LGBT HEALTH
This is a sample from LGBT HEALTH: MEETING THE NEEDS OF GENDER AND SEXUAL MINORITIES

K. Bryant Smalley, PhD, PsyD, MBA, is a licensed clinical psychologist focused on health disparities research. He cofounded and serves as the executive director of the Rural Health Research Institute at Georgia Southern University. The Rural Health Research Institute is an innovative, interdisciplinary hub of research and outreach dedicated to improving health outcomes and reducing health disparities in rural and minority populations. In addition, he is an associate professor of psychology and has served in multiple leadership roles (including director of clinical training) for the PsyD program at Georgia Southern University, a clinical psychology program focused on preparing mental health practitioners for practice in underserved areas. Dr. Smalley currently serves on the American Psychological Association’s Committee on Rural Health, is a Health Equity Ambassador for the American Psychological Association, and has previously been invited to discuss health disparity issues with the White House Rural Council. Dr. Smalley’s work has been funded by organizations including the National Institutes of Health, the Health Resources and Services Administration (HRSA), and the federal Corporation for National and Community Service (CNCS), including Center of Excellence funding through the National Institute on Minority Health and Health Disparities. His research has been published in more than 50 journal articles, books, and book chapters, including publications in LGBT Health, Health Psychology, Journal of Gay and Lesbian Mental Health, International Journal of Transgenderism, Journal of Bisexuality, and Psychology of Men and Masculinity.

Jacob C. Warren, PhD, MBA, is a behavioral epidemiologist specializing in health disparities research. He is the Rufus C. Harris Endowed Chair, director of the Center for Rural Health and Health Disparities, and associate professor of community medicine at the Mercer University School of Medicine, which is dedicated to meeting the health needs of rural and underserved populations. He has served in a variety of academic and research leadership positions, including as a Medical Care section councilor within the American Public Health Association, and has been principal investigator on numerous federally funded research and service grants focused on the study and elimination of health disparities in various groups. His work has been supported by the Centers for Disease Control and Prevention, the National Institutes of Health, CNCS, and HRSA, including Center of Excellence funding through the National Institute on Minority Health and Health Disparities. Dr. Warren has published over 50 journal articles, books, and book chapters, including publications in LGBT Health, International Journal of Transgenderism, Journal of Bisexuality, AIDS Care, AIDS Education and Prevention, and AIDS and Behavior.

K. Nikki Barefoot, PsyD, is a licensed clinical psychologist and assistant director of the Rural Health Research Institute at Georgia Southern University, which is focused on meeting the physical health, mental health, and prevention needs of diverse communities. Her work focuses on health disparities in LGBT and rural populations, including extensive clinical experience in working with the needs of LGBT and other underserved youth. Her work has been published in journals including Rural and Remote Health, Stigma and Health, International Journal of Transgenderism, LGBT Health, Journal of Bisexuality, and Journal of Gay and Lesbian Mental Health.

© Springer Publishing Company
To all the gender and sexual minority trailblazers, current and past.
Thank you.
—Bryant, Jacob, and Nikki
CONTENTS

Contributors xi
Preface xv

Share LGBT Health: Meeting the Needs of Gender and Sexual Minorities

SECTION I. INTRODUCTION AND OVERVIEW

1. Gender and Sexual Minority Health: History, Current State, and Terminology 3
   K. Bryant Smalley, Jacob C. Warren, and K. Nikki Barefoot

2. Sociocultural and Systemic Barriers to Health for Gender and Sexual Minority Populations 15
   Zachary McClain, Rosemary Thomas, and Baligh R. Yehia

3. Health Risk Behaviors in the Gender and Sexual Minority Population 27
   Nathaniel Kralik and Daniel Skinner

SECTION II. OUTCOMES AND CONDITIONS

4. Obesity in Gender and Sexual Minority Groups 45
   Tyler B. Mason, Robin J. Lewis, and Kristin E. Heron

5. Cancer in Gender and Sexual Minority Groups 63
   Gwendolyn P. Quinn, Janella N. Hudson, Michelle T. Aihe, Lauren E. Wilson, and Matthew B. Schabath

6. Chronic Illnesses and Conditions in Gender and Sexual Minority Individuals 83
   Jane A. McElroy and Maria T. Brown

7. Reproductive Health and Parenting in Gender and Sexual Minority Populations 103
   K. Nikki Barefoot, K. Bryant Smalley, and Jacob C. Warren

