



Understanding the Health Needs of LGBT People

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Introduction

Although social acceptance of lesbian, gay, bisexual, and transgender (LGBT) people in the United States has been improving, LGBT individuals continue to face stigma and discrimination. These negative experiences, combined with a lack of access to culturally-affirming and informed health care, result in multiple health disparities for LGBT populations. Thus, there is an urgent need to provide inclusive, high-quality health services to LGBT people so that they can achieve the highest possible level of health. Here, we review LGBT concepts and demographics, discuss health disparities affecting LGBT groups, and outline steps clinicians, health centers, and other health care organizations can take to provide patient-centered care for LGBT people.



LGBT Concepts & Terminology

To understand LGBT populations and their health needs, it is important to first define the distinct core concepts of sexual orientation and gender identity. Sexual orientation is how a person characterizes their sexual and emotional attraction to others. It can be helpful to think of sexual orientation as consisting of three dimensions – behavior, attraction, and identity. These dimensions do not necessarily overlap in a given individual. For instance, some individuals engage in same-sex sexual behavior but do not identify as lesbian, gay, or bisexual; others experience same-sex attraction but are not sexually active with members of the same sex. In two recent studies of American adults using data from the National Health and Nutrition Examination Survey (NHANES), less than half of men and women who reported sexual intercourse with members of the same sex identified as gay, lesbian, or bisexual.^{1,2} This means that health professionals cannot infer an individual's sexual identity from their behavior, and vice versa.

Given the incomplete overlap between behavior, identity, and attraction, the terms “men who have sex with men” (MSM) and “women who have sex with women” (WSW) are often used in research and public health settings to collectively describe those who engage in same-sex sexual behavior, regardless of their identity. However, patients rarely use the terms MSM or WSW to describe themselves.³ Other than “lesbian,” “gay,” or “bisexual,” some patients may prefer terms such as “queer” or “same-gender loving” to describe a non-heterosexual sexual orientation.^{4,5}

Gender identity is a person's internal sense of being a man/male, woman/female, both, neither, or another gender. Everyone has a gender identity. For most, gender identity corresponds with their assigned sex at birth. Transgender people, however, have gender identities that do not correspond with their sex at birth. Transgender persons who are assigned male sex at birth but who identify as female may call themselves transgender women, trans women, or male-to-female (MTF) persons; the terms for people assigned female sex at birth but who identify as male are transgender men, trans men, or female-to-male (FTM) persons. Transgender individuals may alter their physical appearance, often through hormonal therapy and/or surgery, in order to affirm their gender identity, though not all choose to do so. Identifying as transgender does not always mean affirming an identity that is strictly male or female. Some people feel their gender is a mix of male and female, neither male nor female, no gender at all, or another gender altogether. People whose gender identity falls outside the gender binary (male or female) may refer to themselves as genderqueer, gender fluid, non-binary, or other terms.

LGBT Demographics

It is difficult to define the size and distribution of the LGBT population. This is due to several factors, including the heterogeneity of LGBT groups; the incomplete overlap between identity, behavior, and attraction which complicates attempts to categorize individuals; the lack of research about LGBT people; and the reluctance of some individuals to answer survey questions about stigmatized identities and behaviors. However, combining results from multiple population-based surveys, researchers have estimated that approximately 3.5% of United States adults identify as lesbian, gay, or bisexual and that at least 0.3% of adults identify as transgender. This amounts to approximately 9 million individuals in the United States.⁶ Greater numbers of individuals have engaged in same-sex sexual behavior and report attraction to members of the same sex. In one national survey of 15 to 44-year-olds, 12.5% of women and 5.2% of men reported a history of same-sex sexual contact; the proportions reporting some sexual attraction to members of the same sex was 16.1% for women and 6.1% for men.⁷ In addition, the 2010 United States Census has estimated that about 646,000 households throughout the country are headed by same-sex couples.⁸ It is likely that most clinicians have encountered LGBT individuals in their practices, whether or not they are aware of patients' sexual orientations and gender identities.

