Promoting the Health of Gender and Sexual Minorities

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- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a physician or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

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Faculty Disclosure

Contributing faculty, Leslie Bakker, RN, MSN, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for all members of the interdisciplinary team, including physicians and nurses, working in all practice settings.

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Course Objective

More individuals who identify as gender and sexual minorities and their families want culturally appropriate information as well as support and referral. The purpose of this course is to provide healthcare professionals with strategies that promote cultural competency when treating and caring for these patients, supporting the concept of patient-centered care.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define multiple terms related to the concept of sexual identity.
2. Define heterosexism and homophobia and identify how they may be barriers to increasing professional awareness of gender and sexual minorities (GSM).
3. Summarize myths related to the GSM population.
4. Describe research challenges related to the GSM population.
5. Describe select theoretical models related to the development of one's sexual identity (the "coming-out" process).
6. Cite unique health and safety concerns experienced by the GSM population and available resources that healthcare professionals can provide to these patients and their families.
7. Identify culturally appropriate strategies useful for implementing skills, including the application of crosscultural communication.

EVIDENCE-BASED PRACTICE RECOMMENDATION

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

The gender and sexual minority (GSM) population has been acknowledged in healthcare professional literature as "invisible," "hidden," "stigmatized," and "marginalized" and recognized as having difficulty accessing health care, receiving inferior care, or actually being denied care [1; 2]. However, changes in our society have increased awareness about and visibility of the GSM community. Perhaps as a result of these changes, more individuals are "coming out" to their families and friends. GSM youth are questioning their identity or coming out at younger ages than before. As we learn more about the GSM community, the image of a GSM person is changing from an image of one who is lonely, depressed, or ill to one who is a well-adjusted, contributing citizen. More GSM individuals and their families want culturally appropriate information as well as support and referral.

This course brings no expectation that the reader change personal values or beliefs about sexuality or sexual identity. However, it is the hope of the author that reading this course will contribute to the professional's ability to provide culturally competent care for GSM individuals while meeting professional, legal, and ethical responsibilities.

CULTURALLY COMPETENT CARE

Because the GSM population has been considered a subculture in professional literature, a discussion of culturally competent care is fitting. Culturally competent care has been defined as "care that takes into account issues related to diversity, marginalization, and vulnerability due to culture, race, gender, and sexual orientation" [3]. A culturally competent person is someone who is aware of how being different from the norm can be marginalizing and how this marginalization may affect seeking or receiving health care [3]. To be effective crossculturally with any diverse group, healthcare professionals must have awareness, sensitivity, and knowledge about the culture involved, enhanced by the use of cross-cultural communication skills [4; 5].

Healthcare professionals are accustomed to working to promote the healthy physical and psychosocial development and well-being of individuals within the context of the greater community. For years, these same professionals have been identifying at-risk populations and developing programs or making referrals to resources to promote the health and safety of at-risk groups. But, because of the general assumption that individuals are heterosexual, and because of social stigmatization and marginalization, GSM individuals remain comparatively invisible in the healthcare system [4]. GSM youth and GSM elderly, for example, have been called "hidden" [6; 7].

DIVERSITY IN THE GSM COMMUNITY

The GSM population, like the general U.S. population, is a diverse group that may be defined as a subculture, which includes all ages of gay men, lesbian women, bisexual and transgender individuals, and those questioning their sexual identity. Ethnic or racial and cultural backgrounds, education, income, and places of residence further diversify this subculture. One's intrapersonal acceptance or rejection of societal stereotypes and prejudices, the acceptance of one's self-identity as a sexual minority, and how much one affiliates with other members of the GSM community varies greatly among individuals [8]. Some authors stress the diversity within the GSM community by discussing "GSM populations" [9]. For example, it is understandable that a GSM population living in rural areas of the United States would have little in common with a GSM population living in urban areas or "gay-friendly" neighborhoods. Additionally, mental health experts have suggested that "GSM community" symbolizes a single group of individuals who express their sexuality differently than the majority of heterosexual individuals. However, four distinct communities have been identified: lesbian, gay, bisexual, and transgender [10]. Each community is different from the other as well as different from the heterosexual community. A culturally competent healthcare provider should keep this diversity in mind so that vital differences among these smaller groups are not lost when thinking of the GSM population in general.

Commonalities exist among the GSM communities as well. For example, many adolescents, whether gay, lesbian, bisexual, transgender, or questioning their sexual identity, lack sexual minority role models to assist with successful psychosocial development [10].

PROFESSIONAL LITERATURE AND THE GSM POPULATION

Until recently, most professional literature about the GSM population was limited to psychology and sociology publications, with a focus on the prevalence of illnesses in the GSM community, such as depression, suicide, chemical dependency, and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) [8]. Though some information has been gathered, researchers have indicated that much more research and literature development must be done [10]. A body of knowledge related to sexual minority youth has been developed, but scant knowledge exists that addresses aging sexual minorities.

Textbooks and curricula in some professional education programs have begun to include information about the GSM community and its health needs, both medical and psychosocial. Illustrations used in classroom discussions about special populations include GSM populations as well as examples drawn from racial, ethnic, and other diverse groups. In the United States, the media has been presenting healthy portrayals of gay characters (younger characters more so than elderly, however). Still, many GSM individuals have not revealed their sexual identity or suspicion about being a sexual minority. As a result, their unique health and safety needs have been less understood by healthcare professionals, educators, counselors, and others.

A growing number of professional organizations have called for the development of more information about sexual minorities [9; 11; 12; 13; 14; 15]:

- The American Academy of Nurses has recommended that there be "development of knowledge related to healthcare of minority, stigmatized, and disenfranchised populations."
- The National Institutes of Health has called for research related to sexual minority health.
- Healthy People 2030 has included gays, lesbians, and transgender individuals among the targeted groups for reducing health outcome disparities.
- The Gay and Lesbian Medical Association and Columbia University's Mailman School of Public Health has also successfully lobbied for inclusion of the research needs of gays and lesbians.
- A 2007 resolution issued by the American Medical Association (AMA) has called for more information about the GSM population and recommended that its health needs become a part of the healthcare professional's education.
- An Institute of Medicine committee has been tasked with identifying research gaps and opportunities regarding gay/transgender health and preparing a research agenda to help the National Institutes of Health improve research and training in this field.

DEFINITIONS

Clear definitions of the concepts related to sexual identity will be helpful. The following is a glossary of terms used throughout this course [16; 17; 18; 19; 20; 21]:

Asexual: An individual who does not experience sexual attraction. There is considerable diversity in individuals' desire (or lack thereof) for romantic or other relationships.

Aging gay/GSM population: While no clear definition exists, the Centers for Disease Control and Prevention (CDC) uses the age of 65 years or older as a cutoff when talking about aging individuals.

Bisexual: An adjective that refers to people who relate sexually and affectionately to both women and men.

Coming-out process: A process by which an individual, in the face of societal stigma, moves from denial to acknowledging his/her sexual orientation. Successful resolution leads to self-acceptance. Coming out is a lifelong process for lesbian, gay, bisexual, and transgender persons and their families and friends as they begin to tell others at work, in school, at church, and in their communities.

Gay: The umbrella term for GSM persons, although it most specifically refers to men who are attracted to and love men. It is equally acceptable and more accurate to refer to gay women as "lesbians."

Gender and sexual minorities (GSM): A term meant to encompass lesbian, gay, bisexual, trans, queer/questioning, intersex/intergender, asexual/ally (LGBTQIA) people as well as less well-recognized groups, including aromantic, two-spirited, and gender-fluid persons.

Heterosexism: An institutional and societal reinforcement of heterosexuality as the privileged and powerful norm.

Heterosexuality: Erotic feelings, attitudes, values, attraction, arousal, and/or physical contact with partners of the opposite gender.

Homophobia: A negative attitude or fear of nonstraight sexuality or GSM individuals. This may be internalized in the form of negative feelings toward oneself and self-hatred. Called "internalized homophobia," it may be manifested by fear of discovery, denial, or discomfort with being LGBTQIA, low self-esteem, aggression against other lesbians and gay men, or exaggerated gay pride and rejection of all heterosexuals.

Homosexuality: The "persistent sexual and emotional attraction to members of one's own gender" as part of the continuum of sexual expression. Typically not used to describe people.