8. Intimate Partner Violence Among Gender and Sexual Minority Groups 127
   Rita M. Melendez and Jillian Crystal Salazar

9. The Needs of Gender and Sexual Minority Persons Living With Disabilities 143
   Franco Dispenza, Tameeka L. Hunter, and Asha Kumar

10. The Mental Health of Gender and Sexual Minority Groups in Context 161
    Tracy J. Cohn, Stephen P. Casazza, and Elizabeth M. Cottrell

© Springer Publishing Company
11. Suicide and Self-Injury in Gender and Sexual Minority Populations 181
Kimberly H. McManama O’Brien, Richard T. Liu, Jennifer M. Putney, Taylor A. Burke, and Laika D. Aguinaldo

12. Substance Use Among Gender and Sexual Minority Youth and Adults 199
Genevieve Weber and Ashby Dodge

13. HIV and Other Sexually Transmitted Infections Within the Gender and Sexual Minority Community 215
Keith J. Horvath, Nicholas Yared, Sara Lammert, Alan Lifson, and Shalini Kulasingam

SECTION III. SPECIAL CONSIDERATIONS FOR SPECIFIC GROUPS

14. Gender Minority Health: Affirmative Care for the Community 247
lorem d. dickey and Colt Keo-Meier

15. The Health of Racial and Ethnic Minority Gender and Sexual Minority Populations 269
Jacob C. Warren, K. Bryant Smalley, and K. Nikki Barefoot

16. Bisexual Health 293
Jacob C. Warren, K. Bryant Smalley, and K. Nikki Barefoot

17. Advances in Research With Gender and Sexual Minority Youth in the 21st Century 307
Nicholas C. Heck, Lucas A. Mirabito, and Juan P. Zapata

18. Rural Gender and Sexual Minority Health 327
K. Bryant Smalley, Jacob C. Warren, Amanda Rickard, and K. Nikki Barefoot

19. Gender and Sexual Minority Military Personnel and Veterans 345
Nicholas Grant and Jeri Muse

20. Aging, Resilience, and Health in Gender and Sexual Minority Populations 359
Lake Dziengel and K. Abel Knochel

SECTION IV. RECOMMENDATIONS AND FUTURE DIRECTIONS

21. Evidence-Based Approaches for Improving Gender and Sexual Minority Health by Reducing Minority Stress 381
Melvin C. Hampton and John E. Pachankis
22. Recommendations for Practitioners for Providing Competent Care to Gender and Sexual Minority Individuals  
   Matthew R. Capriotti and Annesa Flentje  
   397

23. Future Directions in Gender and Sexual Minority Health Research  
   K. Bryant Smalley, Jacob C. Warren, and K. Nikki Barefoot  
   417

Index  
   425
CONTRIBUTORS

Laika D. Aguinaldo, LICSW
Research Social Worker
Boston Children’s Hospital
Boston, Massachusetts

Michelle T. Aihe, MS
Research Intern
Department of Health Outcomes and Behavior
H. Lee Moffitt Cancer Center and Research Institute
Tampa, Florida

K. Nikki Barefoot, PsyD
Assistant Director
Rural Health Research Institute
Georgia Southern University
Statesboro, Georgia

Maria T. Brown, LMSW, PhD
Assistant Research Professor, Aging Studies Institute
David B. Falk College of Sport and Human Dynamics
Syracuse University
Syracuse, New York

Taylor A. Burke, MA
Doctoral Student in Clinical Psychology
Temple University
Philadelphia, Pennsylvania

Matthew R. Capriotti, PhD
Assistant Professor of Psychology
San José State University
San José, California; and Research Associate
Department of Medicine
University of California San Francisco
San Francisco, California

Stephen P. Casazza, MS
Doctoral Student in Counseling Psychology
Radford University
Radford, Virginia

Tracy J. Cohn, PhD, LCP
Associate Professor of Psychology
Radford University
Radford, Virginia

Elizabeth M. Cottrell, MA
Doctoral Student in Counseling Psychology
Radford University
Radford, Virginia

Iore m. dickey, PhD
Assistant Professor and Doctoral Training Director
Combined Counseling/School Psychology PhD Program
Department of Educational Psychology
Northern Arizona University
Flagstaff, Arizona

Franco Dispenza, PhD, CRC
Assistant Professor of Clinical Rehabilitation Counseling and Counselor Education
Georgia State University
Atlanta, Georgia

Ashby Dodge, LCSW
Clinical Director
The Trevor Project
New York, New York
Lake Dziengel, PhD
Associate Professor of Social Work
University of Minnesota Duluth
Duluth, Minnesota

Annesa Flentje, PhD
Assistant Professor of Community Health Systems
University of California San Francisco
San Francisco, California

