Challenging Respectability: Student Health Directors Providing Services To Lesbian And Gay Students At Historically Black Colleges And Universities

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Challenging Respectability: Student Health Directors Providing Services to Lesbian and Gay Students at Historically Black Colleges and Universities

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Background: Researchers have tended to favor scholarship that looks at institutional forms of support for gay, lesbian, bisexual, and transgender students in the context of resource centers specifically tailored to gay, lesbian, bisexual, and transgender students. Our study makes two distinct contributions to the study of gay and lesbian students of color: (1) We move away from resource centers as a focal point of support for students and attempt to explore the role of student health at 11 HBCUs; and (2) We draw attention to the ways in which health administrators challenge the influence of respectability to promote the delivery of healthcare that is attuned to the needs and experiences of sexual minorities, thereby providing evidence that pushes back against dominant narratives that reinforce HBCUs as homogenous communities of conservatism and homophobia.

Research Question: This study seeks to answer the following questions: (1) How do student health directors at HBCUs promote policies and practices that are attuned to the health of their gay and lesbian students? and (2) What conditions are developed to cultivate a student health center that not only addresses students’ physical health, but is also “in a position to reaffirm these students”?

Teachers College Record Volume 120, 020303, February 2018, 44 pages
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0161-4681

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Participants: Eleven student health directors at 4-year private and public HBCUs.

Research Design: The inquiry is situated within the tradition of narrative analyses. Semistructured interviews were conducted with our participants.

Data Collection and Analysis: We structured each interview around six broad open-ended questions that offered opportunities for us to tease out unique areas of tension during the interview and to “lead the respondent on a journey, to a frame of mind from which she will understand our ‘big’ questions.” These questions included perceptions of challenges and successes of campus inclusiveness for sexual minority students, clinical services, sensitivity training for staff, and the presence of same gender loving brochures and messaging.

Findings: Our data offers a narrative that illuminates the forces that shape the challenges and opportunities for student health directors (SHDs) to engender change within and outside student health centers and how that ultimately affects the provision of health services to gay and lesbian students. More importantly, it showcases how efforts are made to challenge the influence of respectability to ensure student health and well-being. The findings are organized under the following themes: (a) building trust, (b) partnerships, (c) resistance, and (d) envisioning next steps.

Conclusions: We provide an extensive discussion in how student health directors manage the challenges associated with dominant institutional ideologies, as well as critical implications for future research and practice.

Understanding student identities is paramount to the effective work performed by student services professionals because it informs how they can cultivate college campuses that are more inclusive and equitable for all students. In the past 40 years, there has been increasing interest in addressing the specific needs and experiences of college students with minoritized sexual identities, including those who identify as gay, lesbian, and bisexual (Marine, 2011). The experiences of gay and lesbian youth have been explored through sexual identity development models (Abes & Jones, 2004; Abes & Kasch, 2007; Cass, 1984; D’Augelli, 1994). Though more recent models of sexual identity development call attention to the multiple identities inhabited by students (Fassinger, 1998), these models continue to limit the understanding of intersecting ways of thinking about these students’ senses of self (Bilodeau & Renn, 2005; Torres, Jones, & Renn, 2009). Indeed, the few studies examining gay and lesbian students’ coming out narratives in the context of Historically Black Colleges and Universities (HBCUs), for example, suggest students receive inconsistent support in making their sexual identities salient attributes of their collegiate identities (Lemmelle & Battle, 2004; Patton, 2011). The particularities of the coming out experiences of gay and lesbian black youth underscore the need to remain attuned to the nuances inherent in specific social and cultural contexts (LaSala & Frierson, 2012). Indeed, as Kris Renn noted in her overview of LGBT research in higher education, “no longer can it be said that there
is a ‘gap in the literature’ on lesbian, gay, and bisexual college student identities, although there remains a dearth of research on transgender students and LGBT students of color” (Renn, 2010, p. 135).

This paper continues Renn’s call to further our understanding of gay and lesbian students of color; we specifically anchor our study in the context of Historically Black Colleges and Universities (HBCUs). Limited studies of gay and lesbian students at HBCUs demonstrate that conservatism and homophobia—rooted in the ideology of respectability—in black communities represent significant barriers to students’ sense of belonging and positive student identity formation (Harper & Gasman, 2008; Patton, 2011; Strayhorn, 2012). Their findings suggest that HBCUs are failing to provide adequate support for these student populations, thereby compounding the challenges that gay and lesbian students may be experiencing, such as emotional distress from pervasive social stigma and a fear of exclusion and negative treatment from friends, family and the greater society (Almeida, Johnson, Corliss, Moinar, & Azrael, 2009; D’Augelli, 2002). The persistence of stigma attached to gay and lesbian identities has implications for students’ choice to be open and honest with staff and administrators, making it difficult to provide effective support during their time in college (Institute of Medicine, 2011).

We acknowledge that researchers have tended to favor scholarship that looks at institutional forms of support for gay, lesbian, bisexual, and transgender students in the context of resource centers specifically tailored to gay, lesbian, bisexual, and transgender students (Kirby, 2011; Patton, 2011). Our study makes two distinct contributions to the study of gay and lesbian students of color: (1) We move away from resource centers as a focal point of support for students and attempt to explore the role of student health—a dimension of student affairs that is highly underexamined—by interviewing student health directors (SHDs) at 11 HBCUs; and (2) We draw attention to the ways in which these SHDs challenge the influence of respectability to promote the delivery of healthcare that is attuned to the needs and experiences of sexual minorities, thereby providing evidence that pushes back against dominant narratives that reinforce HBCUs as homogenous communities of conservatism and homophobia. As leaders who determine the strategies to achieve the physical and emotional well-being of students, the perspective of SHDs on the relationship between student healthcare and institutional culture is vital in improving the ways in which the field of student affairs considers and thinks through strategies to support students with minoritized sexual identities.

Thus, our study seeks to answer foundational questions pertaining to perceptions around targeted health services for gay and lesbian students at HBCUs. This inquiry is guided by the following primary questions: (1)
How do SHDs at HBCUs promote policies and practices that are attuned to the health of their gay and lesbian students? and (2) What conditions are developed to cultivate a student health center that not only addresses students’ physical health, but is also “in a position to reaffirm these students” (Edwards, 1994, p. 1)? We argue that the SHDs in our study challenge and overcome the influence of respectability on their capacity to provide students with relevant and inclusive healthcare by promoting practices that discourage the influence of assumptions and personal values related to sexuality that negatively bear on clinical interaction with students, developing on- and off-campus partnerships to cultivate the credibility of student health centers as an affirming and inclusive space and expressing future intentions to improve the structure and culture of their student health centers. Our findings provide insight into how student health leaders might think differently about managing challenges—both external and internal to their department—in order to address cultural and structural factors that impede the delivery of effective healthcare for gay and lesbian students.

LITERATURE REVIEW

Our literature review explores three interrelated topics informing the design and rationale for our study, namely: (a) the cultural barriers affecting black gay and lesbian individuals’ access to quality healthcare; (b) how these barriers become manifested within the context of higher education, especially HBCUs; and (c) the role of student health directors in ameliorating these barriers. Our review of the literature suggests that the provision of healthcare may be unequal across student populations and that a culture of respectability helps us frame the persistent silencing of minoritized sexual identities at HBCUs, particularly with respect to the provision of health services.

THE ILLUSION OF RESPECTABILITY AND THE (IN)VISIBILITY OF SEXUALITY IN BLACK COMMUNITIES

Since HBCUs represent a dimension of black communities in the United States, their constituents—students, faculty, and staff—remain susceptible to the social mores enforced by a broader culture of respectability. Through our review of the literature, respectability politics emerged as a helpful analytic to understand a history of practices and institutions that have sought to establish an order of legitimacy within black communities by blunting any values and behaviors that deviate from socially acceptable norms (Cohen, 1999).

With respect to issues regarding minoritized sexualities, the conservative—a sociopolitical philosophy that casts nonnormative behaviors and
ideologies as immoral—nature of black communities and organizations, including schools and churches (Beadle-Holder, 2011; Cohen, 1999; Kirby, 2011; Lemelle & Battle, 2004), have made it difficult for black individuals who identify as gay and lesbian to reconcile both their racial and sexual identities. Indeed, according to Cohen (1999), “the intersection of class, sexuality, and gender in black communities further distinguishes which black [individuals] are privileged within the group” (p. 12). Lemelle and Battle (2004) state that “many black churches that practice the denigration and symbolic assault on homosexuals as theological ritual enhance masculinist attitudes,” therefore, “black males mask their complicity in reproducing heterosexism and sexisms” (p. 48). There is so much fear in being casted out of black communities (i.e., family, church, HBCUs) (Kirby, 2011), gay and lesbian advocacy is rarely discussed, let alone acknowledged (Cohen, 1999). This is not to say that black communities are wholly inhospitable to minoritized sexualities; in effect, some work suggests that these environments also cultivate a heightened sense of resilience amongst black gay and lesbians (Bowleg, Huang, Brooks, Black, & Burkholder, 2003; Meyer, 2010). Tracing the lineage of the broader influence of respectability politics within collegiate environments, however, is particularly appropriate in understanding the provision of services for gay and lesbian students at HBCUs.