LGBT Health Disparities

Health care professionals must be informed about LGBT health for two reasons. First, there is a long history of anti-LGBT bias in health care that continues to affect health-seeking behavior and access to care for LGBT individuals. Until 1973, homosexuality was listed as a disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Transgender status was included as "gender identity disorder" in the DSM up until 2013, when it was replaced by the more patient-centered term gender dysphoria.⁹ (Gender dysphoria refers to distress experienced by individuals whose gender identity does not correspond with their assigned sex at birth. It can manifest itself as clinically significant distress or impairment in social, occupational, or other important areas of functioning. Not all transgender people experience gender dysphoria.) In keeping with a pathologic understanding of homosexuality and transgender identity, many LGBT individuals were subjected to reparative therapies in the past, including electroshock treatments or castration.¹⁰ Reparative therapy has been formally disavowed by many medical and professional societies, but some LGBT patients continue to report discriminatory experiences in health care settings. Because of these experiences or the expectation of poor treatment, some LGBT patients are reluctant to reveal their sexual orientation or gender identity to their providers, despite the importance of such information for their health care.

Another reason that health care providers should be informed about LGBT health is the existence of multiple health disparities that affect these populations (Figure 1). Both an Institute of Medicine Report and the Department of Health and Human Services Healthy People 2020 initiative have documented these disparities and called for steps to address them.^{11,12} Health disparities facing LGBT populations are thought to stem from a lack of informed health care and minority stress. Minority stress refers to the discrimination, stigma, and internalized homo- and transphobia experienced by LGBT individuals in their daily lives; it has been linked to mental health problems and other adverse health outcomes.¹³ For many LGBT individuals, the minority stress they experience on the basis of sexual orientation and gender identity intersects with inequalities associated with race, ethnicity, and social class.¹⁴

Figure 1: Selected Health Disparities Among LGBT Populations.

Higher rates of HIV and other sexually transmitted infections
Lower rates of mammography and Pap smear screening
Higher rates of substance abuse
Higher rates of unhealthy weight control/perception
Higher rates of smoking
Higher rates of depression, anxiety
Higher rates of violence victimization



Members of LGBT communities are more likely than their heterosexual counterparts to experience difficulty accessing health care. Individuals in same-sex relationships have been significantly less likely than others to have health insurance, are more likely to report unmet health needs, and, for women, are less likely to have had a recent mammogram or Papanicolaou test.¹⁵ Differences in insurance coverage have resulted, at least in part, from decreased access to employer-sponsored health insurance benefits for same-sex partners and spouses.¹⁶ It remains to be seen how health insurance expansion under the Affordable Care Act (ACA), as well as the legalization of same-sex marriage throughout the country, will affect access to health care among LGBT Americans.



Sexually transmitted infections, including HIV, are major concerns in some LGBT groups, particularly MSM and transgender women. MSM account for more than two-thirds of all people diagnosed with HIV each year in the United States, despite comprising only 2% of the general population.¹⁷ Young, Black MSM, in particular, are disproportionately affected. The number of new HIV infections in this group rose by 20% from 2008 to 2010.¹⁸ The racial disparity in HIV incidence does not appear to be due to differences in unsafe sexual behavior but rather other factors, such as decreased access to antiretroviral therapy in non-white communities.¹⁹ Data on HIV rates in transgender persons are sparse, but one systematic review estimated an HIV prevalence of approximately 28% in transgender women in the United States.²⁰ Unfortunately, little is known about the risk of HIV and other sexually transmitted infections among transgender men. Aside from HIV, MSM

account for 75% of reported primary and secondary syphilis infections and more than one-third of gonorrhea infections.^{21,22} Outbreaks of hepatitis C infection transmitted by sexual contact have also been reported in HIV-infected MSM in urban areas.²³ Finally, rates of human papilloma virus-associated anal cancers among MSM are seventeen times those of heterosexual men, with even higher rates among individuals concurrently infected with HIV.²⁴