Nicholas Grant, PhD
Congressional Fellow
American Psychological Association
Washington, DC

Melvin C. Hampton, PhD, MDiv
Post-Doctoral Research Fellow
Center for Interdisciplinary Research on AIDS
Yale School of Public Health
New Haven, Connecticut

Nicholas C. Heck, PhD
Assistant Professor of Psychology
Marquette University
Milwaukee, Wisconsin

Kristin E. Heron, PhD
Assistant Professor of Psychology
Old Dominion University
Norfolk, Virginia

Keith J. Horvath, PhD
Associate Professor of Epidemiology and Community Health
University of Minnesota
Minneapolis, Minnesota

Janelle N. Hudson, PhD
Postdoctoral Fellow
Department of Health Outcomes and Behavior
H. Lee Moffitt Cancer Center and Research Institute
Tampa, Florida

Tameeka L. Hunter, MS, CRC
Director of Disability Resource Center
Clayton State University
Morrow, Georgia

Colt Keo-Meier, PhD
Clinical Psychologist
Psychology Lecturer, University of Houston; and
Medical Student, University of Texas Medical Branch; and
Assistant Professor of Psychiatry and Behavioral Sciences, Baylor College of Medicine
Houston, Texas

K. Abel Knochel, PhD
Assistant Professor of Social Work
University of Minnesota Duluth
Duluth, Minnesota

Nathaniel Kralik, BA
Osteopathic Medical Student
Heritage College of Osteopathic Medicine
Ohio University
Dublin, Ohio

Shalini Kulasingam, MPH, PhD
Associate Professor of Epidemiology and Community Health
University of Minnesota
Minneapolis, Minnesota

Ashan Kumar, MS
Clinical Rehabilitation Counselor
Atlanta, Georgia

Sara Lammert, MPH
Graduate Research Assistant
Division of Epidemiology and Community Health
University of Minnesota
Minneapolis, Minnesota

Robin J. Lewis, PhD
Professor of Psychology
Old Dominion University
Norfolk, Virginia
This is a sample from LGBT HEALTH: MEETING THE NEEDS OF GENDER AND SEXUAL MINORITIES

VISIT THIS BOOK’S WEB PAGE  BUY NOW  REQUEST AN EXAM OR REVIEW COPY

Matthew B. Schabath, PhD
Associate Member
Department of Cancer Epidemiology
H. Lee Moffitt Cancer Center & Research Institute
Associate Professor of Oncologic Sciences
Morsani College of Medicine
University of South Florida
Tampa, Florida

Daniel Skinner, PhD
Assistant Professor of Health Policy
Heritage College of Osteopathic Medicine
Ohio University
Dublin, Ohio

K. Bryant Smalley, PhD, PsyD, MBA
Executive Director
Rural Health Research Institute
Associate Professor of Psychology
Georgia Southern University
Statesboro, Georgia

Genevieve Weber, PhD, LMHC
Associate Professor of Counseling and Mental Health Professions
Hofstra University
Hempstead, New York

Lauren E. Wilson, BS
Research Coordinator
Department of Health Outcomes and Behavior
H. Lee Moffitt Cancer Center and Research Institute
Tampa, Florida

Nicholas Yared, MD
Infectious Disease Fellow
Department of Medicine and Division of Epidemiology and Community Health
University of Minnesota
Minneapolis, Minnesota

Baligh R. Yehia, MD, MPP, MSc
Adjunct Assistant Professor of Medicine
Perelman School of Medicine, University of Pennsylvania
Philadelphia, Pennsylvania

Juan P. Zapata, BA
Psychology Graduate Student
Marquette University
Milwaukee, Wisconsin

©Springer Publishing Company
Few would disagree that the past 25 years have been transformative in the lives of gender and sexual minority (GSM) people living in the United States. In that time, we have progressed from a society with virtually no visibility given to the lesbian, gay, bisexual, and transgender (LGBT) community to one in which our gender and sexual minority celebrities are not only increasingly prominent but also are counted among some of the most successful in their fields. Recent years have also seen landmark events such as the federal protection of same-sex marriage that will shape the future in profound ways. It is clear that we are in the midst of the nascent of the most LGBT-inclusive period in history.