RESPECTABILITY AND (IN)VISIBILITY AT HBCUs

The few studies that examine sexuality at HBCUs report that students give greater regard to racial and gender identity, but that sexuality remains hidden or pushed to the margins (Green, 1998; Harper & Gasman, 2008; Patton, 2011; Patton & Simmons, 2008). In their study of five black lesbians at a single HBCU, Patton and Simmons (2008) described overlapping levels of identities (race, gender and sexuality) that result in amplified discrimination as “triple consciousness” (p. 206), a concept that is influenced by W.E.B. Du Bois’s double consciousness (1903) and is similar to Kimberlé Crenshaw’s theory of intersectionality (1991), which “challenges the implication that individuals have one central identity and that identities are fixed” (Young & Meyer, 2005, pg. 1145). One student in the study stated, “I am Black, I’m a woman, and I’m lesbian. I’m at a disadvantage more than the woman next to me. It is harder and it affects me” (p. 206). And because these participants struggled with all three, in order to achieve a sense of belonging on campus, participants were pushed to relegate their lesbian identity to the margins. In a similar study of six black male students at a single HBCU (Patton, 2011), when asked how they identify, they all referred themselves as black and male (p. 85).
According to one student, “the homosexuality responsibility needs to take the backseat to the African American,” mirroring similar sentiments in the prior study. In some cases, institutional policies can regulate the extent to which gay and lesbian students can publicly express their sexual identities. Harper and Gasman (2008) found that “homosexuality was cited as sexual misconduct” in several institutional documents. More recently, Means and Jaeger’s (2013) study of four black male undergraduates at two public HBCUs identified and discussed a sense of internalized homophobia among their participants and the critical importance of affirming spaces on campus in helping them come to terms with their sexual and racial identity. Although the significance of these studies’ findings is constrained by several limitations—small sample size and limited institutional comparisons—they suggest that minoritized sexualities remain an unspoken dimension among individuals and devalued by their institutions.

Negotiating the visibility of multiple identities within HBCUs is a process that affects students’ experiences in seeking health services. A qualitative study, which took place at six HBCUs, posits that students were not aware that their college provided students with condoms and that their student health centers did a poor job facilitating “open sexual health communication” (Warren-Jeanpiere, Jones, & Sutton, 2011, p. 744). A lack of effort, on the part of the institution and/or student health center, may have grave implications for gay and lesbian students, individuals that may need certain resources, such as sexual health education and counseling, more than others given the preponderance of stigmatized rhetoric around minoritized sexualities (Institute of Medicine, 2011). More recently, a study interviewed 24 HBCU health administrators to evaluate the existence and accessibility of formal policies on HIV testing and prevention. Twelve reported formal policies that “create a ‘safe place’ for students to acquire HIV testing and HIV prevention information, reassuring student confidentiality, promoting HIV awareness, and facilitating a campus atmosphere of nondiscrimination” (Warren-Jeanpiere et al., 2011, p. 328). Thirty percent reported that churches, religious groups, parents, faculty, and/or campus administrators as potentially difficult HIV prevention partners, which can be attributed to “potential partners’ conservative beliefs regarding sex and condom distribution” (p. 328). Unsurprisingly, conservative beliefs as both authoritative and prevalent among black communities are well established in the literature (Cohen, 1999; Pattillo, 2007) and have shown to negatively influence the experience of gay and lesbian students at HBCUs.

We must note, however, that the instances highlighting the invisibility of sexuality within black communities is not restricted to HBCUs. Strayhorn and Mullins’ (2012) study, located at a predominately white institution, found that even among a community of black students, members
identifying as gay and lesbian “reported relatively frequent encounters with homophobia and gay oppression” (p. 156). As such, a corollary to this conservatism includes black men and women who identify as lesbian, gay, or bisexual and may mask and hide their sexuality, which can make it difficult to reach out and support this population. The limited research examining sexuality at HBCUs confirms this very idea.

**THE MYTH OF A ONE-SIZE-FITS-ALL APPROACH TO STUDENTS’ HEALTH**

Student health centers represent the primary hub on campus for students to seek information and services to address their health needs. On campus, “the primary purpose of student health services is to provide immediate medical assistance to students who are ill or injured; student health services also encourage individual good health and provide leadership in promoting the concept of a healthy campus” (Dungy, 2003, p. 349). It is no surprise that positive physical and emotional health is related to greater achievement in academic performance (Ruthig, Marrone, Hladkyj, & Robinson-Epp, 2011). Unfortunately, the distribution of these services remains unequal across student groups, suggesting that the disproportionate care received by gay and lesbian students may present a challenge to their college experience (Warren-Jeanpiere et al., 2011).

Student health centers are unable to achieve their mission of addressing the health needs of all students if they operate under a ‘one size fits all’ type of model. Mayer, Bradford, Makadon, Stall, and Goldhammer (2008) claim that the largest barriers that students with minoritized sexualities encounter in seeking care include: (1) the lack of trust on the part of the patient in disclosing his or her sexual identity to their medical provider, (2) the lack of sufficient health professionals with the necessary competencies to engage with questions specific to gay and lesbian students in their medical care, and (3) the lack of services focused on education and prevention for gay and lesbian individuals. In other words, a “one size fits all” type of model, undergirded by heteronormative assumptions, precludes the intentional care of students possessing identities, behaviors, and beliefs that deviate from the realm of respectability (Green, 1998).

Conditions that devalue students’ sexual identity may hinder the ability of institutions, specifically HBCUs, to provide targeted care for their gay and lesbian students. And because student health centers support the physical and emotional wellness of all college students, we are concerned that student health centers may not adequately serve the needs of gay and lesbian students because they are structured “to reward heterosexual behaviors, and punish transgressive behaviors” (Green, 1998, p. 1).
Narratives that pertain to the healthcare of students are considered incomplete without understanding the perceptions of staff that administer such care; to our knowledge, studies focusing on the latter remain non-existent. We are interested in how these same barriers become manifested within the context of HBCUs and where their student health centers fall along a spectrum that ranges from complete dismissal to heightened awareness of and commitment to the health needs of this particular student population.

Although few studies have examined gay and lesbian student health across higher education, none have empirically investigated how SHDs contribute to how students seek care, may it be in the form of physicals, counseling, testing or educational material. Even more so, the health of this population has never been embedded within broader discourses of race—both at predominately white institutions (PWIs) and HBCUs—which is concerning when systems of inequality draw their energy from the prejudicial treatment of marginalized individuals with intersecting identities. Dismissed among student affairs research, studies typically speak of resources, LGBT centers or “safe spaces,” for gay and lesbian students, but health centers are never included in this context and yet they provide strategic visions for the wellness and health of all students on a given campus (Eisenberg & Wechsler, 2003; Westefeld, Maples, Buford, & Taylor, 2001). Our contribution marries these canons of literature to develop a study that attempts to build understanding of how dynamics of race and sexuality come to shape the extent in which students at HBCUs are supported. Therefore, SHDs are the primary unit of analysis of this study as they are positioned to understand and make meaning of how overlapping—clinical and social—issues discourage and encourage the healthcare of gay and lesbian students on their campuses.

CONCEPTUAL FRAMEWORK

HBCUs have unique historical foundations that shape their contemporary campus cultures. During their establishments, many HBCUs were deemed as institutions to not only educate newly freed slaves, but to instill values of white morality (Ferguson, 2005; Frazier, 1957). Ferguson (2005) expresses that blacks who attended these institutions were being “delivered” and made into worthy citizens of our country through the lens of white Protestant ideology. The historical antecedents of conservative sexual ethics, patriarchy, and moral conservatism handed down from both the white Protestant community and the larger African-American community still influences HBCU campus environments today (Harper & Gasman, 2008). Given the specific ideological influences at HBCUs, any inquiries exploring questions of sexuality require a careful approach from researchers.
THE IDEAL OF RESPECTABILITY

Pattillo (2007) asserts that black communities defend and negotiate their presence in American society through an emphasis on respectability, defined as black communities’ “embodiment of sexual conservatism, patriarchal family relations, and intellectual achievement” (p. 104). This standard excludes “any Blacks who [do] not adhere to the most puritanical of structures (i.e., loose women, practitioners of ecstatic religions, as well as gays and lesbians)” (p. 117). In framing her argument, Pattillo emphasizes that black communities “seek to rehabilitate the race’s image by embodying respectability, enacted through an ethos of service to the masses” (Pattillo, 2007, p. 104). In doing so, Pattillo also suggests that members of black communities hold each other accountable to these particular ideals. This ethos of respectability is deeply rooted in racial uplift ideology and a commitment to advance black communities, with pernicious effects like the silencing of conversations around sexuality.

HBCUs are microcosms of larger black communities in that they embody the very ideals of respectability that shape and determine acceptable ways of speaking, behaving and dressing (Harper & Gasman, 2008). While on the one hand these institutions seek to serve black communities via higher education, on the other hand they have yet to prioritize the well-being of students on their campuses who identify as lesbian or gay because these students do not conform to institutional ideals of who their students should be (Patton & Simmons, 2008). The notion of “respectability” illustrates an inherent struggle within black communities, such as HBCUs. These institutions are now at a crossroads and must decide how they will embrace their identities as institutions dedicated to advancing black communities without further marginalizing their gay and lesbian students who are already oppressed within the broader societal context.