LGBTQIA: An acronym used to refer to the lesbian, gay, bisexual, transgender/transsexual, queer/questioning, intersex/intergender, asexual/ally community. In some cases, the acronym may be shortened for ease of use or lengthened for inclusivity. Members of this group may also be referred to as gender and sexual minorities (GSM).

Sexual identity: The inner sense of oneself as a sexual being, including how one identifies in terms of gender and sexual orientation.

Sexual minority youth: Sexual minority youth are those who self-identify with any nonheterosexual orientation or whose gender experience runs contrary to norms. The term is often used to refer to lesbian, gay, bisexual, and transgender youth.

Sexual orientation: An enduring emotional, romantic, sexual, and/or affectionate attraction to another person. Individuals may experience this attraction to someone of the same gender, the opposite gender, or all genders.

Transgender: An umbrella term describing a number of distinct gender positions and identities including: crossdressing, transsexual, nonbinary, and intersex.

HOMOPHOBIA, HETEROSEXISM, AND INTERNALIZED HOMOPHOBIA

Within the general public, controversy associated with the words "homophobia," "heterosexism," and "internalized homophobia" exists. Having an opportunity to consider these terms is necessary to enhance the development of culturally competent care and the application of communication skills. Professional literature has frequently combined the use of the terms "heterosexism and homophobia" when discussing the LGBTQIA subculture, both for the sake of clarity and to emphasize that the terms do not carry the same meanings. Although absolute, universal definitions of the terms are still evolving, a general understanding exists and they are widely used in social science literature, by policy makers, and in the judiciary [16]. They have also been applied in the literature for health professionals.

Discussions regarding the conceptualization and operationalization of these terms, and many others related to homosexuality, have been taking place in an effort to clarify definitions [8; 22]. The words used when discussing homosexuality and the LGBTQIA experience may have political tones, so they must be used carefully [22].

Much professional literature has documented the negative social attitudes toward sexual minorities [23]. These negative attitudes have been frequently referred to as "homophobia." The term was coined in 1967 and defined very specifically as "the dread of being in close quarters with [gay people]...the revulsion toward [gay people] and often the desire to inflict punishment as retribution" [16]. Some in the general population believe that the word "homophobia" always includes a component of violence. The condition was classified as a phobia and operationalized as a prejudice. The phobia manifests as antagonism directed toward a particular group of people, leading to disdain and mistreatment of them [16].

Some individuals in the general population deny that they are homophobic on the basis that they do not condone violence. However, it has been suggested that individuals may be homophobic even when they do not support violence [24]. Additional examples of homophobia include when individuals feel: anxious and afraid, thinking that they may be perceived as gay or lesbian by others; anxious or repulsed when they find themselves attracted to a person of their own sex; or fearful that they have gay or bisexual tendencies [24].

A more appropriate term for the phenomenon of negative social attitudes may be "heterosexism" because it focuses on the normalization and giving of privilege to heterosexuality [25]. The term encompasses the prejudice and social stigma from institutional and interpersonal sources encountered by sexual minorities, including a range of discriminatory experiences, not only those related to phobias and violence [26]. Implicit and explicit forms of discrimination have been included in the definition of heterosexism. For example, the use of noninclusive questions while conducting a patient's sexual history could be considered implicit discrimination because the questions reflect a possible lack of awareness and inclusivity. Mean-spirited, antigay statements or actions by an individual or an institution could be considered explicit discrimination because the action is undeniably direct. A hospital visitation policy that prevents GSM individuals from visiting their partners is another form of discrimination included in the definition of heterosexism.

The subtle and pervasive ways that discomfort with GSM individuals may be manifested have been examined and, in some instances, categorized as "cultural heterosexism," which is characterized by the stigmatization in thinking and actions found in our nation's cultural institutions, such as our educational and legal systems [27]. "Cultural heterosexism fosters individual antigay attitudes by providing a ready-made system of values and stereotypical beliefs that justify such prejudice as natural" [28]. Perhaps the paucity of information about the GSM commu-

nity in basic professional education textbooks has been a reflection of cultural heterosexism. Writers, funding sources, and publishers have been exposed to the same cultural institutions for many years.

Individuals generally begin to absorb these institutional attitudes as children and may consequently develop "psychological heterosexism," which may also manifest as antigay prejudice. Many individuals, as children, have little contact with someone who is openly gay and, as a result, may not be able to associate homosexuality with an actual person. Instead, they may associate it with concepts such as "sin," "sickness," "predator," "outsider," or some other negative characteristic from which the individual wants to maintain distance [28]. Psychological heterosexism involves (among other factors) considering sexual identity and determining that one does not want to think further about it. The direction of this thinking is undeniably negative, resulting in an environment that allows antigay hostility [28]. The impact of antigay prejudice on the physical and mental health of members of the LGBTQIA community and their families should not be underestimated [1; 29].

Sexual minority individuals also are not immune to societal attitudes and may internalize negative aspects of the antigay prejudice experience. Anxiety, depression, social withdrawal, and other reactions may result [4; 30]. While the study of psychological heterosexism, both blatant and subtle, is in the early stages of research, it has had a measurable impact on the mental health of the GSM community [22; 31; 32; 33].

Examples of the range of manifestations of heterosexism and/or homophobia in our society are readily available. Without difficulty, each example presented here may be conceptualized as related to the emotional or physical health of a GSM individual or family member:

- A kindergarten student calls another child an LGBTQ+ slur but does not really know what he is saying.
- A teenage woman allows herself to become pregnant, "proving" her heterosexuality to herself, her family, and her friends.
- A parent worries that her 12-year-old daughter is still a "tomboy."
- An office employee decides to place a photo of an old boyfriend in her office rather than a photo of her partner of 5 years.
- A college student buries himself in his studies in an effort to ignore his same-sex feelings and replace feelings of isolation.
- Two teenage women, thought by peers to be transgender individuals, are assaulted and killed while sitting together in an automobile.
- A female patient is told by a healthcare provider that her haircut makes her look like a lesbian and is examined roughly.
- A gay man chooses not to reveal his sexual identity to his healthcare provider out of fear of a reduction or withdrawal of healthcare services.

The manifestations of heterosexism and homophobia have inhibited our learning about the LGBTQIA population and its needs [9]. Gay patients have feared open discussion about their health needs because of potential negative reactions to their self-disclosure. Prejudice has impacted research efforts by limiting available funding [8]. All of these factors emphasize that the healthcare education system has failed to educate providers and researchers about the unique aspects of LGBTQIA health [29; 34].

MYTHS AND FACTS

Many myths surround homosexuality; a few are outlined below. The origin of these myths may be better understood after examining the history of homosexuality as well as the attitudes toward human sexuality in general. The history of the development of societal norms related to homosexuality includes misconceptions developed during times when research was not available on which to build a scientific knowledge base [1; 35; 36; 37].

Myth: Sexual orientation is a choice.

Fact: No consensus exists among scientists about the reasons that an individual develops his/her sexual orientation. Some research has shown that the bodies and brains of gay men and women differ subtly in structure and function from their heterosexual counterparts; however, no findings have conclusively shown that sexual orientation is determined by any particular factor or set of factors. Many people confuse sexual orientation with sexual identity. The reader may consider reviewing the definitions of these terms when further considering this myth.

Myth: Gay men and lesbians can be easily identified because they have distinctive characteristics.

Fact: Most gay and lesbian individuals conform to the majority of society in the way they dress and act. While some gay men and lesbian women may fit the stereotypes that society holds, LGBTQIA individuals generally look and act like everyone else. Most people never suspect the sexual orientation of a GSM individual.

Myth: Gay individuals are child molesters.

Fact: According to experts in the field of sexual abuse, the vast majority of those who molest children are heterosexual. The average offender is a White heterosexual man whom the child knows.

Myth: Gay people want to come into our schools and recruit our children to their "lifestyle."

Fact: There have been efforts to bring issues related to LGBTQIA history and rights into schools but certainly not to convert anyone. The intent has been to teach adolescents not to mistreat gay and lesbian classmates who are often the subjects of harassment and physical attacks. There is no evidence that people could be "recruited" to a gay sexual orientation, even if someone wanted to do this.

RESEARCH CHALLENGES

The relative lack of professional information about the GSM community reflects the entrenched attitudes of the greater society. Clearly, the call for knowledge development through research is present and needed to prevent the continued stigmatization of the GSM population. Groups that are stigmatized often are mistrustful of the research process. A number of other barriers to conducting research that results in reliable and valid information exist. The following four barriers have been identified as needing urgent attention [6; 7; 8].