With all of these advancements, it is easy for many to overlook the persistence of substantial challenges faced by members of the LGBT community. For example, the ability to marry has not been paired with legal protections for those individuals once wed, and the “married today, fired tomorrow” phenomenon is still a real and present threat for same-sex couples because of a lack of federal nondiscrimination protections in employment. More relevant to this book, legal reform does not sweep away generations of stigma, discrimination, and hostility that have manifested in a shocking array of health disparities and related inequalities. Although we may be in the emergence of a golden age of LGBT rights, we are still under the shadow of hundreds of years of conflict and oppression. With researchers only recently able to begin investigating these dynamics because of an earlier lack of interest, funding, and venues for gender and sexual minority health research, we are only now beginning to realize the magnitude of the challenges that exist.

At the same time, however, we are also learning more about the remarkable levels of resiliency, innovation, and determination that those years of struggle have forged. The LGBT community is diverse yet united, in need yet strong, and oppressed yet resilient. As the field of gender and sexual minority health advances, we are simultaneously learning about the threats and the potential solutions, and combining those two bodies of knowledge is essential to achieving true change.

As such, it is our hope that this book will serve simultaneously as a reference, a call to action, and a guide for change in addressing the multitude of health challenges described in its pages. At all times, we attempt to balance the often troubling reality of the topic being discussed with specific, applied knowledge that can be translated into action and change. We begin the book with an overview of the history, current status, and terminology associated with the health of gender and sexual minority groups, as well as discussion of some overarching themes that are relevant to health topics (e.g., barriers to care and general health risks). We then explore a multitude of individual health outcomes ranging from chronic disease to intimate partner violence, describing what is currently known, what remains to
be discovered, and what avenues there are to improve the outcome. Subsequently, we examine the specific factors impacting the health of particular GSM groups, such as gender minority populations and GSM veterans. We then conclude with a discussion of evidence-based interventions, recommendations for health care providers, and future directions for the field.

The field of gender and sexual minority health may be full of areas of need documented throughout this book that at times can seem overwhelming, but this presents countless areas of opportunity for dedicated professionals and community members to make a true difference. We hope this book inspires you to begin or to continue such work.

—Bryant, Jacob, and Nikki

As an aid for instructors using this text in their course work, an ancillary PowerPoint deck with discussion questions is available for download. To access this PowerPoint deck, qualified instructors should send an email to textbook@springerpub.com.
Share

LGBT Health: Meeting the Needs of Gender and Sexual Minorities
CHAPTER 2

Sociocultural and Systemic Barriers to Health for Gender and Sexual Minority Populations

Zachary McClain, Rosemary Thomas, and Baligh R. Yehia

As discussed throughout this book, the lesbian, gay, bisexual, and transgender (LGBT) community has recently gained more visibility and social acceptance than ever before. Some of the progress the LGBT community has made in regard to civil liberties includes the 2010 repeal of “Don’t Ask, Don’t Tell,” and the 2013 United States Supreme Court ruling that Section 3 of the Defense of Marriage Act was unconstitutional. Additionally, reports from the Institute of Medicine (IOM), the Department of Health and Human Services (HHS), and the Joint Commission have highlighted the need for increased attention to the health needs of the LGBT community. However, cultural, structural, and other barriers still exist to achieving true social and health equity for gender and sexual minority (GSM) populations, and many protections remain at the mercy of shifts in political power. Ongoing challenges include the lack of federal anti-discrimination laws, inequalities in access to appropriate and affirming health care, and systemic social factors that predispose gender and sexual minorities to poorer health outcomes ranging from cancer to violence (Valanis et al., 2000; Walters, Chen, & Brieding, 2013). The magnitude of these health disparities is discussed in detail throughout this book. This chapter aims to provide an overview of: (a) the current social and cultural climate for GSM populations; (b) the individual, systemic, and environmental barriers to health for GSM populations; and (c) recommendations for addressing these barriers. For a
summary of these barriers, and recommendations for addressing them, see Table 2.1. Additional recommendations for practitioners can be found in Chapter 22.

## SOCIAL AND CULTURAL CLIMATE FOR GSM POPULATIONS

Social acceptance of the LGBT community has increased dramatically over the past decade. In fact, 92% of GSM adults report that society is more accepting than it was 10 years ago, and attribute this to increased visibility of GSM people (Pew Research Center, 2013). However, as a population, GSM individuals lack key nondiscrimination protections related to their sexual orientation and/or gender identity. As of June 2016, only 18 states have specific, inclusive, nondiscrimination protections for the LGBT community (Human Rights Campaign, 2015). Moreover, numerous states have introduced bills to bar transgender individuals from gender-affirming use of public restrooms and to limit transgender youth from fully participating in school (Human Rights Campaign, 2015), and as of the publication of this text the fate of transgender military servicemembers remains undecided. In addition to the lack of formal protections, GSM individuals and families are more likely to experience poverty, homelessness, obstacles to quality education, and family disruption than their non-GSM peers (Burwick, Gates, Baumgartner, & Friend, 2015).