METHODS

We employed semistructured interviews as our method in order to widen and improve our understanding of the ways sexual minority students are supported and, thereby, the degree to which campus healthcare accounts for sexual minority identities among student populations. Because we are interested in SHDs perceptions of their department’s experiences with their impressions of the overall culture of their institution as it relates to addressing gay and lesbian student health, we situate our inquiry within the tradition of narrative analyses (Caduri, 2013). As such, we position participants’ voices as the primary sources through which we can describe SHDs’ discursive of their treatment of lesbian and gay students within the purview of their services.
Eleven SHDs participated in the study. All participants identified as black and/or African American. Nine of them identified as women and two of them as men. Five of the directors (45%) are medical doctors, two (18%) are registered nurses, two have degrees in public health, and one has a Ph.D. in clinical psychology. At the time of this study, the range of their tenure as SHDs ranged from 1 to 15 years, with an average of 5 years.

In terms of the institutional sampling, the HBCUs for which these SHDs worked varied on a number of institutional characteristics including region (the South, mid-Atlantic, and Midwest), size, and religious affiliation. Because our participants represent 10% of HBCUs ($n = 105$), we refrain from providing additional information about our participants’ institutions in order to protect their anonymity.

DATA COLLECTION

In designing this study, we were acutely aware of the conservatism (Harper & Gasman, 2008) and the influence of respectability (Cohen, 1999; Patillo, 2007) in challenging efforts that promote greater inclusion of sexual minorities within black communities, including HBCUs. We chose interviewing as our method because it allowed us to elicit the perspective of SHDs on the ways in which institutional culture affects their practice in supporting students (Lamont & Swidler, 2014). The quantity of our interviews was constrained by resistance on the part of institutions to speak on the topic of sexual minority student health. We invited SHDs from 91 HBCUs to participate in this study. Numerous efforts, including e-mails, phone calls, and voicemails, were met with little or poor responses; often student health directors were constrained by senior administrators, who forbade them to speak with us, or were too afraid to speak on these issues for fear of institutional retribution, and therefore declined our invitation to participate. We were successful in scheduling interviews with a total of 11 institutions: seven private, 4-year institutions and four public, 4-year institutions.

Interviews were digitally recorded and lasted between 60 ($n = 7$) and 90 ($n = 4$) minutes. Transcription of data was outsourced to a third party, who was approved by our institutional review board. We structured each interview around six broad open-ended questions that offered opportunities for us to tease out unique areas of tension during the interview (Alvesson & Karreman, 2011) and to “lead the respondent on a journey, to a frame of mind from which she will understand our ‘big’ questions” (Dilley, 2002, p. 133). These questions included perceptions of challenges and successes of campus inclusiveness for sexual minority students, clinical services, sensitivity training for staff, and the presence of same gender
loving brochures and messaging (see Appendix A). No one institution is the same and, thus, we wanted to give each participant the opportunity to discuss the ways in which sexual minority health is addressed (if any) as it relates to their institutional context. Follow-up questions were predicated on the response of each participant, which allowed us to key in on the impact of specific campus cultures and events that either challenged or promoted efforts to address gay and lesbian student health.

DATA ANALYSIS

We conducted three waves of data analysis. Each time, all the authors reviewed and coded transcripts separately before sharing and deliberating on interpretations. Framed by the ideology of respectability and the literature related to the experiences of gay and lesbian students at HBCUs, we chose to employ selective coding in order to key in on the phenomenon of respectability as it related to healthcare for gay and lesbian students (Creswell, 2012). Each member of the research group participated at every stage of the analysis, and we came together via in-person or virtual meetings to make sense of our codes and emerging themes. In each of these meetings, we shared and discussed our codes, as well as our rationale for our interpretations, especially those that were conceived differently. This process became increasingly important once we began to collapse codes to create themes that captured more complex ideas because it gave each of us the opportunity to continually identify potential and personal biases (Conrad, Haworth, & Millar, 1993). To ensure validity of our data and analysis we followed up with participants if we needed to clarify how interactions with their students or campus events transpired in order to make sense of the magnitude of the challenges they expressed. Additionally, we were also able to use institutional websites to confirm the existence of campus events and programming mentioned in the interviews (Yin, 2003).

In the first wave of coding we began with a list of a priori codes that had emerged from our literature review, including: (a) ideas/perceptions of homophobia; (b) overall impressions of campus culture; (b.1) campus culture specifics with regard to sexual identities/behaviors; (c) education for faculty/staff with regard to issues of sexuality; (d) education for faculty/staff with regard to effective health care; and (d.1) education for faculty/staff specific to marginalized groups (e.g., minoritized sexualities) (see Appendix B). In our second and final wave of coding, we identified dominant patterns and relationships among the initial list of codes and collapsed them into several categories, including the addition of themes that emerged from the coding that had not been accounted through a
priori codes, e.g., (e) barriers to inclusive practice and (f) working across institutional boundaries. We later developed these codes into major themes that “resemble a coherent explanation [and] description of the . . . phenomenon under study” (LeCompte, 2000, p. 150).

POSITIONALITY

As with any study, our positionalities—experiences, beliefs, and identities—shaped our perspective and how we approached the design of the study and interpreted the findings and influenced how we interacted with our participants from the very start to the end of each interview. It is important for each of us to “reflect about [ourselves] in relation to others . . . and to acknowledge the multiple roles, identities and positions that researchers and research participants bring to the research process” (Milner, 2007, p. 395). As we progressed in our research, we derived our framing from our understanding as “positioned subjects” in our approach to this inquiry (Conrad et al., 1993), that is to say: as agents engaged in making sense of everyday life through our own experiences and investments. Collectively, the four authors of this paper share a multitude of racial and ethnic, gender, and sexual identities. Two of us are gay men, one of us is queer, and another one is a heterosexual woman. Racially and ethnically, we all identify in different groups: black, white, Asian American and Latino. These identities became particularly salient as we designed our research project as they informed our anti-deficit commitment in understanding SHDs’ labor for minoritized sexualities within HBCU settings. In addition to our personal identities, all of us have worked alongside HBCUs in our various capacities—as students, teachers, and researchers.

We each reflected on the challenges of exploring issues of sexuality with individuals who, despite addressing issues affecting gay and lesbian student populations, do not engage with contemporary discourses on gay and lesbian-related research. Thus, we must note that awareness of language that is commonly used to discuss issues of sexuality is, in itself, a marker of privileged access to information. As Hammersley and Atkinson (2007) have remarked on the inseparability between methods and findings, it is important for researchers to remain attuned to the ways in which our positionality and own instruments of inquiry (e.g., interview approaches and researcher’s dispositions to asking questions) both invite and foreclose specific forms of engagement with participants.
FINDINGS
The findings are organized under the following four themes: (a) building trust, (b) partnerships, (c) resistance, and (d) envisioning next steps. Despite the fact that these 11 SHDs vary in background and experience, their perceptions of supporting the healthcare of gay and lesbian students on their HBCU campuses demonstrate a consistent pattern in which notions of respectability manifested in many forms to challenge and discourage policies, practices, and conditions needed to support and reaffirm them. Although they were frustrated by the difficulty of supporting this population on their campuses, participants’ responses were also accompanied by strategies and solutions that were used to overcome barriers that emerged from the insistency of institutions or individuals to maintain and enforce the boundaries of respectability. Our data offers a narrative that illuminates the forces that shape the challenges and opportunities for SHDs to engender change within and outside student health centers, and how that ultimately affects the provision of health services to gay and lesbian students.

CARING FOR EACH OTHER: BUILDING TRUST
HBCU SHDs participating in this study acknowledged that the services they provide to students are not only pertinent to students’ sexual and physical health, but also to their overall well-being. Despite the positive intentions of our participants, many of them believe that their students are not making adequate use of healthcare on campus because they do not “feel included in the community.” According to our participants, inclusion was predicated on their ability to build trust with their students.

In describing the mission of her student health center located at a southern, private HBCU, Charlene, commented that her staff use “a holistic approach, and we’re trying to work with the students in all of the things that come with that. I think a lot of times we think of them, when they leave home, they’re just here to go to school but that’s not what we deal with. We deal with the anxiety, all of that.” In effect, the holistic approach taken by these administrators is telling of the importance of forging meaningful relationships between providers and patients, especially with regards to questions specific to patients’ sexualities.

In pursuing a holistic approach to students’ health, issues of trust were of particular concern for several of our participants as they believed a lack of trust between patients and providers proved detrimental to the open communication necessary to provide effective care for students, particularly those who identify as gay or lesbian. One administrator, Diane, stated
how upon taking her post as the director of the student health center, she realized that “the students didn’t trust confidentiality. That was a big thing when I got here. They just didn’t trust that the information would be safe. They didn’t trust that people generally cared about them in the clinic.” In this instance, caring for students entailed that staff understood the social implications of students disclosing any aspect of their sexual identity. Moreover, it meant taking the necessary steps to help students understand the procedures used to maintain their confidentiality in order to alleviate their fear or mistrust of the center. And even when trust is established between a student and health provider, that trust must continue to be cultivated. Diane stated,

I had one gentleman who would come in with his partner regularly for testing, but didn’t, for years, until he was about to graduate, start checking the homosexual box on my sign-in sheet. . . . I think that they are starting to become more comfortable because I’ve tried to create a comfortable space for them to come and use the community partners that we do have to help reach them.

The degree of trust between students, health care provider, and health center is a function of the provider’s ability to create and strengthen an environment where students feel safe and included. Although it is unclear if, perhaps, the said male student did not identify as “homosexual” in the past, Diane believed that cultivating a space that encouraged trust between provider and student was key in caring for gay and lesbian students.