First, establish clear definitions of the populations. Because there is no consensus on the definitions, it is impossible to accurately estimate the percentage of the population that would be classified as gay or lesbian. For example, the 2010 U.S. Census counted same-sex couples but did not count single gays or lesbians. Estimates of these singles range from 2% to 20% of the U.S. population [8; 38; 39]. Community survey data for 2019 indicates that 980,000 households in the United States were same-sex couple households (about 1.5% of total coupled households). Among these, approximately 58% consisted of married couples and 42% consisted of unmarried partner households [39]. For 2020, the census form included separate categories for

"opposite-sex" and "same-sex" spouses and unmarried partners; however, the U.S. Census Bureau does not ask individuals about their sexual orientation or gender identity [40]. While different definitions and measures of sexual orientation have been used since the 1860s, the definition of sexual orientation should include self-identity, behavior, emotional attractions, cultural affiliation, and those aspects of sexual orientation that may change across developmental periods [16]. The term "transgender" is also difficult to define and measure, partly because it has been less examined than other terms, such as "heterosexual," "homosexual," "bisexual," "gay," or "lesbian." Generally, the term "transgender" includes several populations, including transsexuals and crossdressers. Further defining each of these populations creates additional challenges [8]. Consensus on the definitions of "youth" and "elderly" and other demographic terms is needed as well.

Second, construct valid and reliable measures of sexual orientation and transgender identity that accurately represent their definitions. Without clear conceptual definitions, development of valid and reliable measures is difficult to achieve. Different measures exist, but there is no consensus. In addition, there is limited literature discussing when and where the measures should be used [8].

Third, sample rare and hidden populations [8]. Large-scale random surveys are expensive, and researchers often must conduct smaller studies and use samples of convenience [9]. This sampling method may result in biased and uninformative data. For example, studies examining the prevalence of suicide among lesbian and gay youths and adults have yielded inconsistent results, in part because of the absence of good data. Additionally, researchers have had to rely on retrospective data from individuals after they self-label, disclose, and volunteer to participate in research projects [41]. Other factors may also impact sampling. For example, while studying GSM elderly, qualitative research sampling has been affected by deaths and memory changes, resulting in incomplete interviews [42].

Homophobia and heterosexism place LGBTQIA studies outside the mainstream in terms of importance as well as allocation of resources [9]. While difficulties with sampling have been used as a rationale for denying funding for research into LGBTQIA matters, effective sampling methods have been developed for surveying other rare populations, for example, ethnic minority groups or age groups [8]. These same methods can be used with the LGBTQIA community [9].

The fourth challenge is to undertake the study of sensitive topics [8]. Sensitive research has been defined as "studies in which there are potential consequences or implications, either directly for the participants in the research or for the class of individuals represented by the research" [43]. Clearly, research related to the LGBTQIA community must be considered sensitive, especially as the research relates to health. Subjects may have unresolved health issues relating to their sexual identity, they may find it difficult to reveal their sexual orientation or transgender identity, or they may be concerned about violence or discrimination if their responses are not kept confidential [44]. Also, because some states consider certain sexual behaviors illegal (despite many existing state laws, including sodomy laws, being invalidated by the Supreme Court), revealing one's sexual orientation could result in legal action or discrimination [9; 43]. Maintaining confidentiality is vital. One study suggests that online approaches to sensitive social research (e.g., online surveys) may provide opportunities to make visible the "silenced and invisible voices" of both the GSM and other marginalized, hard-to-access populations in an environment that is safe and provides anonymity [45].

SEXUAL IDENTITY MODELS

Understanding gay identity development is required to provide adequate care for LGBTQIA youth [46]. This is applicable to all ages of LGBTQIA individuals.

Interest in the study of sexual identity development substantially increased in 1969, which is generally accepted as the year that the Gay Liberation Movement was born [47]. In the early morning hours of June 28, New York City police raided the Stonewall Inn, a known gay bar in New York's Greenwich Village. The police conducted a "routine" raid of the bar, making arrests. Gays had been accustomed to this oppressive action, but on that morning, the bar patrons and their supporters fought back [47]. The same thing happened the next evening, but the crowds had grown in number, strength, and unity. Those events, known as the "Stonewall Riots," created movement toward awareness of the LGBTQIA community, its concerns, and its needs. This and subsequent events led to an increase of GSM individuals identifying themselves to family, friends, and others. Interest in the concept of sexual identity and its development also subsequently grew.

Some knowledge of this watershed event helps to explain the increased awareness of the LGBTQIA community, which includes the study of the sexual identity development process. Conducting research about this process is difficult because the developmental task of establishing personal identity, which includes establishing sexual identity, may not yet have been completed. Consequently, LGBTQIA youth may be unaware of or unclear about their sexual identity.

Coming-out models have generated much interest in developmental concerns related to sexual identity, thus bringing attention to gay and lesbian youth. However, the models may not be applicable to all individuals. The models, which have been developed from exclusively male samples, have not fully considered the diversity that exists among individuals of different backgrounds, ethnicities, and genders. Using theoretical models with female sexual minority samples has not always been helpful. Using data from young men also has been problematic because not all young men use sex to help them determine their identity; rather, they often know who they are prior to engaging in gay sex [41].

Initially proposed more than 30 years ago, coming-out models describe the arrival of same-sex identity by means of a series of steps or stages. These stages delineate when, in the development of same-sex identity, recognition of, making sense of, naming, and publicizing oneself as lesbian or gay occurs. The models are nearly universal in their stage sequence regarding the ways that LGBTQIA youth move from a private, at times unknown, same-sex sexuality to a public, integrated sexuality. Development has been generally perceived as linear and universal among individuals who share some real or hypothesized commonalities. Bisexuality has been seldom addressed in the models [41].

CASS MODEL

Cass was the first to articulate a model of LGBTQ identity [48]. Believing that individuals have an active role in the acquisition of a LGBTQ identity, Cass suggested that individuals pass through six non-age-specific stages [48]:

- Identity confusion: The individual is conscious of being different.
- Identity comparison: The individual believes that he or she may be LGBTQ but attempts to act heterosexual.
- Identity tolerance: The individual realizes that he or she is LGBTQ.
- Identity acceptance: The individual begins to explore the GSM community.
- Identity pride: The individual becomes active in the GSM community.
- Identity synthesis: The individual fully accepts himself or herself and other LGBTQ individuals.

Cass believed that individuals could be in more than one stage at a time and that they could return to a stage already passed through without it being considered regression.

TROIDEN MODEL

In 1989, Troiden posited four age-specific stages in the LGBTQ identity process, which contrasted with Cass's non-age-specific stages [49]. Troiden's four stages are: sensitization, identity confusion, identity assumption, and commitment. The sensitization stage, which begins before puberty, finds the individual experiencing LGBTQ feelings without understanding the implications for self-identity. The identity confusion stage, which occurs during adolescence, is when the individual realizes that he or she may be LGBTQ. During the identity assumption stage, the individual comes out as a GSM person, usually first to the LGBTQ community and later to the heterosexual community. During the commitment stage, the individual lives as a GSM individual.

OTHER MODELS

Other models have been developed, as well. For example, it has been suggested that the Kübler-Ross theory of grieving might serve as a sexual identity model [50; 51]. While the stages of grieving (i.e., denial, anger, etc.) are not clearly demarcated, the Kübler-Ross model has been helpful to understanding what an individual experiences during the coming-out process. The model has also been useful to understanding the responses of family members to self-disclosure by a LGBTQIA individual [41].

Regardless of the model considered, many LGBTQIA youth become aware that they are experiencing sexual thoughts and feelings different from those of their peers at a time when they are trying to master the developmental tasks of adolescence, including achievement of identity, self-esteem, and social skills [52]. While gay adolescents must go through the same developmental tasks as heterosexual adolescents, GSM youth have additional identity development factors to incorporate into their self-concept [53]. For example, they are forced to learn to manage a stigmatized identity often without active support and modeling from their parents and family [54]. Thus, a GSM youth is trying to manage at least two tasks simultaneously: human maturation and establishment of self-identity as a sexual minority youth. A GSM youth from a racial minority is working concurrently on a third task related to developing personal identity, that of incorporating a racial identity into the personal identity.