### Discrimination and the LGBT Community

Over two-thirds of sexual minority people report discrimination in their personal lives and between 15% and 43% of sexual minority individuals have experienced some form of discrimination at work (Sears & Mallory, 2011). More disturbing is the prevalence of hate-motivated violence affecting the LGBT community. Research demonstrates that gay men face higher rates of hate crime violence than lesbians, bisexuals, African Americans, or Jewish Americans (Stotzer, 2012). Rates of discrimination and hate-motivated violence are even higher among the transgender community (Grant et al., 2011). The National Transgender Discrimination Survey (NTDS) reports that 90% of transgender respondents report harassment, mistreatment, or discrimination on the job (Grant et al., 2011).

In 2015, 67% of GSM homicide victims of hate crimes were transgender women, and 54% of those victims were transgender women of color (Walters et al., 2013). High rates of violence and victimization in the transgender community led to the 2015 formation of a Congressional task force on Transgender Equality in response to the “epidemic of violence against the transgender community” (Human Rights Campaign, 2015). However, transgender individuals, especially transgender women of color, continue to bear an elevated burden of hate-motivated violence and discrimination even beyond that faced by the rest of the LGBT community.

GSM youth are greatly impacted by discrimination and harassment, and are at higher risk of childhood maltreatment compared to heterosexual youth (Burwick et al., 2015). Over 50% of GSM students have personally experienced discriminatory policies and practices at school. Moreover, 56% and 38% of GSM youth report feeling unsafe at school because of their sexual orientation and gender identity, respectively
TABLE 2.1: Individual, System, and Environmental Barriers to GSM Health and Associated Recommendations

<table>
<thead>
<tr>
<th>BARRIERS</th>
<th>RECOMMENDATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td></td>
</tr>
<tr>
<td>Discrimination in health care</td>
<td>• Providers and health care staff should receive LGBT cultural competence training.</td>
</tr>
<tr>
<td></td>
<td>• Health systems should adopt inclusive and affirming policies.</td>
</tr>
<tr>
<td></td>
<td>• Sexual Orientation and Gender Identity/Expression should be included in health system nondiscrimination policies.</td>
</tr>
<tr>
<td>Lack of health coverage for GSM individuals</td>
<td>• Advocating for inclusion of GSM health needs as part of basic health plan coverage should continue.</td>
</tr>
<tr>
<td>System</td>
<td></td>
</tr>
<tr>
<td>Lack of provider competency and lack of resources</td>
<td>• LGBT competent providers should be identified and promoted.</td>
</tr>
<tr>
<td></td>
<td>• LGBT clinical and cultural competency should be included in medical and health professional education.</td>
</tr>
<tr>
<td></td>
<td>• LGBT cultural competency should be included in all health care staff training and continuing education.</td>
</tr>
<tr>
<td>Lack of research and data</td>
<td>• Medical records should be updated to collect data on LGBT populations.</td>
</tr>
<tr>
<td>Environmental</td>
<td></td>
</tr>
<tr>
<td>Lack of federal or state nondiscrimination protections</td>
<td>• Advocacy to improve GSM equality should continue.</td>
</tr>
<tr>
<td>Physical and clinical spaces</td>
<td>• Materials showing diverse GSM people should be on display in clinical settings.</td>
</tr>
<tr>
<td></td>
<td>• Bathrooms should be gender neutral or single use.</td>
</tr>
<tr>
<td></td>
<td>• LGBT symbols can be displayed either in the clinical space or worn by staff.</td>
</tr>
<tr>
<td></td>
<td>• The electronic medical record should collect information on name in use, gender identity, sexual orientation and relationship status beyond “married or single.”</td>
</tr>
</tbody>
</table>

GSM, gender and sexual minority; LGBT, lesbian, gay, bisexual, and transgender.

(Kosciw, Greytak, Palmer, & Boesen, 2014). GSM youth also face disproportionate rates of homelessness. Approximately 40% of homeless youth identify as GSM and 68% attribute their homeless status to family rejection due to their sexual orientation and/or gender identity (Durso & Gates, 2012). Taken together, these systemic and persistent societal factors limit the ability of GSM individuals to achieve ideal health.