Under the aegis of this particular health director, Diane’s institution undertook a comprehensive survey of their students’ satisfaction with health services to increase the trust between students and services. Diane credits this initiative as one of the primary reasons why their sexual health services have improved:

I’ve done a lot of one on ones, and nurses have gone out, we’ve just been there, and just developed relationships of trust. I think that’s been the main thing on this campus. But, the utilization of our services has increased [so] tremendously that we can’t even keep up, and that’s why we also try to keep our services, our partnerships in place, because we need that extended service, we need that counseling.

Developing trust between healthcare providers and patients not only begets an increased use of their clinical services, but also an opportunity to reiterate the importance of creating a supportive and welcoming environment for patients of all sexualities. When serving gay and lesbian students, some of the SHDs addressed ways in which their practice enabled
students to realize that their services were not only confidential, but also a space where they could receive care regardless of their sexual orientation. Shanice, from a southern, public HBCU, believes that making gay and lesbian students feel at ease is consequential to collecting information about their health needs. She stated:

I try to normalize it. What I say is often I see this in people who have same sex partners. I’ll just ask the question. Are you sexually active? Are you having sex, and with whom? Men, women or both? Keeping your tone very level; men, women, or both? So they can answer the question, leaving it very open-ended. . . . [Students] think whew, I don’t have to go past that barrier, leaving it very open.

By asking open-ended questions, healthcare personnel are conscious not to develop any presuppositions; language between patient and provider matters. Not only do gay and lesbians students need to feel welcomed before they come to receive health care, but the need to feel safe also requires a provider’s physical and linguistic sensitivity to the nature and history of sexual minority politics on campus and how these politics bear on student’s willingness to be open and honest. “Using language that’s inclusive when I’m doing presentations . . . and having literature that has various depictions of couples or cultures in it,” according to Judith, a health director at a mid-Atlantic public HBCU, is critically important. Indeed, providing this space for openness is a key component of creating trust between the provider and the patient and an inability to partake in this type of care was, ultimately, deemed unacceptable by our participants. As Charlene noted:

Students weren’t coming in because they felt they were being judged. And you just can’t do that to be a healthcare provider. That’s not what you signed up for. And so just training them to understand that your religious preference, you have to learn to turn that off, or not push that off on our students, I’m okay, you can believe what you want to believe, you can be bible-toting, or whatever you want to do, that’s fine. But you cannot do it in the detriment of students, and you cannot discuss religion with the student unless that student asks you, because we have a religions department, we have a chapel, we have all of that on campus . . . that’s not the job of the Student Health Center.

What is most significant in this SHD’s statement is the way in which she frames a holistic form of care for students as a nonjudgmental space vis-à-vis their sexual orientation. In sharing this SHD’s experiences, we
are cautious not to presume that a health provider’s religious beliefs are necessarily irreconcilable with patients’ myriad sexual orientations; rather, what is telling about this approach is the pursuit of an opening space where students can develop a trusting relationship with their provider.

The relationship between patient and health care provider is the most immediate and meaningful partnership forged at these services, though by no means the only type of partnership facilitated by student health centers. In these examples, SHDs’ perceptions on the importance of trust emerge as a leading theme in their attitudes towards students and the types of interventions they pursue towards improving their services. The visibility, or recognition, of gay and lesbian students within the context of student health at some HBCUs seems cloudy at best, yet it is evident that the SHDs in our study are intentionally creating opportunities to make space for these students’ experiences to be welcome into their practice. Some of our participants noted the challenge of contending with the conservative climate on their campuses. However, they were explicit to express greater efforts to modify or develop new programming to address gay and lesbian student health.

WE CAN’T DO IT ALONE

Building trust with students is not an isolated event. In fact, participants discussed the importance and benefits of partnering across campus and with external organizations in order to help students feel safe and maintain healthy lifestyles. Although student health centers may seem to be the apparent destination for both clinical and educational services related to health, according to SHDs, we find that this may not be the case for gay and lesbian students. Because the notion of identifying as gay or lesbian, or possessing same gender attraction, counters notions of respectability within black communities, black gay and lesbian students may not perceive student health centers—by virtue of being a part of the overall HBCU campus—as particularly warm and welcoming despite their “commitments to all students,” as noted in several of our interviews. By working in partnership with other individuals and groups, student health centers provided gay and lesbian students the opportunity to receive health care services or education from a variety of channels that may better reflect their level of comfort.

A physician from a Southern public HBCU, Beverly, stated: “I think for us, we say we’re very inclusive and we have this open door, and so we know that the students shouldn’t perceive a barrier, but I do wonder if we need to be more intentional in our reaching out?” Despite Beverly’s commitment to serving and welcoming all students, there is a recognition that
the perception of “inclusivity” may not be sufficient. Health centers, like any other space, can be structured to align themselves with heteronormative values that can create conditions of exclusivity for gay and lesbian students. According to Lawrence, SHD at a Southern public HBCU: “We have a variety of students who probably are gay or lesbian but for whatever reason on our campus they’re not feeling comfortable in disclosing what their sexual preferences are.”

Common among across our participants, the role of partnerships—through peer educators, faculty, leadership roles, and with outside organizations—plays a significant role because it provides student health centers with visibility and cultivates their credibility among gay and lesbian students as safe and affirming spaces. By openly identifying as gay or lesbian, students may be susceptible to fears of mistreatment and social castration. They may use student health for any reason, but they may not be forthcoming to their health provider about their sexual orientations, making it difficult to provide appropriate medical advice and services to this population. Every institution in this study expressed their total commitment to serving all students, regardless of their sexual orientations. Inclusivity is an inherent aspect of their mission, but it is insufficient as a means to serve a student group that may not see itself included in that term. Forming partnerships with individuals and on- and off-campus organizations served as an opportunity for SHDs to promote greater inclusivity in healthcare and health education.

Identifying and recruiting students to serve as health ambassadors, or peer educators can be an effective means to reach out to marginalized student communities, especially students who may not be comfortable receiving services from unfamiliar staff. According to Charlene: “We have a peer education group that works closely with our department that actually has partnered with the lesbian group on campus . . . and they’ve done joint presentations together. They did something last year called [redacted], where they all came together and students could ask all of the questions that they wondered about but were afraid to ask.”

Peer health educators can be effective in spaces that may be difficult for health centers to reach. Put simply, students trust students—they bring credibility to the issues at hand, empower other students, and role model and reinforce healthy practices. In this particular case, representatives of the student health center partner with a student group to develop an event that would allow students to ask questions and discuss issues they might be hesitant to ask openly. This demonstrates that there is a demand for space for students to feel that they can be honest without judgment, while receiving the information they need. More specifically, Diane discussed how her student health center has “trained two people from the
LGBT5 community; one student and one faculty to do rapid HIV testing” because the hope is that “they would be able to do more outreach within their community and be able to increase HIV screening.” Reasons for working with those who are open members of the LGBT community on campus are twofold: There is credibility for the information and services endorsed by these members, and they may be able to recruit students for HIV screening in ways that are sensitive to those who may not be out, or open about their sexuality, in terms of their sexual practices, identities, or “preferences,” as some of our respondents explained them. And the inclusion of a faculty member can also help students see professors as potential sources of mentoring outside of the classroom, making it clear to students that there are multiple channels of support. In synthesis, peer educator groups are the conduits to convey pertinent student health center messages and services to students who may be uncomfortable seeking the same from health personnel and staff.

Beyond administrative and clinical staff and students, partnerships with faculty can be an effective means to improve services and engage students to examine their choices and behaviors within a scholarly and research framework. According to a Robyn, a SHD at a private, southern HBCU, “we have some really great faculty who are doing research around sexual orientation, sexual health, HIV and STI. . . . And I know that we have Dr. [redacted] who does a lot of work on that and has a lot of conversations with our students.” The participant’s institution uses faculty, as one avenue, to provide health education. For many students who consider faculty as trusted mentors or role models, such partnerships can reach students who may be unwillingly to attend or participate in the services and education provided by the student health center. Faculty, however, are not the only institutional employees who go above and beyond their scope of responsibilities to support student health.

At two private Southern campuses, SHDs take on leadership roles with campus groups or departments devoted to gay and lesbian students. Diane, for instance, is “on the advisory board for an LGBT resource center,” and Mark is “the advisor for the LGBT group on [redacted] campus.” As part of the advisory board, Diane explains how the student health center works with the resource center:

There are some activities they have planned and I was sharing what we’re doing in the [Health Center], so that’s where the idea came to partner, so that the resource center could be a cosponsor for the activity, for the sexual assault event . . . I [also] mentioned that we’re doing the HIV training, and two students said they wanted to be trained, so they were invited to the training.
By joining the resource center, Diane created an open channel between the two organizations for collaboration and even the recruitment of students to deliver pertinent services. Such collaboration, as in “the sexual assault event,” can provide critical visibility to demonstrate alignment of values between both the student health center and the LGBT resource center. Additionally, the presence of administrators in LGBT spaces ensures that up-to-date and appropriate health information is being communicated to these students, that the perceptions of the student health centers are positive and affirming for gay and lesbian students, and that health is a priority in the lives of these students. Additionally it allows the student health center to keep a pulse on students’ needs and to ensure the education and services provided are sensitive to any new and critical emerging issues that may be hidden from the public eye.