Little research has examined the influence that ethnicity has on sexual identity development. Because the social category of ethnicity includes a complex interaction of factors, such as culture, religion, family, country of origin, and social experience, researchers have found it difficult to identify which of these factors is responsible for the observed differences being studied. In an effort to begin to identify general ethnic group differences and to create a foundation for research of the factors that influence ethnic and sexual minority development, some researchers have begun exploring the aspects of sexual identity development among male youths. They have found that Latino youth may report the earliest awareness of same sex attractions because of the role that masculinity plays in their culture. For these youth, as well as for African American and Asian American youths, the process of developing one's sexual identity cannot be well understood through the application of the traditional models discussed earlier. This is because these models suggest a uniform timing and sequencing of "coming out" events that has not been demonstrated in these minority youth populations [55; 56].

Table 1 and ***Table 2*** present select summary statements from the research related to ethnic sexual minority male youths [55]. These summary statements do not capture human differences or explain the development of or role of cultural norms that should be kept in mind while considering ethnic sexual identity development.

COMMON DEVELOPMENT EXPERIENCES	
Milestone	**Findings**
Timing of development milestones	All ethnic groups included in the sample (e.g., White, African American, Latino, Asian American) experienced the following timing in a similar way.
Same sex attractions	15 to 17 years of age
First disclosure	Usually about 17 years of age to a close female or gay friend
Disclosure to family	Common experience in that the timing differed
Internalized homophobia	No increased level noted in this sample population, contrary to the authors' predictions.
Integration of ethnic and sexual identities	Many youths reported that they felt pressure to choose between their ethnic and sexual identities. About half of the ethnic minority youths felt that they fully accepted their ethnic and sexual identities.
Same-sex romantic and sexual involvement	Rates of sexual involvement were a function of age and disclosure. Findings suggested that youths of all ethnic groups develop same-sex relationships after they disclose their identity to others. No ethnic differences emerged in rates of same-sex involvement.
Source: [55]	*Table 1*

ETHNIC-SPECIFIC DEVELOPMENTAL EXPERIENCES	
Milestone	**Findings**
Timing of identity milestones	Latino youths reported earlier awareness of same-sex attractions than African American and White youths.
Sequencing of identity milestones	Most African American youths in the sample engaged in sex before labeling their sexual identity. Asian American youths overwhelmingly engaged in sex only after labeling themselves as gay or bisexual. Asian American gay and bisexual youths reported first engaging in sex with men about three years later than all other youths.
Disclosure to family members	Less than half of ethnic-minority youths reported disclosure to family members, even though models of sexual identity development presume that disclosure to family members is a necessary milestone in the development of a positive sexual identity. Silence about sexuality among Asian American families and the rigid gender roles in Latino families may lead to increased rates of internalized homophobia in addition to feeling that their same-sex attractions are reprehensible, thus becoming less likely to disclose their sexual identity to members of their family and ethnic community.
Opposite-sex romantic and sexual relationships	Asian American youths were found to be the least likely to report sexual and romantic relationships with women. Among White, African American, and Latino cultures, not dating has implications for homosexuality. Youths may develop heterosexual relationships to mask their same-sex attractions from family members and peers and/or to test whether these relationships will "cure" them.
Source: [55]	*Table 2*

Using data from the first national probability sample of Black, White, and Latinx sexual minority people in the United States, researchers examined whether and how sexual identity development timing and pacing differs across demographic subgroups [57]. The sample included 1,491 participants 18 to 60 years of age from three distinct birth cohorts. The sexual identity development milestones measured included first same-sex attraction, first self-realization of a sexual minority identity, first same-sex sexual behavior, first disclosure to a straight friend, and first

disclosure to a family member. Participants from more recent cohorts reported earlier and accelerated pacing of milestones relative to those from older cohorts. Subgroups defined by sex and sexual identity varied in milestone timing and pacing, with gay males reporting an earlier onset of some milestones. Participants who used newer identity labels (e.g., pansexual, queer) reported younger ages of milestones relative to bisexual participants but similar ages to lesbian and gay participants. Black and Latinx participants reported some milestones at younger ages than White participants [57].

Models of the sexual identity process suggest that there are certain behaviors that a healthcare professional might observe related to the different stages of "coming out." Application of cognitive dissonance theory helps to explain the origins of behaviors that could be matched to some of the stages of a model. According to this theory, there is a tendency for individuals to seek consistency among their cognitions (i.e., beliefs and opinions) because they want to conform to society's expectations and attitudes. When individuals perceive that their beliefs and opinions do not conform to those of society, intrapersonal tension and discomfort develop. In an effort to reduce the tension or dissonance, individuals will try to adjust their thoughts, attitudes, and behaviors, thus attempting to conform. Those individuals who first recognize feelings of same-sex attraction may experience emotional turmoil. When discrepancy between attitudes and behaviors exists, the attitude will most likely change to accommodate the behavior [58; 59]. Using data collected through interviews and focus groups, one study analyzed the coming-out narratives of 20 transgender people [60]. The analysis revealed that coming out requires navigating others' gender expectations, others' reactions, and the threat of violence. Transgender individuals do not simply decide to "come out" and then stay out. Rather, they make strategic decisions about gender and gender identify disclosure based on specific social contexts. Coming out is an ongoing, socially embedded, skilled management of one's gender identity [60].

Common health problems associated with the stages of a four-stage model of the sexual identity (coming-out) process have been identified. For example, during the identification stage, the health picture has been described as "rather gloomy" and includes feelings of severe guilt, reduced self-esteem, overwhelming aloneness, and physical manifestations, such as ulcers and other health problems [61; 62]. More recently, LGBTQ identity formation and the implications for healthcare practice have been addressed [63]. Healthcare professionals must understand the importance of demonstrating awareness of gay or lesbian existence through, for example, the use of inclusive interviewing techniques. Antigay attitudes and stereotypes may hinder the healthy development of a child at the respective stages [64]. For example, positively managing the developmental task of industry versus inferiority may be impaired when youth experience a sense of little or no worth as a result of rejection.

UNIQUE HEALTH AND SAFETY CONCERNS

Many similarities exist between the LGBTQIA population and the general population related to health and safety concerns. For example, all individuals of any age should feel safe, which is a foundational need [64]. Yet, differences between the populations do exist. Heterosexism and homophobia may create environments that place LGBTQIA individuals of any age at increased risk for safety and health concerns [30; 65].

YOUTH

Results from the 2021 National School Climate Survey, which included 22,298 LGBT student participants, have illustrated this risk [66]. A note about the 2021 Survey: Because of the COVID pandemic, the authors had to adapt and modify some survey questions according to changes in school structures and instructional methods. The report continues to include findings about LGBTQ+ students' school experiences overall, but also discusses key findings about the differences between

students in online only, in-person only, and hybrid learning environments [66]. Schools nationwide are hostile environments for a distressing number of LGBTQ+ students, the overwhelming majority of whom routinely hear anti-LGBTQ+ language and experience victimization and discrimination at school. As a result, many LGBTQ+ students avoid school activities or miss school entirely [66]. The 2021 Survey found [66]:

- 81.8% of LGBTQ+ students reported feeling unsafe in school because of at least one of their actual or perceived personal characteristics.
- 68.0% of LGBTQ+ students felt unsafe at school because of their sexual orientation, gender identity, and/or gender expression characteristics.
- Overall, LGBTQ+ students in online-only learning environments were least likely to feel unsafe at school due to a personal characteristic; those in in-person only learning environments were most likely to feel unsafe.
- LGBTQ+ students most commonly avoided school bathrooms (45.1%), locker rooms (42.6%), and physical education or gym classes (39.4%) because they felt unsafe or uncomfortable.
- 78.8% of LGBTQ+ students reported avoiding school functions or extra-curricular activities because they felt unsafe or uncomfortable.
- LGBTQ+ students who had been only in in-person learning environments did not differ from those who had been in hybrid learning environments with regard to avoiding spaces at school.
- 32.2% of LGBTQ+ students missed at least one entire day of school in the past month because they felt unsafe or uncomfortable; 11.3% missed four or more days in the past month.
- 16.2% of LGBTQ+ students reported having ever changed schools due to feeling unsafe or uncomfortable at school.
- Nearly all LGBTQ+ students (97.0%) heard "gay" used in a negative way (e.g., "that's so gay") at school; 68.0% heard these remarks frequently or often, and 93.7% reported that they felt distressed because of this language.
- 95.1% of LGBTQ+ students heard the phrase "no homo" at school; 63.3% heard this phrase frequently or often.
- 89.9% of LGBTQ+ students heard other types of homophobic remarks or slurs; 44.2% heard this type of language frequently or often.
- 91.8% of LGBTQ+ students heard negative remarks about gender expression (e.g., not acting masculine or feminine enough); 56.2% heard these remarks frequently or often.
- 83.4% of LGBTQ+ students heard negative remarks specifically about transgender people; 39.5% heard them frequently or often.
- 58.0% of students reported hearing homophobic remarks, and 72.0% of students reported hearing negative remarks about gender expression from teachers or other school staff.
- Overall, students who attended school only in-person heard anti-LGBTQ+ remarks more frequently than did students who attended school only online or in a hybrid setting.
- Only 10.9% LGBTQ+ students reported that school staff intervened most of the time or always when overhearing homophobic remarks at school; only 8.8% of LGBTQ+ students reported that school staff intervened most of the time or always when overhearing negative remarks about gender expression.
- LGBTQ+ students who were in in-person only learning environments reported the lowest levels of staff intervention on anti-LGBTQ+ remarks.