BARRIERS TO HEALTH CARE FOR GSM POPULATIONS

Although the previous barriers impact health in ways related more to social standing and lived experiences, other barriers to health are more direct. Such barriers
to care for GSM individuals are multifactorial and can be divided into individual, system-based, and environmental factors. Individual barriers are those that exist on a personal level, such as resource limitations, lack of insurance, and transportation challenges. System-based barriers relate to health system policies, health care practices and guidelines, and availability of LGBT-competent providers. Environmental barriers refer to the context in which care is delivered, including the physical and sociocultural environment.

Individual Level Barriers: Health Coverage for GSM Populations

The Affordable Care Act (ACA) expanded health care access for millions of Americans, including the LGBT community. Expanded insurance coverage, non-discrimination provisions, and recommendations for routine data collection on health disparities in the LGBT community are key components of the ACA important to improving the health of GSM individuals (Ranji, Beamesderfer, Kates, & Salganicoff, 2014). Additionally, the Department of Health and Human Services issued regulations barring discrimination based on sexual orientation and gender identity in health insurance marketplaces and health plans (HHS, 2016), one of the first times such provisions have been federalized.

Since the implementation of the ACA, the Health Reform Monitoring Survey found decreases in the number of uninsured sexual minority adults (22% in 2013 to 11% in 2015; Karpman, Skopec, & Long, 2016). However, additional data on rates of insurance for GSM populations is limited. Moreover, despite the progress made by health reform, 19 states have not expanded Medicaid coverage to reach those who fall into a “coverage gap,” potentially leaving many in the GSM population without health insurance. Expansion of the Medicaid program (i.e., inclusion of poverty in adult eligibility for Medicaid benefits) is particularly important because GSM adults experience rates of poverty as high or higher than cisgender heterosexual adults (Albelda, Badgett, Schneebaum, & Gates, 2009). Additionally, the National Transgender Discrimination Survey (NTDS) found that transgender individuals are four times more likely than the general population to live in extreme poverty (i.e., household income less than $10,000 per year), placing transgender adults at even higher risk for being uninsured in states that did not expand Medicaid (Grant et al., 2011).

System Level Barriers: Provider Competency and Availability of LGBT Health Care Resources

Given that 56% of sexual minority adults and 70% of transgender individuals report experiencing discrimination in health care settings, it is paramount that providers create a safe, healing space for their GSM patients (Snowdon, 2013). Although many GSM patients have safe, comforting interactions with their medical providers, some delay or do not seek care because of the discrimination, stigma, social isolation, and violence associated with their sexual orientation and/or gender identity (IOM, 2011). GSM patients often seek out providers who are comfortable working with the LGBT community because they are nervous about their health care provider’s reactions to their sexual orientation and/or
gender identity (Neville & Henrickson, 2006). In fact, 29% of sexual minority individuals and 73% of transgender individuals perceived that they would be treated differently (i.e., negatively) by medical personnel if they were open about their sexual orientation and/or gender identity (Neville & Henrickson, 2006). Furthermore, many GSM individuals believe that they may even be denied health services due to their sexual orientation and/or gender identity (Lambda Legal, 2010).

Identifying providers and health organizations that understand the unique health care needs of GSM populations is challenging. One study found that only 15% of academic medical institutions in the United States had an available list of LGBT-competent physicians associated with their institution. Furthermore, in terms of LGBT-competency training, the majority of institutions did not have any at all (52%), 32% had some training available, and only 16% reported comprehensive LGBT-competency training (Khalili, Leung, & Diamant, 2015). The American College of Physicians recommends that future physicians be trained in culturally and clinically competent GSM health care, and call for increased understanding of the health needs of the GSM population by practicing physicians (Daniel, Butkus, & Health and Public Policy Committee of American College of Physicians, 2015), but it is unclear to what extent this recommendation is translated into curricular change.

Many studies have examined what GSM patients want from a provider. A study of GSM adolescents found that sexual minority youth want to be treated with respect and have a provider who is well educated and a good listener (Ginsburg et al., 2002). Further, research with gender minority youth identified additional needs from providers, such as the following: time to speak with them privately, patience to hear their concerns, flexibility to appreciate their individual identity, and validation that they know who they are (Hawkins, 2009). Similar needs have been identified by GSM adults. For example, transgender adult patients have identified that they want providers to be easy to talk to, nonjudgmental, fair, and respectful (Bockting, Robinson, Benner, & Scheltema, 2004). These findings highlight the need to ensure that providers are trained to ask culturally sensitive questions about sexual orientation and gender identity, and that health organizations increase visibility of LGBT-competent providers.

System Level Barriers: Lack of Research and Data

The IOM’s (2011) report on improving the health of GSM people identified that one of the main challenges in understanding their health needs is the lack of data. Questions about sexual orientation and gender identity are often overlooked in demographic surveys conducted in research. Given the discrimination and stigmatization that GSM individuals face, questions about sexual orientation and gender identity must be carefully and competently asked. Depending on how sensitively the questions are asked, GSM individuals may not disclose and thus accurate data may not be captured. Over the past few years, however, more reliable data collection, research, and a better understanding of barriers to health care access for GSM individuals have emerged (Daniel et al., 2015).
Electronic health records (EHRs) hold great potential as a source of data collection for GSM populations and the IOM (2011) recommends routine sexual orientation and gender identity data collection on all patients. Many health system EHRs do not yet have explicit fields to collect this data but do provide options to record the gender of sexual partners. However, research has shown that documentation of the gender of sexual partners in EHRs is low (45%) (Nguyen & Yehia, 2015). Recent changes in mandates for health care professionals require the inclusion of both sexual orientation and gender identity in EHRs in order to reach higher designations of meaningful use (and thus enhanced reimbursement; Cahill, Baker, Deutsch, Keatley, & Makadon, 2016); however, the benefits of this enhanced data collection are likely many years away and there is a lack of cultural competency training regarding affirming methods of collecting such information. Furthermore, such data collection requirements are subject to changing political climates (e.g., following the 2016 US Presidential election federal requests for the inclusion of sexual orientation and gender identity questions to be added to Census surveys were rescinded).

Environmental Level Barriers: Discrimination of GSM Populations Within Health care

As discussed previously, the LGBT community faces many barriers to accessing and receiving health care, including discrimination within the health care system, heterosexism, fear of disclosing sexual orientation and/or gender identity, and lack of insurance. Compared to heterosexual individuals, sexual minority individuals are more likely to delay or avoid necessary medical care (29% vs. 17%; Khalili et al., 2015). This may be secondary to prior negative health care experiences, concerns about confidentiality, and/or fears of homophobic or stigmatizing reactions (Mayer et al., 2008). A survey by Lambda Legal (2010) found that 8% of sexual minority and 27% of transgender individuals have been refused needed health care, and almost 11% of sexual minority and 21% of transgender people reported health care professionals using harsh or abusive language toward them. Likely as a result, many GSM individuals continue to be reluctant to disclose their sexual orientation or gender identity when receiving medical care (Mayer et al., 2008). All of these findings may lead GSM patients to avoid needed medical care or withhold information important to their medical treatment.

Research around discrimination in health care has focused primarily on GSM adults; however, GSM youth are also affected. Sexual orientation and gender identity typically emerge during adolescence, making this developmental period particularly vulnerable to discrimination and stigmatization. In order to address these barriers, key stakeholders in the health of GSM youth have weighed in on the barriers and provided recommendations to help those in the health care field to be cognizant of what may be preventing these youth from seeking the affirming care they deserve. In a policy statement on office-based care for GSM youth, the American Academy of Pediatrics acknowledged that the effects of homophobia and heterosexism can contribute to health disparities, particularly mental health disparities (Levine et al., 2013). Additionally, the Society for Adolescent Health and Medicine released a position paper that clearly stated that GSM youth face
added challenges because of the difficulties of the coming out process, as well as societal discrimination and bias against GSM individuals (Reitman et al., 2013). Finding ways to provide affirming care to all GSM individuals, and especially to children and youth, will be critical in curbing the ongoing problems of discrimination and alienation from health care.

Environmental Level Barriers: Physical and Clinical Spaces

The physical environment of a clinical space is important to many patients. A systematic review to determine the effects of physical environment stimuli on health determined that sunlight, presence of windows, and pleasing aromas positively affected patient satisfaction and well-being (Dijkstra, Pieterse, & Pruyn, 2006). Along these lines, studies have shown that patients treated in single bedrooms are more likely to be satisfied with their care than those in multiple bedrooms, while health care settings that are noisy are associated with reduced patient satisfaction. Additionally, windowless hospital rooms are linked to anxiety and depression, and, conversely, art in patient rooms is associated with reduced anxiety and pain levels (Schweitzer, Gilpin, & Frampton, 2004). These results demonstrate the critical role the health care environment has in improving health outcomes and creating satisfying experiences with health care.

GSM individuals face barriers when interacting with the physical space of the health care environment as well as the procedural environment. Most health care spaces do not signal that they are safe spaces for GSM individuals. The majority of posters, pamphlets, and materials from the clinical space show heterosexual individuals or couples. Additionally, rainbow pride flags for the LGBT social movement are rarely visible. Gender affirming and inclusive bathrooms are not commonplace. On a more individual level, barriers for GSM individuals permeate into the medical record, where incorrect names and pronouns are used, and intake forms frequently lack affirming language regarding relationship status (Deutsch & Feldman, 2013). Taken together, these can lead to unwelcoming or poor experiences for GSM individuals that may discourage them from interacting with the health care system itself.

A study of GSM adolescents explored factors that make them feel safe in a health care setting and found that the top factors identified as important were not related to their sexual orientation, but instead, the clinical environment: the cleanliness of the health care space, instruments, and provider (Ginsburg et al., 2002). However, GSM adults would like staff to be friendly, courteous, and respectful of appropriate name and pronoun use, specifically when handling phone calls and appointments (Bockting et al., 2004). Lastly, both GSM adults and adolescents are concerned with discussions around confidentiality and access to medical records. Therefore, providers should be explicit that the care they receive is confidential and protected (Ginsburg et al., 2002; St. Pierre, 2012).

RECOMMENDATIONS

Every health care institution should strive to create a caring, honest, clean, and confidential system that provides a welcoming and competent environment for
all patients, including GSM patients. These systems should take into consideration the significant barriers GSM individuals face to get the care they deserve. In order to do so, systems should focus on addressing the barriers on the levels of the providers, clinical environment, and policy. Research and programming to address health disparities, improve health outcomes, and ensure quality care for GSM populations are also needed to achieve true health equity.

The health care space for GSM individuals is greatly influenced by those who inhabit it—the providers and staff. First and foremost, LGBT-competent providers should be easily identified. This awareness, or “outing,” of competent clinicians can very quickly put GSM patients at ease. LGBT-competent providers can be identified with cyber outings (i.e., a list of LGBT-friendly providers on an institution’s website) and/or buttons, pins, or stickers on a provider’s identification badge or white coat. Clinical providers should work to be comforting, nonjudgmental, and open to all patients, especially GSM patients. Providers should ask open-ended questions and not assume that the individual seeking care is cisgender and/or heterosexual. Furthermore, the use of gender-neutral pronouns and asking, not assuming, how the individual identifies in terms of gender and sexual orientation should be encouraged when working with all patients. Medical providers should be keenly aware of the unique health needs of sexual and gender minority individuals, and the profound discrimination, stigma, social isolation, and violence they may experience on a daily basis. From the front desk to the examination room, clinical staff should be knowledgeable in how to interact and communicate with GSM individuals (McClain, Hawkins, & Yehia, 2016).

In order to create providers who are competent in the care of GSM individuals, medical centers need to provide training in their unique health care needs. In particular, for physicians, LGBT-competency training should be part of their medical education curriculum from the very first year. Similar curricula should be in place for nurse practitioners, nurses, physician assistants, and medical assistants. Hospitals and medical centers should provide LGBT-competency training for all medical staff, and support continuing education focused on ongoing cultural competency.

The environment or physical, clinical space of an institution should be LGBT-friendly. This can be achieved by placing health information materials that are inclusive of the GSM diversity in our society, such as pamphlets that show GSM individuals or couples. Clinical spaces should display posters that also are LGBT-inclusive. Furthermore, the microenvironment of the clinical space (e.g., the health record) should also be LGBT-inclusive, and in particular, sensitive to gender minority patients. Medical providers should urge their institution to make certain that a patient’s medical record uses their preferred name and pronoun. An LGBT-friendly and competent environment can enhance the care for the LGBT community and create clinical spaces that are free from discrimination (McClain et al., 2016).

■ CONCLUSION

Social and cultural acceptance of the LGBT community has improved dramatically over the past decade. However, significant discrimination, stigmatization,
and violence still occur for GSM individuals. This discrimination has even permeated the health system and the individuals who constitute it, leading to multiple disparities in health outcomes for GSM individuals. GSM individuals may not even seek care out of fear of a negative outcome or a previous experience of discrimination or homophobia. Furthermore, even when GSM individuals decide to seek care, they may encounter an environment that is not equipped to provide LGBT-competent care. The awareness of these barriers, and the research that surrounds them, has created an environment of inquiry and provided researchers, institutions, and policy makers the opportunity to make improvements. Key stakeholders in the care of GSM individuals, such as the American College of Physicians and the American Academy of Pediatrics, have made recommendations and policy statements advocating for equal, competent, and sensitive care for the GSM population. We now know that identifying and breaking down barriers to health care for GSM individuals not only improves health outcomes for these individuals, but also reduces the discrimination and violence this community faces on a daily basis.

REFERENCES


© Springer Publishing Company