Mark, takes on a more active role and explains his position as advisor to the campus LGBT group:

The first year we went to the HRC, which is the Human Rights Campaign last October, and we’ll be going again this October. We just have different programs that we put on campus where we bring in individuals from the community and other colleges and we have little forums about defining what LGBT is; debunking some of the stereotypes that are associated with different groups, and also we go over the health risks. We bring in the [county name withheld] Health Department and they provide different educational workshops pertaining to that specific population, and the risks that are associated with it.”

In this particular case, partnership takes on a deeper meaning beyond campus collaborations or cosponsorship. Through the position of advisor, Mark has an active role in shaping the purpose and role of the campus LGBT group. This opportunity gives him critical insight in how social and academic factors shape the choices, behaviors and experiences of these students, which in turn can mediate the ways in which they seek healthcare and health education. And more importantly, his formal presence among the campus LGBT group brings greater credibility for the student health center. When discussing current strategies to recruit more gay and lesbian students to use the available resources, both Mark and Diane expressed the need for greater effort into improving gay and lesbian affinity groups. According to Diane, “We have our gay and lesbian student group. We’re trying to reach out them. They’re here but they’re not as vocal as I think they could be. We are trying to help them find their voice.”

In addition to expanding dialogue to include various topics concerning the LGBT community at large, SHDs can also facilitate partnerships with
outside organizations, such as the county health department or those that are faith-based, to address both structural and cultural barriers. Lorraine discussed how her campus, small and under resourced (Gasman, 2008), makes it challenging for her to address health issues associated with all of her students. According to Lorraine, “I work with . . . just whatever I can think that would help the students to stay healthy and prevent them from health risks. That’s what I offer them.” With very little resources on campus, she depends on the relationships with the local county health department to provide services and education pertinent to gay and lesbian students. In a similar vein, many HBCUs maintain a religious identity that may hinder an institutions’ ability to serve gay and lesbian students. Lorraine stated:

We are a spiritual Christian institution here and we provide spiritual leadership here on campus. If it’s someone that they won’t know here on campus, they just want to talk to someone . . . we are in contact with people from the outside that will come onto campus and talk to them about their spiritual needs.

She is sensitive to the fact that students may have faith-related issues that cannot be comfortably addressed on campus due to their sexuality. This particular instance demonstrates that “health,” in addition to physical and emotional measures, can also encompass spirituality, and that student health centers can help mediate relations between students and outside religious organizations.

The formation of partnerships can be challenging. For instance, Beverly explained the difficulty of finding faculty to assist with gay and lesbian services:

I can say a couple of folks that I really went into depth with indicated that they did not want to be associated with this type of service because they felt that they would be identified as being a part of that particular community. They did not want to jeopardize, one person I remember in particular did not want to jeopardize their tenure because for whatever reason they thought that that could very well happen.

During the process of recruiting representatives across the campus, one faculty member did not want to risk their academic career. This is, perhaps, indicative of the nature of the campus climate that is constrained by the boundaries of respectability. The faculty member may have believed that association with these efforts to support gay and lesbian students would be perceived as behavior unfitting of a future tenured faculty member. Despite Beverly’s intentions, this particular evidence demonstrates that
the successful formation of partnerships must also work in tandem with an institutional culture conditioned for such campus arrangements.

Consequently, partnerships, unified under common goals and beliefs, may widen access to resources for gay and lesbian students. Through our findings we see that partnerships between student health centers with students, faculty, and outside organizations are meaningful ways to understand the needs of and provide for an increasingly visible population, as well as those individuals who choose not to self-identify. Partnerships limit the pressure for students to come forward in order to receive the resources or education they may need.

“HIDING YOUR HEAD IN THE SAND” RESISTANCE

Nine participants disclosed that many of their challenges in openly and expanding services to gay and lesbian students stemmed from conservative campus climates. A quote from Valerie captures the general sentiment of this section: “You know we are in the Bible belt. There are just so many political things here in [location withheld] that preclude having conversations” pertaining to issues of sexuality. Several SHDs revealed similar challenges due to their campuses being located in the South, and due to the conservative climate of the region it was often times difficult to engage in discourse about how to best serve their gay and lesbian students. These same SHDs are aware of the challenges that gay and lesbian students encounter, and they are working toward identifying ways, in spite of the conservative nature of the region, to care for these students in a more open manner.

Judith recalled an uncomfortable incident with a Christian student organization:

One of the Christian organizations on campus was making flyers that were offensive. The [gay and lesbian] students felt threatened by them, sort of talking about marriage issues, that type of thing, so we had a meeting with student affairs, talking about it, how we can handle it and basically just trying to increase a feeling of safety so that people did not feel that they were under attack.

There is a tension present on HBCU campuses within health services and the broader campus context as a whole. Some HBCUs are often forced to reconcile black conservative Christian values while serving diverse students, some of whom are not deemed as living “acceptable” lifestyles. For Lorraine, “everything is very rooted in religion so we pray, which I don’t think some universities do, like that’s a no-no, but here it’s okay to talk about Jesus . . . you know, praise God we made it.” Navigating
this polarizing spectrum proves to be difficult; institutional cultures that express and/or condone disdain for gay and lesbian students negatively affect and undermine the work of student service administrators, including SHDs, to support this student population.

Our participants shared ways in which the influence of conservative views and values undermine their efforts to provide the healthcare and health education they believed their students needed. Charlene discussed the difficulty of managing clinical staffs’ beliefs while maintaining the integrity of her office as an inclusive space for all students. In one instance there was a clinician that refused to acknowledge and serve students that were openly gay or lesbian, often citing religious beliefs as grounds for their choice:

I have one particular staff person that is very religious and so it's been interesting, and we’ve had to go to HR about the change in our policies and our practices, and had to have them, HR, reinforce what we’re trying to do, and to say if this is not something you can abide by or you believe in, you might want to think about employment somewhere else, and it's really come down to that.

Deeming this behavior as unacceptable, Charlene took immediate action so that the gay and lesbian students present on her campus could be adequately served. Her story illuminates how resistance to inclusive practices can come from within the ranks of her office. She followed up and stated, “We just can’t afford to I guess stick our heads in the sand and think that this is going to go away.”

Robyn had a similar attitude and was met with resistance. Using a well-known annual event that brings students and communities from across the country together, this health educator decided to use this opportunity to promote HIV-testing:

I thought how about we use this opportunity to send a message about knowing your status and protecting yourself. I could get magnum condoms for free and make condom packs and have my students workers; I have a team of volunteers. . . . So when I first brought this up to admin and for the planners of homecoming, it’s like ok, you can’t do that. We do not want testing, HIV testing at the [name of event withheld].

Eventually Robyn was able to persuade the administration to give her a table outside the boundaries of the event and years later, a table inside. The inclusion of sexual health education stood against the event’s values of tradition and respectability. In challenging the sentiments present on these campuses many of the SHDs believe, amidst considerable
challenges, that it is their duty to challenge and transform unsupportive practices toward gay and lesbian students and ensure that their practices also receive the adequate care that they strive to provide to all students.

Values and ideologies held by individuals and institutions can shape the degree in which SHDs and their centers approach outreach to their gay and lesbian student populations. These instances demonstrate how boundaries of respectability are drawn and enforced to challenge the efforts of SHDs to support the health of all students on their campuses.

STRATEGIES FOR SUPPORTING BLACK GAY AND LESBIAN STUDENTS AT HBCU

According to our participants, their student health centers are currently at the initial stages of addressing the health needs of gay and lesbian students. Any ease in openly caring for these students has been a fairly recent occurrence, partly due to changing conditions—supportive administration, the emergence of LGBT resource centers—on campus and in the nation. Although this study highlights ways in which SHDs are currently caring for this student population, emerging from our analysis were strategies they would like to employ in the future. It is important for us to highlight how these they, in spite of institutional cultures, hope to advocate and advance the care for gay and lesbian students, as students’ well-being is part of a holistically positive collegiate experience.

As mentioned previously, developing conditions on campuses, to prime them for greater change is pertinent for health centers hoping to increase LGBT efforts. Lawrence explained what is needed for his campus:

I think that the first thing will be to do what we are doing now, which is to have that dialogue on campus, to create a more inclusive environment so that students aren’t afraid to come out and talk about whatever it is that they need to talk about to address their health issues; to have educational sessions for not just students who may identify themselves as LGBT but also for students who don’t, to understand that it is okay to be different.

Expanding campus discourse on the value of difference and diversity can work toward desensitizing those who find issues pertaining to sexuality as polarizing or perverse and it can demonstrate to all students an institution’s commitment to students, regardless of one’s sexual identity. Furthermore, this commitment can signal to students, afraid to openly seek out health advice, a changing climate that is more comfortable and accepting. This change, however, cannot occur in silos. As noted in the data above, Lawrence makes a point to provide education to all students,
indicating that improving the conditions of gay and lesbian students must include all students. A change in climate can have positive effects on student health outcomes as students feel more comfortable being honest with their healthcare provider. Lastly, it is equally important for changes to occur within student health centers.

Conditions within student health centers must also change to create a space that is welcoming and inclusive to students. This can be accomplished in three ways. First, dominant in our study was the need to improve the cultural competency, possessing the knowledge and sensitivity to address health concerns specific to a patient’s identity, of healthcare personnel. Shanice stated:

I’m actually taking notes as I’m talking to you about getting some maybe sensitivity training, because I think that the staff, even if they’re older and may have certain views, I want to say that the bottom line is always patient care, and taking care of them the best way that we know how, and then making sure the staff has the tools to ask those questions and feel comfortable and that the student feels comfortable too, just talking to us.

In Shanice’s case, the beliefs and views of her staff should not negatively influence their ability to serve students. Student health personnel—staff, nurses, and physicians—who expressed disdain toward or were uncomfortable serving gay and lesbian students, can contribute to a chilly and unwelcoming environment, encouraging students to avoid the health center and its representatives and services. Additionally, allowing these “views” to shape student interactions can encourage students to offer up minimal information during their visits. Negative interactions can alter how students perceive the student health center and encourage them to seek advice, accurate or not, from outside sources. “Sensitivity” training for all staff may help reduce the possibility of negative interactions with students. In a similar vein, Mark suggested hiring “a counselor that considers him or herself LGBT.” At one institution, the student health center partners with the local AIDS foundation, who sends trained staff to provide (general and sexual) health education to gay and lesbian students. But what makes these staff particularly effective are their own sexual identities and experiences that enable them to build trust with the students on campus. According to Mark, “because I’m not a gay male; no matter how much I try to immerse myself in culture and that kind of thing, there’s still a level of comfortableness that happens when you directly identify with the person who is talking to you.” Concordance, based on race, sexuality, or religion, between patient and provider, matters. What Mark is suggesting in his statement is the importance and effectiveness of congruence
based on sexuality, which can improve how health personnel provide pertinent and appropriate advice and treatment to students. Second, some SHDs mentioned the possession of brochures and pamphlets that not only addressed gay and lesbian health issues, but also had pictures of same-gender couples. Beverly stated:

It’s all about how we market things . . . things we’re going to put in place that makes everyone feel comfortable . . . I think that including everyone, in some of our publications, in our marketing themes, will be helpful as well, because we didn’t do that previously.

The assumption here is that by having these publications, open and accessible in the health center, every process—from the marketing of services to the treating of students—plays a critical role in building an inclusive space. Developing or purchasing marketing pieces that speak to the gay and lesbian community can be effective in welcoming students, but the feeling of inclusivity must also be carried through to the interactions with student health center staff.

Supporting gay and lesbian students, especially as it pertains to their healthcare, is no longer a questionable issue for the HBCU campuses involved in this study. It is, however, a matter of “how.” Our data is an indication that these campuses are changing their practices, with some moving at much faster paces than others. On one end of the spectrum, some institutions are still trying to incorporate gay and lesbian issues within the broader campus discourse on inclusivity, whereas others are finding new ways to expand and improve their current services. Collaborations, or partnerships, with outside individuals and organizations and improving conditions within the student health center can be considered meaningful and effective methods to affirm and support the health needs of gay and lesbian students.

LIMITATIONS

Although we interviewed individuals with different backgrounds and expertise, their perspective comes from a location of leadership and authority. This location represents a single slice of a much broader narrative in how gay and lesbian students are supported and challenged on their campuses. The current study lacks the voices and perspectives of students and other SHC staff to validate our participants’ responses. Because HBCUs are not monolithic institutions, those additional perspectives could shed significant light in how differences (e.g., location, size, financial resources) among institutions can help explain the varying degrees of support gay and lesbian students receive at
their respective campus. A discussion of recommendations for future research to address these limitations is provided later in the article. Lastly, we also believe that the implications of our study reach beyond our findings, and we thus include a brief discussion of the challenges in conducting research on HBCUs.

Conducting research related to HBCUs is particularly difficult because researchers have exploited these institutions and their leaders in the past. The classic example is that of Harvard sociologists Christopher Jencks and David Riesman (1967). These men conducted research or as they called it “slow journalism” on HBCUs and with little investigation and no empirical research, they labeled HBCUs “academic disaster areas,” noting only a few exceptions (Gasman, 2006). National media outlets carried Jencks and Riesman’s words, including *Newsweek* and *Time*. This publicity scarred the reputation of HBCUs and limiting funding opportunities for decades (Gasman, 2006). As a result of the national coverage of the Jencks and Riesman study, the very existence of black colleges, as well as continued financial support, were called into question. Furthermore, black college leaders felt duped—as if they had provided a well-rounded portrayal of their institutions to the researchers, but all that was represented in the article were the problems and the mistakes. Because of the lingering mistrust that stems from this and other incidents, many black college administrators do not complete surveys nor participate in research projects pertaining to their institutions (Gasman, 2008).

Despite the fact that several of the authors of this article have extensive relationships with HBCUs and their leaders and the fact that one of the researchers attended an HBCU, it was still difficult to gain participation on the part of HBCU SHDs for this study. Added to a history of guarded behavior was the subject of the research. Sexuality is a difficult issue to discuss and according to past researchers, it is considerably difficult to discuss gay and lesbian students and their concerns on HBCU campuses (Harper & Gasman, 2008; Patton & Simmons, 2008). We mentioned earlier that our invitation to participate in the study evoked responses emblematic of the ideology of respectability in which SHDs were fearful of speaking on issues that were sensitive to their institution. However, we also acknowledge that a lack of response could also be due to the fact that SHDs are busy individuals and their schedules could not accommodate time for this study.
DISCUSSION

Notions of respectability challenge how and to what extent practitioners, including SDHs, serve their gay and lesbian students. Despite the challenges noted above, SHDs remain resourceful in forging meaningful partnerships and finding new opportunities to reinforce their commitment to support gay and lesbian students. Our findings contribute to the literature’s limited knowledge about student health in student affairs, especially in caring for minoritized sexualities, and provide a glimpse of how respectability unfolds as it related to the healthcare and health education for the said group. Moreover, framing the study around the ideology of respectability gave us an opportunity to examine its presence, as it relates to student health at HBCUs, and to establish empirical evidence that chips away at the dominant narrative of black communities that exclude individuals that do not (or are unwilling to) conform to heteronormative standards and values of living—the voices of our participants represent such evidence.

One participant noted a faculty member who avoided participating in health education programming for fear that he would not be awarded tenure. A university holds an event that draws thousands of people and represents an opportunity to raise awareness of HIV and STIs among students and community members, but initially fails because it did not align with the traditions and values espoused by the event. Religious values and practices are deeply prevalent at participants’ institutions and often operate to constrain and negatively affect student health centers’ abilities to reach out to and provide critical services to gay and lesbian students. In the eyes of our participants they can certainly shape the manner in which students seek care. And yet, this recognition of respectability by SHDs, and the effort they assert to temper its effects counters dominant narratives that homogenize these institutions, and the entities that make up each campus, as oppressive toward gay and lesbian students (Harper & Gasman, 2008). We do not suggest that the marginalization of these student populations do not exist at many institutions, rather, interviews with our participants show that student health centers, even as they deviate from institutional norms, remain focused, in spite of the dominant institutional culture, on their students’ physical and emotional health. The influence of respectability is certainly situational. In the matter of SHDs and their perspective on the challenges of supporting gay and lesbian students, it has little influence on our participants’ efforts to improve the healthcare conditions for these students.

Student health directors establish a vision in how their student health centers provide clinical services and health education to help students
They address the physical health, and in some cases, the psychological health of students as well. Our findings contribute significantly to our understanding of SHDs as purveyors of affirmation, even in spite of less-than-welcoming campus environments for gay and lesbian students. Rooted in the idea of holistic care, our participants’ perspectives offered us a glimpse of the multitude of ways they support the overall well-being of their gay and lesbian student constituents. Many of the SHDs alluded to the fact that helping students maintain their physical health had to include identifying strategies to affirm students’ sense of belonging as a black and gay or lesbian individual. Pushing against a discourse that has inextricably bounded gay and lesbian individuals with sex and the AIDS epidemic (Cohen, 1999), we found that SHDs—in the manner that they supervise their staff, alter clinical protocols and language, build relationships across campus with students and faculty, and form partnerships with external organizations—were advocates for improving their campuses’ conditions in order to improve students’ sense of belonging as a critical means to address their health. At times, improving these conditions included cultivating spaces free of any values that may question students’ perceptions of SHCs as welcoming and safe. In other words, our participants were applying a holistic approach in caring for these students by taking into account both biological and social, as well as spiritual factors that shape the ways in which students procure health education and healthcare (Leininger & McFarland, 2006). By improving the conditions, from inside the clinic to across and outside the campus, in which students feel more comfortable and secure in disclosing their identities and seeking care, providers are able to better deliver healthcare and health education to their gay and lesbian student populations (Benkert, Hollie, Nordstrom, Wickson, & Bins-Emerick, 2009; Lindahl, Lidén, & Lindblad, 2011; Sloane & Zimmer, 1993). These strategies and their effectiveness mirror the broader literature related to improving marginalized students’ sense of belonging (see Strayhorn, 2012, for an extensive review).

In providing a more nuanced understanding of how respectability can represent challenges to caring for all students, the current study is the first (to our knowledge) to elicit the viewpoints of SHDs on the topic of gay and lesbian students at HBCUs. The studies conducted by Harper and Gasman (2008), Patton (2011), and Patton and Simmons (2008) confirm our findings that respectability—represented in the concepts of campus culture or environment—can negatively shape the manner in which students choose to express and/or disclose their sexual identities and practices. In contrast to these studies, our findings give us no reason to believe that the norms and practices that may invalidate minoritized sexual
identities, reported by their student participants, exist in every aspect of an institution. Harper and Gasman (2008) concluded that the 11 HBCU campuses in their study had not “endeavored to create inclusive environments for students” (p. 346) who identified outside the heterosexual category. Similarly, Patton (2011) and Patton and Simmons (2008) spoke of their campuses (i.e., research sites) as a single entity, when in fact, we know that colleges and universities are made up of several divisions and departments. By focusing on SHDs, we are able to showcase how institutional agents do and can maneuver around the strain of respectability at their campuses, thereby establishing evidence that among HBCU campuses, effort is actually being made to develop more inclusive environments for gay and lesbian students. Our 11 participants demonstrate—through their plans and past actions to support gay and lesbian students on their campuses—that researchers must be more mindful in the way they develop associations between their units of analysis and surrounding factors. Findings from these studies have been critical to the shape and design of our study, but we wanted to shift influence away from vague concepts such as institutional culture or environment to specific individuals on college campuses who are shaping the quality of student experiences and perceptions.

Prior literature (Cohen, 1999; Kirby, 2011) illustrates the difficulty of black communities, including churches and faith-based organizations, to embrace their gay and lesbian members; HBCUs are no different. However, all too often, sexuality and spirituality—framed by national political discourses (Ellingson, Tebbe, Haitsma, & Laumann, 2001)—are perceived as mutually exclusive identities, when in reality, addressing a student’s faith may also be the path toward affirming students’ sexual identity and supporting their overall health. Indeed, some of our participants discussed the constraining influence of faith on an institution’s or an individual staff member’s ability to care—to make them feel welcomed and comfortable—for gay and lesbian students. One participant, Lorraine, is an example of an individual tearing down the division between sexuality and spirituality with her attitude expressed in this sentiment: “It’s ok to talk about Jesus.” Lorraine will seek out the appropriate individuals or organizations—on and off campus—to step in should a student feel that the resources available to them are insufficient. Considering the conservative nature of HBCUs (Harper & Gasman, 2008), her beliefs and actions push against the unfair criticism directed at all HBCUs as insular, antiquated, and regressive institutions and pushes for a framework that can account for how external agencies collaborate with institutions to improve students’ experiences. These community partnerships, we should note, are not exclusive to issues of sexuality (e.g., the organic farm at Paul Quinn College that tithes to the neighborhood, “We Over Me”, 2014),
but gesture to the ways in which SHC directors can mobilize change by acknowledging the limitations of their own infrastructure and connecting beyond the walls of their institutions.

Overall, the examples emerging from our interviews help us reframe Student Health Centers as gateways to community partnerships, effectively creating bridges between the local health resource centers and multiple members of their college/university setting. Rather than operating as silos within their restrictive institutional contexts, the SHDs demonstrate creative ways of partnering with student groups, nonuniversity organizations, and community health organizations as a way of addressing structural issues that would otherwise hinder their ability to serve gay and lesbian students.

The specific examples emerging from a close examination of SHDs’ responses and initiatives for gay and lesbian students emphasize the collaborative enterprises undertaken between various internal constituents, as well as external organizations part of and their local communities. Rather than serving as standalone entities, the SHDs in our study continue alluded to the various ways through which they use and enhance resources in their local contexts. The reciprocity between HBCUs’ Student Health Centers, their community partners, and multiple members within their campus community is, in effect, emblematic of the ethos that elevates HBCUs as institutions that strive to integrate themselves through partnerships that benefit both students and community members alike (Gasman, 2007). Indeed, the community partners bolster SHDs’ efforts to create more hospitable environments for gay and lesbian students. In turn, community partners’ access to HBCU student populations enables them to increase their visibility and demonstrate that supportive environments for gay and lesbian students extend beyond collegiate experiences. By focusing on SHDs’ references to their work within and beyond their campus community, our approach draws attention to the diffuse understanding that we have when invoking the issues of “campus culture” as the primary culprit for lack of support for gay and lesbian students.

RECOMMENDATIONS

Based on our interviews with health center directors at select HBCUs, we offer several recommendations for future research and practice. As this study is the first to capture the perspectives of SHDs at HBCUs on the subject of gay and lesbian students and services for them, much additional research is needed.
RESEARCH

With careful planning, researchers could expand upon our study, interviewing more health directors as well as student affairs professionals and perhaps institutional presidents. It would be beneficial to get a deeper sense of the commitment to gay and lesbian students on HBCU campuses.

Likewise, our study has focused on the perspectives and perceptions of student health directors and their services for gay and lesbian students. Future studies can further garner the opinions and perspectives of gay and lesbian students and their use of student health services in an attempt to not only inform the research in this area but inform practices on HBCU campuses. Our study aimed to explore SHDs’ perceptions as an attempt to understand the forms of institutional support and resistance that gay and lesbian students receive. We acknowledge that extrapolating from this data to give voice to students’ experiences is ineffective. Rather, our hope is that this study encourages health practitioners to realize their potential as critical partners in developing and fostering welcoming environments for gay and lesbian students. We also hope that future researchers explore the myriad sexual identities represented within the sexuality spectrum beyond the gay/lesbian binary, as well as integrate the experiences of transgender and gender-variant individuals who make use of health resource centers at HBCUs, as well as address the emerging concerns from broader research that highlights how women who have sex with women (WSW) also need to be included in preventative measures for safer sex (Cloete, Sanger, & Simbayi, 2011). Lastly, there are at least 21 LGBT student groups across all HBCUs and exploring how these student coalitions build partnerships with offices to increase acceptance and inclusivity afforded to them would be helpful.

Our findings highlight the importance of SHDs and the reach they have across their campuses to support and affirm students. Far too often, student health is detached from the everyday happenings of their campuses when in actuality student health center clinicians engage and help manage the everyday challenges that students face. In light of the recent national attention on student sexual assault and suicides, future research would continue to explore the role and influence of student health centers in student affairs and strengthen the empirical evidence related to student health, development and achievement.
PRACTICE

The outcomes from this study outline multiple implications for our practice. First, our findings encourage—if efforts have yet to be made—HBCU campuses to move toward openly discussing sexuality on their campuses. These types of discussions are critical in that they are connected to the very lives of gay and lesbian students and the general student population and represent a significant step in developing a truly inclusive campus. Second, both condom use and HIV/AIDS testing are lower among black populations and on HBCU campuses and this results in negative health outcomes for black students (Warren-Jeanpier et al., 2011). The many forms of respectability—highlighted in our findings—on campuses can hinder the efforts of SHDs and their centers to employ the most effective methods in protecting students’ health. In regards to condom distribution, SHDs at other HBCUs or campuses with a history of conservatism may find it helpful to work with external and reputable public agencies or nongovernmental organizations to circumvent the influence of their campuses, which may find condom distribution as a practice deviating from their core values and beliefs. Third, based on our exploratory findings, cultivating more inclusive and effective programming and practices for gay and lesbian students, and others with marginalized and intersecting identities, may require stronger and institutionalized collaborations with student services, as student health does not occur in a vacuum. Student outcomes are explained by a multitude of factors that include students’ social and developmental well-being. Formal collaborations with student services may offer student health centers a wider view and sense of possibilities in how they can better reach and communicate to their gay and lesbian students. Lastly, the field of student affairs is very much rooted in the belief that improving staff cultural competency is a key dimension in successfully supporting students (ACPA & NASPA, 2015). Staff at student health centers may accrue significant benefit from attending the same trainings and institutes (even together)—professional development that they may not have received during their clinical education—that focus on improving student services for students from a variety of backgrounds.
CONCLUSION

For many colleges and universities, including HBCUs, taking action to support their gay and lesbian students can be new terrain for a student health center and the institution itself. They may have little idea on where to begin, let alone best practices in serving students. By first asking questions, then coordinating with campus departments and groups and outside organizations, and creating a more welcoming environment at the student health center with the use of strategic marketing and by providing training to personnel, health centers can improve the conditions in which greater services and education are offered to their gay and lesbian constituents.

Evidence suggests that HBCU students perceive great risk and a threat to their livelihood on campus if they are identified as gay or lesbian. As we have demonstrated, student health centers often provide a safe space for these students within the larger conservative HBCU environment. Although it might be a risk, we hope that those individuals leading and working at HBCU health centers will work to educate their campuses about the issues that gay and lesbian youth face. HBCUs are known for their nurturing environments that empower and shape the future of their students. This nurturing spirit must extend to all students, not merely heterosexual students. As the nation pushes forward in its acceptance of its gay and lesbian citizens, so should HBCUs. It is time for HBCUs to reconcile their Christian traditions (regardless of their public or private status) and the growing diversity in their student bodies. Not doing so is detrimental to the future health and livelihood of their students.
NOTES

1. The scope of this study is limited to the healthcare provisions to lesbian and gay students. Thus, we stray away from the shorthand of “LGBT” as an acknowledgement that this study does not explicitly explore the experiences of bisexual, transgender, and/or gender-variant students. Though our participants made a couple of references to transgender healthcare, the primary focus of the survey instrument and interviews was aimed at explicitly capturing the experiences of gay and lesbian students. Indeed, the primary focus of this study is to capture the level of institutional awareness to health needs specific to gay and lesbian students as manifested through the services provided by health directors at HBCUs. As such, the majority of the references to students’ sexual identities in this paper revolve around students’ sexual practices given the nature of Student Health Directors’ praxis. In the instances in which we do adopt the “LGBT” term, we do so to echo participants’ language.

2. Based on web searches and calls to institutions, 14 HBCUs did not possess a student health center, or they outsourced their clinical services to external providers, private hospitals, and clinics. Since these providers are not affiliated with the institution nor do their doctors and nurses frequent the campuses and would have little awareness of any institutional barriers, they were not included in this study.

3. HBCUs have a long history of not participating in national surveys or research studies, especially when majority institutions administer studies. Their resistance is due in part to researchers using collected data to hurt HBCUs. In addition, HBCUs have resisted participation in studies pertaining to sexuality and sexual orientation (Harper & Gasman, 2008).

4. Two-year institutions were included in the sample, but none responded to our invitation.

5. We acknowledge that the current study examines the role of student health centers in the lives of gay and lesbian students. However, our participants—in their attempts to achieve a more inclusive community may use the term “LGBT” as a shorthand to speak about anyone of these students. We may use this term to maintain consistency with our participants.
REFERENCES


Green, B. C. (1998). Thinking about students who do not identify as gay, lesbian, or bisexual, but…. *Journal American College Health, 47*(2), 89–91.


APPENDIX A

Interview Protocol

Hello all:

Before the actual interview, please remember the following…

a. Remind the participant of the purpose of our study. (This part does not need to be recorded.) Below is a snippet from our proposal which includes the study’s purpose and guiding questions:

“This study explores how HBCUs are or are not addressing the needs of gay and lesbian populations. We go beyond social and academic experiences to illuminate the manner in which HBCUs provide services dedicated to the health of their gay and lesbian students. Our study is guided by the following research questions: (1) How are HBCUs addressing the healthcare needs of gay and lesbian students; and (2) What challenges do administrators within healthcare and counseling units on HBCUs campuses encounter when providing services to lesbian and gay students?”

Ask him/her if there are any questions before proceeding.

b. (Begin recording) Ask the participant to review the confidentiality agreement if he/she has not done so. Once reviewed, ask they/ her/ him, “Do you agree to this interview as outlined in the consent form?” (If yes, proceed with the interview)

c. Ask them to say their name and position. (We will not attribute their names/ institutions to any quotes, but we ask them to do this in order to keep the data organized.)

d. Additionally, let each person know that if she/ he regrets saying something during the interview, the person has the right to strike that from the recording. All he/ she needs to say is “Please strike that.”

e. The interview questions are listed below. In my brief experience with interviews, it’s always nice to approach it with a “conversation” oriented manner. Participants tend to open up a bit more. Feel free to reframe the questions as necessary.

Questions:

1. What would say is the mission of the student health center?

2. As director of the student health center, how does your vision for student healthcare encompass the health of gay and lesbian students?
3. In your opinion, what are the most pressing challenges gay and lesbian students encounter at your institution and as it pertains to accessing quality care? If applicable: What efforts are made to ensure those challenges are addressed?

4. Do you believe that your institution’s campus climate encourages gay and lesbian students to seek out health services? If yes, how? If not, why?

5. Do you encounter challenges related to addressing the health of gay and lesbian students? If so, what are they and how are those challenges addressed?

6. Do you have any final comments about anything we have discussed?
APPENDIX B

Sample Transcription Coding

Data codes are as follows:

Ideas/Perceptions of homophobia = IPH; Overall impressions of campus culture = ICC (campus culture specifics with regard to sexual identities/behaviors = ICC-S); education for faculty/staff with regard to issues of sexuality = ES; education for faculty/staff with regard to effective health care = EHC (education for faculty/staff specific to marginalized groups (e.g., minoritized sexualities) = EHC-M)

R = Researcher; P = Participant

R: How would you say your office addresses the health of gay and lesbian students?

P: We try to be all encompassing and reach all students no matter their orientation, their religion, their cultural backgrounds. I think that people have a misconception that all students at HBCUs are the same because they’re all brown, and they’re not necessarily all brown, that’s changing. But even in they are ... there’s a difference in culture if somebody is coming from the Caribbean versus African nations versus Hispanic cultures. I think that that is a huge misconception when it comes to HBCU. I try to reach all of my students, no matter where they fit in in that conglomerate of different subsectors within our community. So that means using language that’s inclusive when I’m doing presentations and that kind of thing, having literature that has various depictions of couples or cultures in it, using language that is relatable to all of the students.

R: What would you say are some of the most pressing challenges that gay and lesbian students encounter at your school as it pertains to accessing quality health care?

P: I think that it is, not that they can’t access it per say, but maybe they don’t want to. I think that there’s a huge barrier: emotional barriers, social barriers, so just feeling included in the community. Even though our school is very fashionable and it just seems like we’re real cutting edge on that kind of thing and fashion forward and all that, it’s still extremely conservative [ICC]. Everybody crams in for chapel services on Sunday and everybody sings in the gospel choir or your best friend does. I think it puts a lot of pressure on them to live up to what they perceive as a certain standard that might have been set at home, and they think that once they get to school they
can kind of break out of that and it’s still the same once they get here. I have a lot of students who I know are, even though they don’t self-identify as homosexual, I know that they’re engaged in homosexual activity. I know that they’re dating, you know, men dating men or even women dating other women, but it takes them a long time to disclose outwardly.

I had one gentleman who would come in with his partner regularly for testing, but didn’t, for years, until he was about to graduate, start checking the homosexual box on my sign-in sheet. I think a lot of that has to do with 1) at this age they’re still exploring; they’re still trying to figure it out. I don’t think that that is very different or unique at any school with this age group whether it would be a white university or a black university, but I think that there’s an added pressure when we add our religious and our cultural views onto that [ICC]. It’s very much present here. I encounter it, too, when I go to planned events and that kind of thing. I’ve had to kind of gently nudge the culture in the right direction as far as testing and services [ES], but I think that they are starting to become more comfortable because I’ve tried to create a comfortable space for them to come and use the community partners that we do have to help reach them.

R:  What kind of community partners do you have?

P:  We work with [name redacted] which is right up [name redacted] and they will test anybody, but their main focus is minority gay men, and then [name redacted] has a great staff there, [name redacted] which we know has great outreach services for gay youth in the area, and so having their workers on hand as well to, because I’m not a gay male; no matter how much I try to immerses myself in culture and that kind of thing, there’s still a level of comfortableness that happens when you directly identify with the person who is talking to you, you know what I mean [ES]. So having testers and that type of thing that are reflective of them makes them more comfortable so they know I can come upstairs and get tested and it’s going to be fine and nobody’s going to judge me or look at me crazy if I ask for female condoms and I’m a man. It’s like, okay baby here you go and they’re on their way.

R:  So you talked about some of the social pressures. Can you talk about some of those about the social pressures on students and why they wouldn’t want to access care?
P: It’s kind of hard to articulate it. Like I said, everything is very rooted in religion so we pray, which I don’t think some universities do, like that’s a no-no, but here it’s okay to talk about Jesus at commencement, you know, praise God we made it. Let’s say a prayer, that’s just how it is, and so I think with it and even if there aren’t saying, because they would never say God condemns homosexuality and even anything like that, I’ve never heard anything of that nature said, it’s still if you come from a place, a southern Baptist home where that’s not okay in the context of Christianity, those feelings are going to transfer to wherever you are if we’re always talking about Jesus and God, even if it’s not said [IPH]. You see what I’m saying?

R: Got it. I do.

P: Like I said, a lot of my guys will be a part of a gospel choir or a part of fraternal organizations and that kind of thing, but again those are very much rooted in Christian beliefs. Until they kind of find their own voice, they aren’t really out with it. I will say that even some of our systems here in the health center weren’t making people feel comfortable. Prior to me getting here they were actually doing HIV testing in the clinical area. So if you wanted to come and get tested, you would have to come to the front desk and they would say, “Okay what are you here for,” and you would say, “Oh I would like to get testing” and “What did you say, like I can’t hear you, as there’s 100 students behind.” [EHC] So they just really feel didn’t feel like there was confidentiality; what’s going in my record; is my record being pulled every time I come in here and this is being noted. I don’t want this to be in my [name redacted] record even though I’m being tested at [name redacted].

Those feelings even if it didn’t happen to you, it spreads like a disease and so once one student finds out and another student finds out and so I use that same theory to revamp it. So okay we’re going to take the testing outside of the clinical area; we going to have it up in my office; we’re going to use outside agencies so that they are not my patients until they decide to come to [name redacted] for treatment. Even if their gonorrhea and chlamydia test comes back and I might have to call them to tell them, they’re still not my patient until they sign a release form for me to get their labs to come down here. So they make the conscious choice to come to [name redacted] to be serviced.

Our staff I think with me being here is a lot more sensitive to the sexual needs of our students [EHC]. If they’re calling on the phone
and they say I want to be tested, they transfer them to me, then I can get into that in-depth conservation with them and then refer them right to the services that they need. I think that just again creating that environment where everybody feels comfortable to come in and seek services was really important.

R: Do you believe that your institution’s campus climate, encourages gay and lesbian students to seek health services? If yes, how; if not, why? I think you touched a little bit on that as far as why they may or may not.

P: We’re trying. I think that working with... we have [name redacted] which is our gay and lesbian student group. We’re trying to reach out to them. They’re here but they’re not as vocal as I think that they could be. So I think that trying to help them find their voice, too, on campus and not be so shy. So I can’t have an event for gay men on campus. It would be pointless, nobody would come [ICC-S]. There would be maybe five, maybe, if I said this is specifically for. You see what I’m saying.
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