The vast majority (83.1%) of LGBTQ+ students who attended school in-person at some point during the 2021–2022 academic year experienced in-person harassment or assault based on personal characteristics, including sexual orientation, gender expression, gender, religion, actual or perceived race/ethnicity, and actual or perceived disability. Among LGBTQ+ students who were in in-person only or hybrid learning environments [66]. An estimated 76.1% experienced in-person verbal harassment (e.g., called names or threatened) specifically based on sexual orientation, gender expression, and gender at some point in the past year. Nearly 61% of LGBTQ+ students were verbally harassed based on their sexual orientation, 57.4% based on gender expression, and 51.3% based on gender. The Survey also found that 31.2% were physically harassed (e.g., pushed or shoved) in the past year based on based on their sexual orientation, gender expression, or gender; 22.4% were physically harassed at school based on their sexual orientation, 20.6% based on gender expression, and 20.5% based on gender. In addition, 12.5% of LGBTQ+ students were physically assaulted (e.g., punched, kicked, injured with a weapon) in the past year based on their sexual orientation, gender expression, or gender. The number of LGBTQ+ students were harassed or assaulted at school based on other characteristics included 34.4% based on actual or perceived disability, 29.0% based on religion, and 23.3% based on actual or perceived race/ethnicity. Further, 53.7% of LGBTQ+ students were sexually harassed (e.g., unwanted touching or sexual remarks) in the past year at school.

LGBTQ+ students who attended school online at some point during the 2020–2021 academic year were asked about their experiences with online harassment based on personal characteristics during the school day by students from their school. Among those who attended school online at some point during the 2021–2022 academic year [66]:

- 36.6% were harassed online based on their sexual orientation
- 31.8% were harassed online based on their gender expression
- 30.3% were harassed online based on their gender

Students who were in online-only learning environments experienced higher rates of online harassment based on sexual orientation, gender, and gender expression than those who were in hybrid learning environments. Additionally, many LGBTQ+ students reported online harassment based on other characteristics [66]:

- 17.3% reported being harassed online based on their actual or perceived disability
- 13.7% reported being harassed online based on their religion
- 13.2% reported being harassed online based on actual or perceived race/ethnicity

There is some evidence that students may be less likely to report harassment and assaults related to their gender and sexual identity, perhaps because of a lack of trust in authority figures. In the 2021 Survey, 61.5% of LGBTQ+ students who were harassed or assaulted in school did not report the incident to school staff, most commonly (69.6% of students) because they did not think school staff would do anything about the harassment even if they did report it [66].

Students in in-person learning environments reported harassment to school staff at higher rates than did students in online only or hybrid settings; 49.5% of students who attended school online (both online only and hybrid) stated that they did not report victimization online and instead only reported these experiences to staff when they attended school in person [66]. Of those students who did report an incidence, 60.3% said that school staff either did nothing in response or told the student to ignore it [66]. Staff responses to reports of harassment and assault were similar across all three types of learning environments [66].

Most LGBTQ+ students (58.9%) has experienced LGBTQ+-related discriminatory policies or practices at school. Some of the most common discriminatory policies and practices experienced are those that targeted students' gender, potentially limiting their ability to make gender-affirming choices and negatively impacting their school experience [66]:

- 29.2% had been prevented from using their chosen name or pronouns in their schools
- 27.2% had been prevented from using the bathroom that aligned with their gender
- 23.8% had been prevented from using the locker room that aligned with their gender
- 20.6% had been prevented from wearing clothes deemed "inappropriate" based on gender
- 16.0% had been prevented from playing on the sports team that is consistent with their gender

Many LGBTQ+ students also experienced other forms of discrimination [66]:

- 25.2% of LGBTQ+ students were disciplined for public affection (e.g., kissing, holding hands) that is not similarly disciplined among non-LGBTQ+ students.
- 16.6% of LGBTQ+ students were prevented from writing or talking about LGBTQ+ issues in extracurricular activities.
- 15.6% of LGBTQ+ students were prevented from writing about or doing school projects about LGBTQ+ issues.
- 12.3% of LGBTQ+ students were prevented from wearing clothing supporting LGBTQ+ issues.
- 12.3% of LGBTQ+ were prevented from forming or promoting a gay student alliance.
- 11.3% of LGBTQ+ students shared that school staff or coaches had prevented or discouraged them from playing sports because they identified as LGBTQ+.

LGBTQ+ students who had only been in in-person learning environments during the academic year were far more likely to experience any form of LGBTQ+-related discrimination than those in the other types of learning environments. A hostile school climate affects students' academic success and mental health. LGBTQ+ students who experience victimization and discrimination at school have worse educational outcomes and poorer psychological well-being [66].

While there is some evidence that societal attitudes are less oppressive than in the past, contemporary GSM youth will nevertheless experience a lifetime of exposure to entrenched negative societal attitudes. Consequently, healthcare professionals who have an awareness of and sensitivity to sexual minority youth and their unique health and safety concerns are in a position to assist the youth to manage their developmental tasks and address their health needs as they mature. The goal should be to encourage young adults to be comfortable with themselves, thus becoming more likely to demonstrate sound health practices.

The "homosexual adolescent" was first acknowledged by empirical social science in 1972 [69; 70]. Additional empirical research reports were not available until the late 1980s, and sexual minority youth continued to remain largely invisible, even within the lesbian and gay community, until the 1990s [71]. Fortunately, the body of professional literature related to GSM youth has been evolving quickly.

Many LGBTQIA youth say they knew at an early age that the sexual thoughts and feelings they were experiencing were somehow different from other youth, but they did not understand the meaning of the difference. Although much variability among GSM youth exists, the average age of same-sex attractions is approximately 10 years of age for boys and 11 years of age for girls [72]. It is not until adolescence, when the capacity for abstract thought has been developed, that youth are able to analyze their responses to others and place these responses and associated feelings in a larger context [73]. Behaviors and feelings that adolescents recognize as gender atypical may result in fear of humiliation or physical violence, shame, and judgment as unhealthy or deviant [74].

Events in our nation's schools have contributed to public awareness of the prevalence of humiliation and violence among students. The school environment must be considered when thinking about the unique health and safety needs of LGBTQIA youth. "Because young people spend so much time in schools, and because of the relationship between academic achievement and later accomplishments, these settings are of crucial importance to understanding the transition of lesbian, gay, and bisexual youth into early adulthood" [69]. Survey results from public school educators and administrators have revealed that while public school educators acknowledge that problems for LGBTQIA youth exist in schools, administrators believe there are adequate programs already in place to handle the needs of the LGBTQIA youth population [75]. Several sources, documenting the dangerous and punishing atmosphere in school for some LGBTQIA youth, have challenged this perception [65]. This and other problematic attitudes in the schools have a significant impact on the academic performance and goals of LGBTQIA students, including absenteeism, lower grades, and foregoing post-secondary education [66]. Heterosexist peer cultural norms make LGBTQIA youth extremely vulnerable in the school setting.

Middle and high school students report that sexual orientation and gender expression are among the top three reasons students in their schools are bullied or harassed. LGBT students in middle school may face more bullying and harassment than their high school peers, which mirrors the environment among the general student population [66]. The National School Climate Survey revealed that 68.0% of LGBT students felt unsafe at school because of their sexual orientation and 43.2% because of their gender expression [66]. In one study, approximately 73% of students interviewed indicated that they would be "very upset" if someone called them gay or lesbian, but only 61% indicated that they would report its occurrence, even when it was done to someone they knew personally [76]. In addition, 76.1% of LGBTQIA students report having been bullied and harassed at school in the past year, and more than one-half reported experiencing some form of electronic harassment ("cyberbullying") in the past year [66]. The most frequent types of harassment are deliberate exclusion, being the target of mean rumors or lies, and sexual harassment.

Some parents and teachers believe that verbal harassment, which belittles, demeans, and ridicules, is normal teasing and common among teens. This is reflected in comments such as, "Those are just words the kids use these days." It has been suggested, however, that while teasing appears to be a positive experience for most young people, ridicule is clearly not desirable. Ridicule has been connected with low self-esteem and several clinical symptoms, such as hostility, depression, and interpersonal sensitivity. Peer ridicule may also be a tremendous source of stress for some youth, and the effects of frequent, repeated ridicule have been found to be cumulative [77]. Also, self-labeling at an earlier age exposes the GSM youth to verbal harassment and/or assault for a longer period of time. This longer exposure increases the risk of stress and the potential for damaging effects on the youth's health unless access to helping resources is provided. This increased risk for GSM youth may be the result of externalized and internalized homophobia that is more pronounced during adolescence than at other times in the life cycle [78].

The effects of ridicule should also be applied to transgender youth. Young gay men are more likely than heterosexual men to experience increased harassment, especially if they display behaviors that are interpreted as feminine [72]. The effects of prolonged, chronic stress associated with discrimination may contribute to health problems, such as hypertension, in adult gay men [79].

LGBTQIA youth may employ many coping strategies in an attempt to understand themselves and their place in society. Some may withdraw physically and emotionally, perhaps in an effort to avoid discovery. Others may turn to substance use or develop eating disorders. Among LGBTQIA youth, the rates of suicide ideation and attempts have been reported to be alarmingly high [80]. Some LGBTQIA youth strive for academic or athletic achievement, perfectionism, or become overly involved in extracurricular activities in an effort to avoid their feelings [10]. Still others, as a reaction against unacceptable thoughts

and attractions, may exaggerate their heterosexuality and engage in promiscuous behavior [81]. Many become homeless. According to a report published by the National LGBTQ Task Force (NLGBTQTF), an estimated 20% to 40% of the 1.6 million homeless American youth are LGBT [82]. Some of these youth, when they came out to their parents or guardians, were told to leave home. Some left home to escape physical, sexual, or emotional abuse. Youth who end up at homeless shelters have also reported being threatened, belittled, and abused by shelter staff [82].

EVIDENCE-BASED PRACTICE RECOMMENDATION

The American Academy of Child and Adolescent Psychiatry recommends that clinicians should inquire about circumstances commonly encountered by youth with sexual and gender minority status that confer increased psychiatric risk, including bullying, substance abuse, and suicide.

(https://www.jaacap.org/article/S0890-8567(12)00500-X/fulltext. Last accessed September 27, 2024.)

Level of Evidence: Expert Opinion/Consensus Statement

Legal events have occurred that demonstrate a growing awareness of the specific legal needs of the GSM youth population. For example, in 1996, a gay student in the Wisconsin public school system was awarded over $900,000 in damages when a federal jury found school officials liable for not protecting the student, who had experienced several years of harassment, including physical and psychological assault. During the years of harassment, the student had dropped out of school twice, required surgeries for injuries from assaults, run away from home, and tried to kill himself several times. He was subsequently diagnosed with post-traumatic stress disorder [83]. In the spring of 2009, an 11-year-old Massachusetts boy died by suicide after enduring constant bullying at the middle school he attended, including being called "gay" and "faggot," even though the boy had not identified himself as gay [84]. Just two weeks later, the suicide of an elementary school student in Georgia was also attributed to anti-LGBT bullying. This student also had not identified himself as gay. Their deaths prompted the introduction of the Safe Schools Improvement Act, H.R. 2262. This act (which amends the Safe and Drug-Free Schools and Communities Act of 1994) requires schools to implement comprehensive antibullying policies and to include bullying and harassment data in their needs assessment reporting. Any school that receives federal funding must implement an antibullying policy that identifies categories often targeted by bullies, such as race, religion, sexual orientation, and gender identity/expression [85].

GSM youth must eventually develop interpersonal skills that allow them to meet other GSM youth. Like other adolescents, they must develop a sense of personal attractiveness and a healthy self-esteem while learning that risky sexual activity, more common among these adolescents, does not promote emotional health. They must learn same-sex relationship skills while integrating their public and private selves to create their LGBTQ identity. Not all LGBTQIA youth experience difficulties; many are resilient and resourceful, manage stressors well, and develop into productive and healthy adults [86]. Research exploring development of this resiliency is needed.

There is a vital connection between a sense of community and psychological well-being. While other minorities have family to role model for them and protect them, sexual minority youth usually do not have such support. Sexual minority adults who could serve as positive role models may fear that they will be accused of "recruiting members" or behaving inappropriately [10]. Sexual minority adults are often sensitive to stimulating false beliefs among the general population.

Although many LGBTQIA youth are self-disclosing at younger ages, many factors affect the decision to do so. For example, disclosure of one's sexual orientation to healthcare providers may depend on where in the sexual identity process the individual finds herself or himself [62]. Physical factors, such as being deaf, or social factors, such as financial sup-

port, may also have an impact on the coming-out process. Disclosing too early could jeopardize the support that already exists [87]. Studies have demonstrated that disclosing sexual orientation to family members during the high school years may create some danger for LGBTQIA adolescents, including, as previously discussed, abuse and the threat of being made homeless [82].

Not all GSM youth are aware of their right to medical confidentiality. LGBTQIA youth who know their rights have been found to be more likely to discuss sexual orientation and concerns with their healthcare providers. Most who do not discuss sexual orientation have said that they would have done so had they known that their confidentiality was protected [46; 88].

Many resources are available to LGBTQIA youth and their families, particularly in metropolitan regions. For example, Parents, Families, and Friends of Lesbians and Gays (PFLAG), an organization that works to unite GSM individuals with family and friends, offers support, education, and advocacy through online information sharing and community chapter efforts. Additional resources, including hotlines for youth, are provided at the conclusion of this course. Before recommending a resource, healthcare professionals should assess it for absence of social bias and provision of a professionally neutral environment [2].

ADULTS

LGBTQIA adults have also experienced increased incidents of violence. The Federal Bureau of Investigation (FBI) has consistently ranked antigay violence as the second most frequent form of bias-motivated crime. In 2022, the FBI reported that 17.2% of the total 11,288 reported single-bias incidents had been motivated by bias related to sexual orientation [67]. Additionally, the National Coalition of Anti-Violence Programs reported a slight decrease (compared to the previous year) in the number of incidents of anti-LGBT violence (825 incidents) but a significant increase in incidents involving physical and sexual violence [68].

Health maintenance and promotion are important to the LGBTQIA community, but these issues have received little attention in the general public's health-related media. Many Internet sites provide health information related to sensitive topics for the general population as well as the GSM population. However, a difference exists between the general population and the LGBTQIA population when the GSM individual cannot talk further with a healthcare professional about a sensitive topic because of fear of stigmatization or discrimination. Some Internet sites have been able to address, in part, the sensitive health information needs of the GSM community (see ***Resources***).

Distress caused by the experiences of marginalization, stigma, prejudice, discrimination, and internalized homophobia is a consistent theme of the professional literature. Research has suggested that most gay men and lesbians adopt negative attitudes toward their sexuality early in their developmental histories. As previously discussed, because health problems often begin in youth, internalized homophobia may also affect health indirectly, especially when operating below consciousness in adults [18]. The coming-out process has been identified as a source of chronic stress, resulting in psychogenic suppression of the immune response for the LGBTQIA individual. A direct correlation has been found between where in the coming-out process an individual is and an increased incidence of physical illness, such as malignancies and some infectious disease processes other than HIV/AIDS [89]. Internalized homophobia has also been associated with high-risk sexual behaviors, such as practicing unsafe sex. Research has explored the potential influence of these negative attitudes on health experiences and behaviors, particularly those of gay men as related to HIV and AIDS. Difficulties with intimacy and other aspects of relationships may manifest as well, including an inability to disclose HIV status to sex partners [90]. African American men who have sex with men have been found to be less likely to identify themselves as gay, more likely to report having sex with women, and less comfortable discussing their behavior with friends. They have also been found to exhibit higher levels of internalized homophobia [90].

Prejudice and fear of discrimination have resulted in difficulty accessing or avoidance in seeking health care [35]. While some healthcare providers have acknowledged that LGBTQIA individuals are part of their patient populations, they have determined that sexual orientation does not need to be addressed [8]. Others have indicated that they believe gay men and lesbians deserve to be ill or that they are unworthy of treatment. Reports exist of a "rough" or "violent" digital rectal exam on a patient after the patient was discovered to be gay [8]. One study examined both implicit and explicit bias against lesbian women and gay men among first-year heterosexual medical students with an emphasis on two predictors of such bias—contact and empathy [91]. A total of 4,441 students participated in the study. Nearly one-half (45.8%) of respondents with complete data on both bias measures expressed at least some explicit bias, and most (81.5%) exhibited at least some implicit bias. Amount and favorability of contact with gay/lesbian patients predicted positive implicit and explicit attitudes. Cognitive and emotional empathy predicted positive explicit attitudes, but not implicit attitudes [91]. Another study found that implicit preferences for heterosexual people versus GSM people are pervasive among heterosexual healthcare providers. The study examined attitudes among 2,338 medical doctors, 5,379 nurses, 8,531 mental health providers, 2,735 other treatment providers, and 214,119 nonproviders in the United States and internationally between 2006 and 2012 [92].

Prejudice has also resulted in legal and legislative actions with potentially negative consequences for the LGBTQIA population. For example, in 2004, the Michigan House of Representatives proposed a piece of legislation known as the "Conscientious Objector Accommodation Act" (House Bill 4660). This bill would have allowed healthcare providers the right to refuse to provide services that conflict with their beliefs [93]. While the bill did not pass, opponents expressed concern about its potential to harm the health of LGBTQIA persons. Other measures (introduced in Arkansas, Michigan, Rhode Island, South Dakota, Texas, Vermont, and West Virginia) would allow pharmacists and other healthcare providers to refuse treatment or medication to anyone by citing ethical, moral, or religious grounds. Georgia law already states that "it shall not be considered unprofessional conduct for any pharmacist to refuse to fill any prescription based on his/her professional judgment or ethical or moral beliefs" [94].

Some progress has been made, however. For example, in 2003, a California appeals court ruled that healthcare providers cannot discriminate against patients based on their sexual orientation. The decision was the result of a lawsuit filed by a gay woman who perceived discrimination based on the religious beliefs of providers at an infertility clinic [95].

The controversy surrounding same-sex marriage has led to unique healthcare access debates and decisions, including extension of health and other employment benefits to an employee's same-sex partner. Along with the Supreme Court ruling state-level same-sex marriage bans unconstitutional on June 26, 2015, there have also been significant changes to healthcare laws. Starting in 2015, any insurer that offers healthcare coverage to opposite-sex partners must also offer coverage to same-sex partners [96]. Married same-sex couples are also ensured the same tax credits and out-of-pocket costs as married opposite-sex couples on private plans in all states.

AMA Resolution 414 calls for recognition of the healthcare and other needs of the LGBTQ population, while acknowledging that more professional knowledge and skills about the LGBTQIA population are needed [13]. Health concerns among the LGBTQIA population include: cancer; family concerns, including domestic violence; immunizations; infectious diseases, such as sexually transmitted infections (STIs), HIV/AIDS, and hepatitis; mental health, including suicide, body image, and eating disorders; substance use; and violence [8; 9].

Bisexual Health Issues

Existing research about bisexual health is scarce in large measure because the health issues that directly affect the bisexual population have either been ignored or treated as identical to the issues that affect heterosexuals or gay men and lesbians. Bisexuals have been found to experience greater health disparities and a greater likelihood of experiencing depression than the broader population [97].

Estimating the frequency of bisexuality in the United States depends on how it is defined (i.e., in terms of behavior, attraction, or self-identity) and ranges from 0.7% to 12.9% in men and from 0.3% to 5.9% in women [98]. Some individuals who have sex with both women and men choose not to identify themselves as bisexual. Others acknowledge the orientation but do not necessarily involve themselves with more than one gender. The distinction between identity and behavior is an important one. To gain a better understanding of the unique needs of the bisexual population, healthcare providers should consider the individual's sexual behavior, not simply his or her sexual identity. The National Gay and Lesbian Task Force has published recommendations for creating a friendlier "bi-culture," particularly for the provision of HIV/STI prevention services [98].

Transgender Health Issues

A report released by the Movement Advancement Project finds that transgender people are among the most vulnerable communities in America. Transgender women and transgender people of color are particularly affected, and they face enormous barriers to their safety, health, and well-being [99]. Transgender health issues include many of the same concerns as for lesbians, gays, and bisexuals, but even less research is available that has studied the effects of stigma, violence, and social and economic marginalization. Very few surveys ask about transgender status. Only one national study (the National Transgender Discrimination Survey) has focused exclusively on transgender people in the United States [99]. Problems related to stigma may be worse for transgender youth than for LGBQ persons. These youth strive to remain invisible and appear indistinguishable from their nontransgender peers in order to avoid harassment and abuse. However, this results in isolation and prevents them from seeking appropriate mental health or medical care until a crisis has arisen [76; 78; 100]. The same issues may be applied to transgender adults as well, including being stigmatized by prominent gay and lesbian movements and organizations [43].

Prejudice and lack of knowledge create significant barriers to medical and social services and care for transgender individuals of all ages. They also contribute to this population's underutilization of health and social services [101]. While the Affordable Care Act has decreased the number of transgender people without health insurance, transgender people continue to report low insurance rates and high rates of negative health outcomes [102]. According to the Movement Advancement Project, 44% of the LGBTQ population lives in states that do not have LGBT-inclusive insurance protections [103]. Transgender individuals must educate healthcare professionals about transgenderism and related concerns before adequate care can be offered [99; 101]. Some transgender organizations have been advancing toward this goal by working with public health, medical, and mental health researchers [43].

Cancer

Breast cancer is one of the most researched topics in lesbian health [8]. Lesbians have a richer concentration of risk factors for breast cancer than any other subset of women in the world [30]. Obesity, alcohol consumption, smoking, and nulliparity contribute to the risk of developing breast cancer, and avoidance of a healthcare system that has been discriminatory of lesbians in the past may result in delayed cancer detection and treatment. Lack of health insurance for unmarried partners has created access barriers to quality health care, including screening and prevention [36; 104]. While few differences between the diagnosis and treatment of lesbian and heterosexual women have been found, lesbian women have demonstrated a puzzling increase in the number of chemotherapy-induced side effects, possibly resulting from aspects of internalized homophobia, fear of compromised care, or other causes [105].

Screening for male cancers, such as prostate and testicular cancer, as well as colon and anal cancer may be negatively impacted because of the challenges for gay men in receiving care. Many gay men are reluctant to tell their healthcare providers about their sexual orientation due to fears of discrimination affecting the quality of care they will receive [106]. Lack of insurance coverage for unmarried partners is another barrier [106; 107]. Research has suggested that gay and bisexual men with health histories of STIs and/or anal intercourse are at increased risk for anal cancer [8]. Human papillomavirus (HPV) has been associated with the development of anal cancer, but much research must be done related to subtypes of HPV and anal cancer incidence, including the use of anal Pap smears for early detection [8]. Healthcare professionals working with men who have sex with men are in an excellent position to initiate this research.

Family Concerns

Family concerns affect a growing number in the LGBTQIA community. Because gay and lesbian parents may face loss of custody of children or loss of hospital visitation rights as a result of their sexual orientation, researchers have had difficulty determining the prevalence of gay and lesbian parents raising children. According to the data from the 2019 American Community Survey, 14.3% of same-sex couple households reported at least one child 18 years of age and younger residing in the home [39]. Children of Lesbians and Gays Everywhere (COLAGE) is a valuable resource for a obtaining a wide range of information about children of gay parents (see ***Resources***).

The "lesbian baby boom" is a phrase that has been used to describe the increasing numbers of lesbians who have come out and are choosing to have children [8]. While donor insemination constitutes the majority of the pregnancies among lesbians, other routes to parenthood have been explored by lesbians and gay men. Research has shown no negative outcomes for children raised by gay or lesbian parents nor has it demonstrated that those children are more likely to become gay or lesbian [108]. Several national organizations have adopted policy statements in support of gay and lesbian parents [109; 110].

Because healthcare facilities do not always recognize same-gender couples as a family, visitation eligibility has often been denied to partners or nonbiologic parents [111]. The Joint Commission has defined "family" as "the person(s) who plays a significant role in the individual's (patient's) life. This may include a person(s) not legally related to the individual" [111; 112]. The AMA also supports equality in health care for partners and legal recognition of domestic partners for hospital visitation rights [113]. While many biologic families of LGBTQIA individuals are supportive and do not interfere with partner decisions regarding care, other biologic families may ignore and reject partner wishes, even when wishes have been discussed and documented by the gay patient.

In 2010, the U.S. Department of Health and Human Services adopted a rule that requires "any hospital receiving Medicare or Medicaid funds to have written visitation policies that prohibit discrimination on the basis of sexual orientation and gender identity" [114]. The rule also stipulates that a patient must be informed of their right to visitation by anyone they wish, including (but not limited to) a friend, a domestic partner (including a same-sex domestic partner), a spouse (including a same-sex spouse), or any member of their family.

Immunization

Vaccination needs for gay and lesbian individuals are not so different from the general population, except that gay and bisexual men are at increased risk for contracting viral hepatitis [107]. Accurate data regarding the success of vaccination campaigns is not available. Existing information has suggested that vaccination rates for men who have sex with men are low [115]. Few men are vaccinated against hepatitis B, even though the vaccine has been available since the mid-1980s [115]. Attitude, social norm, perceived risk of contracting the virus, expectancies regarding the outcome of vaccination, interaction between risk perception and outcome expectancies, and perceived vulnerability have been found to be predictors of vaccination intention [116; 117; 118].

Healthcare providers should include vaccination histories as part of their patient assessment and recommend vaccinations as indicated. The use of interviewing techniques that demonstrate a non-judgmental attitude and awareness that a patient may be gay, even if he is in a heterosexual marriage, is also important.

Sexually Transmitted Infections and HIV/AIDS

STIs among the general population are well-known health problems. Stigmas associated with STIs and LGBTQIA sexual behaviors have made determining the prevalence rates of STIs in men who have sex with men difficult; however, these men appear to be at more risk than the general population [119]. The relatively high incidence may be related to multiple factors including individual behaviors, the number of lifetime or recent sex partners, rate of partner exchange, and frequency of sex without use of a condom [119]. Also problematic is the increased incidence of drug resistance. Gonorrhea in men who have sex with men has been reported to be resistant to fluoroquinolones [120].

AIDS has been diagnosed for more than half a million men who have sex with men. More than 300,000 have died since the beginning of the epidemic. Men who have sex with men comprised 67% of all new HIV infections in 2022 and account for more than half of the 1.2 million existing infections, even though only about 2% of men in the United States reported having sex with other men [121; 122]. While a decline in the rates of STIs in gay and bisexual male groups was reported following the start of HIV/AIDS prevention programs, data has indicated a rise in reports of unprotected anal sex. Also, young men who have sex with men are reportedly at particular risk for HIV because they are more likely to engage in high-risk behaviors [8; 121]. The effect of behavioral changes on HIV transmission has not been determined. According to the CDC, from 2021 to 2022, HIV diagnoses increased 5% among gay and bisexual men overall, but trends varied for different groups of gay and bisexual men [122]. From 2021 through 2022, the largest number of diagnoses of HIV infection was among gay and bisexual men 25 to 34 years of age. Of 37,981 men diagnosed with HIV infection in 2022, Black/African American gay and bisexual men accounted for the largest number (14,553 or 38%) of HIV diagnoses , followed by 12,167 Hispanic/Latino men (32%), and 9,112 White gay and bisexual men (24%). Three percent (1,056) of multiracial men were diagnosed, 2% (795) of Asian men, 1% (215) American Indian/Alaska Native gay and bisexual men (1%), and less than 1% (83) Native Hawaiian/Other Pacific Islander gay and bisexual men [122; 123; 124]. Many Black/African American and Hispanic/Latino gay and bisexual men, particularly young men, do not know that they are infected [122; 123; 124]. Research has suggested that non-gay-identified men may be more responsive to intervention education than gay-identified men. This has been attributed to less exposure to prior intervention messages, leading to a greater impact from initial exposure [125]. Additional research is needed to identify which behavioral strategies (e.g., reducing unprotected anal sex, having oral sex instead of anal sex, using condoms) most effectively reduce transmission of STIs and HIV/AIDS among gay men [125]. An increasing number of HIV cases among heterosexual Black women has drawn attention in the media to a phenomenon known as the "down low." While this phenomenon is too complex to address fully here, the term is used to describe the behavior of men who have sex with men as well as with women, but who do not identify themselves as gay or bisexual [126]. Often, their female partners are unaware that these men are also having sex with men. While the term is thought to have originated in the African American community, the behaviors associated with the term are not new and not specific to Black men who have sex with men [126]. The media has linked the "down low" to the Black AIDS epidemic, but the CDC has reported that there is no data to confirm or refute publicized accounts of HIV risk behavior associated with these men [126].

STIs are thought to be more common among women who have sex with women than among sexually active women who are heterosexual. Transmission risk may vary by the specific STI and sexual practice (e.g., oral-genital sex, penetrative sex items) [127].

Although disease incidence among these women appears to be less than among the heterosexual female population, HPV and other organisms are transmissible woman to woman [8]. Transmission of HPV can occur with skin-to-skin or skin-to-mucosa contact, which can occur during sex between women [127]. HPV has also been associated with the development of genital warts and invasive cervical cancer. The CDC has recommended that all women undergo Pap test screening according to national guidelines, regardless of sexual preference or sexual practices [127].

According to the Centers for Disease Control and Prevention, women who have sex with women, particularly adolescents and young women as well as women with both male and female partners, might be at increased risk for STIs and HIV on the basis of reported risk behaviors. A continuum of sexual behaviors reported by these patients indicates the need for providers to not assume lower risk for women who have sex with women, highlighting the importance of an open discussion about sexual health.

(https://www.cdc.gov/std/treatment-guidelines/wsw.htm. Last accessed September 27, 2024.)

Level of Evidence: Expert Opinion/Consensus Statement

To address racial, ethnic, and geographic disparities that have contributed to HIV prevention gaps, the U.S. Department of Health and Human Services launched the Ending the HIV Epidemic in the U.S. (EHE) initiative in 2019. The goal of the initiative is to reduce new HIV infections in the United States by 90% by 2030 [128]. In July 2021, the CDC awarded $117 million in EHE funding to state and local health departments to rebuild and expand HIV prevention and treatment efforts in 57 priority jurisdictions. The jurisdictions include 50 local areas that account for more than half of new HIV diagnoses, and seven states with a substantial rural burden [128]. Approved EHE funding across all U.S. federal agencies was $613 million for fiscal year 2023 [128].

Although there are now more options than ever before to reduce the risk of acquiring or transmitting HIV, some options are more effective than others. Combining prevention strategies may be most effective [124].

Mental Health

The LGBTQIA population may be at increased risk for mental distress, mental disorders, substance abuse, and suicide because of their exposure to stressors related to society's antigay attitudes [8; 31]. Studies examining the prevalence rates for suicide ideation have shown that the rates are elevated among gay and bisexual men as well as among lesbians, and particularly those who grow up in religious households as well as those for whom religion is important [8; 129; 130; 131].

The U.S. Preventive Services Task Force asserts that lesbian, gay, bisexual, transgender, and queer (LGBTQ) teens are at increased risk of depression and recommends screening for major depressive disorder in adolescents 12 to 18 years of age.

(https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-children-adolescents. Last accessed September 27, 2024.)

Level of Evidence: B (There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.)

Clinical studies have indicated that sexual orientation may be a significant predictor of eating disorders. Gay men have demonstrated more dissatisfaction and a greater desire to be thin than heterosexual men [132]. Studies of the role that masculinity and femininity play in relation to men and women who develop eating disorders have shown that men and women with higher levels of femininity have greater levels of dieting behaviors [133]. A negative and inaccurate sense of body image (body dysmorphic disorder) is a primary cause of eating disorders in women and men [132].

Support systems and networks are known to be important to one's mental health maintenance. While social institutions, such as church, family, and the legal system, are generally thought to be less supportive of GSM individuals than they are of heterosexual individuals, important helpful changes have been occurring in many of these institutions [134]. Selected church leadership has been in public view related to the acceptance of openly LGBTQ theologians in the church. