, she served as a research assistant for Dr. Bianca Wilson and conducted health and community psychology research to advance social justice for communities of color.

**Dr. Sandra A. Mills**, graduated from Meharry Medical College, and completed an Emergency Medicine Residency at Highland General Hospital in Oakland, California. Dr. Mills is board certified in emergency medicine and a Fellow of the American College of Emergency Physicians. She practiced 25 years in the Bay Area. Currently, she is working on her 2nd novel and is on faculty at UCSF Medical School.