Several other health indicators and diseases are differentially distributed between LGBT and non-LGBT groups. Compared to heterosexual adults, lesbian, gay, and bisexual individuals are more than twice as likely to smoke.²⁵ Sexual minority adolescents more commonly engage in unhealthy weight control behaviors and misperceive their weight compared to their peers,²⁶ and lesbian women have a higher prevalence of overweight and obesity compared to other women.²⁷ In addition, gay, lesbian, and bisexual individuals experience more depression and anxiety than their heterosexual counterparts and are more likely to attempt suicide,²⁸ transgender populations probably also experience higher burdens of mental distress and attempted or completed suicides, although rigorous data on this subject are sparse.^{29,30} In addition, substance

use disorders affect gay, lesbian, and bisexual adults more than others.^{31,32} The higher burden of substance abuse and mental health disorders in LGBT patients is thought to stem from the need to cope with minority stress. There are few data on the incidence of cancer in LGBT groups, primarily due to failure to collect sexual orientation and gender identity information with cancer surveillance statistics. However, missed screening opportunities and the greater burden of some cancer risk factors in LGBT groups – such as smoking, alcohol abuse, and for breast cancer, nulliparity – raise concern that the incidence of certain cancers in LGBT groups may exceed that of the general population.

Finally, despite increasing social acceptance, violence and victimization related to homo- and transphobia continue to impact LGBT groups. Sexual minority high school students are more likely than their heterosexual counterparts to be threatened or injured with a weapon while at school, be bullied, and avoid school because of safety concerns.³³ LGBT adults are also victims of violence; after race and ethnicity, sexual orientation is the most common motivation for hate crimes reported to the Federal Bureau of Investigation.³⁴ Such events often produce an environment of stress and intimidation even for those not directly impacted. While the prevalence of intimate partner violence appears to be similar between same-sex and opposite-sex couples, partner abuse in LGBT relationships has been under-recognized and under-addressed by the medical community.³⁵ Intimate partner violence likely affects transgender individuals more commonly than those who are heterosexual, gay, lesbian, or bisexual.³⁶

LGBT Health Across the Life Course

There are many other issues that impact the health and well-being of LGBT individuals aside from health disparities. Getting to know one's patients as individuals who experience social, structural, and interpersonal challenges can be helpful for understanding the impact these can have on their health.

Sexual and gender minority youth face particular challenges; in addition to navigating the developmental issues faced by all adolescents, they must establish a sense of their own sexual and gender identity, decide when and to whom to “come out”, and often confront social ostracism and family rejection. In severe cases, family rejection may take the form of expelling the child from the home; this has contributed to a higher burden of homelessness among LGBT youth.³⁷ However, it is important to note that many LGBT youth, as well as adults, show remarkable resilience to life challenges. Research has shown that family acceptance of LGBT adolescents and young adults leads to greater self-esteem, social support, and better health outcomes, as well as protection against substance abuse, depression, and suicidal ideation.³⁸

LGBT adults often enter into committed romantic relationships, much like their heterosexual counterparts. Since June 2015, same-sex couples across the country have had the legal right to marry. In addition to granting same-sex couples the same material and legal benefits available



to others, access to marriage is shown to be associated with better health outcomes³⁹ and with greater feelings of social inclusion among LGBT individuals, whether or not they are married.⁴⁰

Many LGBT adults raise children or have a desire to do so. In the 2002 National Survey of Family Growth, 52% of gay men and 41% of lesbian women expressed a desire to have children.⁴¹ Approximately 19% of gay and bisexual men and 49% of lesbian and bisexual women report having had a child.⁴² The pathways to becoming a parent for lesbian and gay couples vary. In some cases, children being raised by same-sex couples are the products of previous, opposite-sex relationships,⁴³ although this number may be decreasing as individuals come out at younger ages. Otherwise, fostering and adoption, as well as donor insemination and surrogacy, provide potential pathways to child-rearing.

Beyond marriage and child-rearing, LGBT individuals face unique challenges as they age. Today's LGBT seniors grew up in periods of less social acceptance of LGBT people, and thus may harbor greater fears of stigma and discrimination than their younger counterparts. Such fears may become particularly acute when LGBT elders are no longer able to live independently and must move into communal housing arrangements or avail themselves of social services, prompting some to newly conceal their sexual orientation after years of living openly.⁴⁴ Because they are less likely to have children, LGBT elders may have fewer options for family support in the face of illness and disability. Older adulthood may also be more economically precarious for partnered but unmarried LGBT individuals, as they do not have access to spousal, survival, or death benefits through Social Security, and thus may be impoverished by the death of a partner. These challenges notwithstanding, many LGBT persons demonstrate resilience as they age. Indeed, a majority of respondents in one survey of aging LGBT individuals felt that their LGBT status had prepared them for aging by fostering inner strength.⁴⁵

Creating an Inclusive Environment

How can health centers begin to address the health needs of their LGBT patients? The first step is to create an environment inclusive of all LGBT people. LGBT patients report that they often search for subtle cues in the environment to determine acceptance.⁴⁶ Simple changes in forms, signage, and office practices can go far in making LGBT individuals feel welcome.⁴⁷ For instance, intake forms can be revised to include sexual orientation and gender identity. The Institute of Medicine recommends inclusion of structured data fields to obtain information on sexual orientation and gender identity as part of electronic health records. As of 2016, HRSA (Health Resources & Services Administration) requires health centers to report sexual orientation and gender identity data in the uniform data system. Whether obtained via face-to-face history-taking, paper forms, or secure electronic mechanisms, information on sexual orientation and gender identity permits clinicians to identify their LGBT patient, and thus better meet their health needs. Regardless of how it is obtained, it is critical to assure both appropriate use of the information and confidentiality.

Health care settings should also develop and prominently display non-discrimination policies that include sexual orientation, gender identity, and gender expression; this is a requirement for organizations accredited by the Joint Commission. All staff members, including receptionists, medical assistants, nurses, and physicians, can be trained to interact respectfully with LGBT patients, including using patients' preferred names and pronouns. Educational brochures on LGBT health topics can be made available where other patient information materials are displayed.^{48,49} The Joint Commission has recommended these and other approaches in a field guide; it can serve as a self-assessment tool for clinicians or health centers seeking to become more inclusive.⁵⁰ Since 2011, all health care organizations participating in Medicare or Medicaid are required to allow patients to decide themselves who may visit them or make medical decisions on their behalf, regardless of sexual orientation or gender identity.

LGBT-Affirming Clinical Encounters

Beyond environmental cues and LGBT-inclusive policies, clinicians can also make strides in improving the health of their LGBT patients by fostering a welcoming environment within the examination room and by educating themselves about LGBT health topics. Taking an open, non-judgmental sexual and social history is key to building trust with LGBT patients. Rather than making assumptions about patients based on appearance or sexual behavior, clinicians should ask open-ended questions, mirroring the terms and pronouns patients use to describe themselves. For example rather than asking a patient: "Are you married?" or "Do you have a boy/girlfriend?", consider asking "Do you have a partner?" or "Are you in a relationship?", and "What do you call your partner?" Such questions allow clinicians to initiate a discussion about

relationships and sexual behavior without assuming heterosexuality. In the process of obtaining information on sexual orientation and gender identity, it may become clear that clinicians are some of the first individuals to whom patients have disclosed their non-heterosexual identity or transgender status. Reassuring responses from health care providers may thus be important for patients in the nascent stages of coming out. However, coming out is an individual process, unique to each person’s family and social circumstances, and aside from providing support, clinicians should be wary about encouraging or discouraging the pace or form of this process.

Not all clinicians can become experts in LGBT health, but they should learn to address some of the specific health concerns of this population.⁵¹ Training about LGBT health is sparse in medical schools; a recent report demonstrated that a median of only five hours during all of clinical training was devoted to LGBT issues at United States and Canadian medical schools.⁵² In the absence of formal instruction in this area, clinicians can turn to multiple national guidelines and recommendations. For instance, the Centers for Disease Control and Prevention (CDC) provide recommendations on the screening for and prevention of sexually transmitted infections in MSM.⁵³ These include yearly screening for HIV, syphilis, gonorrhea, and chlamydia; the recommended screening interval is shortened to three to six months for those at particularly high risk, such as individuals with multiple or anonymous sexual partners or those who use illicit drugs in conjunction with sex (Figure 2). Hepatitis A and B vaccination is also recommended for all MSM.

Figure 2: Recommended Annual[†] Sexual Health Screening for MSM (CDC)

HIV Serology
Syphilis serology
Urine NAAT* for <i>N. gonorrhoeae</i> and <i>C. trachomatis</i> for those who had insertive intercourse in the past year
Rectal NAAT* for <i>N. gonorrhoeae</i> and <i>C. trachomatis</i> for those who had receptive anal intercourse in the past year
Pharyngeal NAAT for <i>N. gonorrhoeae</i> for those with a history of receptive oral intercourse in the past year**

* Nucleic acid amplification test.

** Pharyngeal testing is not recommended for *C. trachomatis*.

† The screening interval is shortened to 3-6 months for those with multiple or anonymous sex partners or those who use drugs in association with sex.

Given the high rates of HPV-associated anal cancers in MSM, especially those with HIV, some authorities recommend anal cytology screening for such patients, followed by high-resolution anoscopy when abnormalities are found; however, the utility of screening has not yet been demonstrated in a clinical trial.⁵⁴ The CDC recommendations differ from those of the United States Preventive Services Task Force (USPSTF), which support HIV and syphilis but not chlamydia and gonorrhea screening for MSM. The ACA has adopted the USPSTF's recommendations as the basis for reimbursement; it is unclear if this will jeopardize payment for CDC-recommended services.⁵⁵ Lesbians and bisexual women should be screened with Papanicolaou smears as indicated for all women, as should transgender men who have not had surgical removal of the cervix. There are no formal guidelines regarding screening for sexually transmitted infections in lesbians or bisexual women or in transgender persons. Providers should screen these individuals based on their risk factors, as determined through a careful sexual history.

Given the high incidence of HIV in some LGBT populations, HIV prevention constitutes a critical aspect of the care of many LGBT patients. In addition to safer sex counseling and the identification and treatment of sexually transmitted

infections, non-occupational post-exposure prophylaxis (nPEP) and pre-exposure prophylaxis (PrEP) are recommended by the CDC for individuals with a high risk of HIV infection. nPEP refers to the use of antiretrovirals following a sexual exposure to HIV. Therapy must begin within 72 hours of exposure and is typically continued for four weeks.⁵⁶ Providers uncomfortable prescribing nPEP themselves should identify a local resource to which patients can be referred in a timely manner; emergency departments are often able to provide this service. PrEP consists of daily antiretrovirals taken in advance of sexual exposure along with provision of condoms and safer sex counseling.⁵⁷ Providers can access clinical practice guidelines on the use of PrEP from the CDC (cdc.gov/hiv/prep).

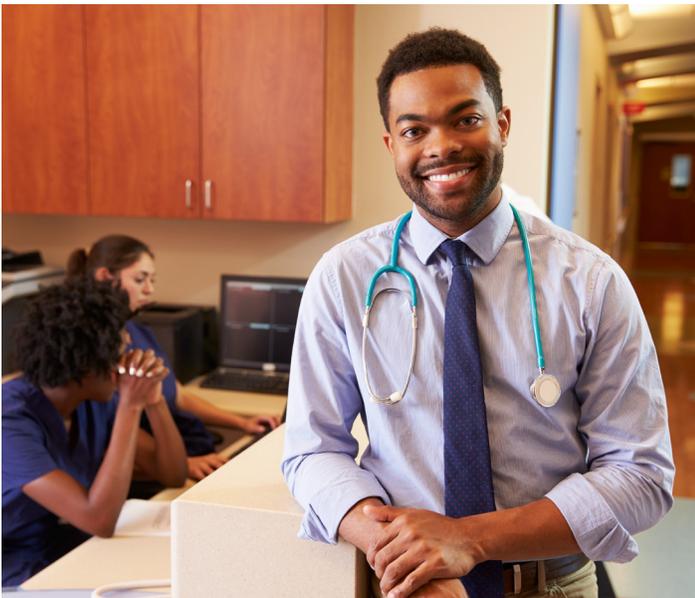
Resources are also available to assist providers in learning about the care of transgender patients. Online primary care protocols for

transgender patients are available from the Center of Excellence for Transgender Health (www.transhealth.ucsf.edu). The National LGBT Health Education Center offers an online transgender health course for medical providers as well as other transgender-specific training materials (www.lgbthealtheducation.org). In addition, the World Professional Association for Transgender



Health offers Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (www.wpath.org). An area of particular confusion for many primary care providers is cancer risk and prevention in transgender patients. In general, transgender persons who have not undergone gender-affirmative surgeries or used hormonal therapy should be screened for prostate, breast, or cervical cancer according to established guidelines for their assigned sex at birth. Use of an anatomic inventory, which documents which organs a patient has at the current time, may help ensure that the appropriate screening tests are recommended and performed.⁵⁸ However, for those patients who have undergone surgery or hormonal treatments, screening recommendations must be modified. For instance, mammography is suggested for male-to-female transgender persons over age 50 who have taken feminizing hormones for more than five years due to a theoretically increased risk for breast cancer, and Papanicolaou smears are not indicated in the assessment of surgically-constructed neovaginas.⁵⁹ Female-to-male transgender individuals who have had chest reconstruction should still have yearly chest wall screening and axillary examinations in light of the small possibility of developing cancer in residual tissue.

Conclusion



The success of health care organizations of all types—from health centers and hospitals to academic medical centers and the many community-based services with which they work—depends on providing high-quality and effective care while keeping costs in check. In the case of LGBT people, successful health care organizations must end LGBT invisibility by identifying the sexual orientation and gender identity of their patients and then using this knowledge to address the issues of greatest concern for the care of LGBT patients. These include behavioral health, HIV prevention, and transgender care. However, in many ways providing culturally competent care to LGBT patients does not differ from providing patient-centered care to any other group. As with all patient populations, effectively serving LGBT patients requires clinicians to understand the cultural context of their patients' lives, modify practice policies and environments to be inclusive, take detailed and non-judgmental histories, educate themselves about the

health issues of importance to their patients, and reflect upon personal attitudes that might prevent them from providing the kind of affirmative care that LGBT people need. By taking these steps, clinicians will help ensure that their LGBT patients, and indeed all their patients, attain the highest possible level of health.

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Resources

The Fenway Guide to LGBT Health, 2nd edition. American College of Physicians. 2015. www.acponline.org/fenway

Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide. The Joint Commission. 2011. www.jointcommission.org/lgbt

The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. Institute of Medicine Report. 2011. <http://iom.nationalacademies.org/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx>

Healthy People 2020 LGBT Health - <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health>

Center of Excellence for Transgender Health - www.transhealth.ucsf.edu

World Professional Association for Transgender Health - www.wpath.org

The National LGBT Health Education Center, www.lgbthealtheducation.org, has online webinars and learning modules, as well as the following publications:

- Ten Things: Creating Inclusive Health Care Environments for LGBT People
- Collecting Sexual Orientation and Gender Identity Data in Electronic Health Records: Taking the Next Steps
- Do Ask, Do Tell: Talking to your provider about being LGBT

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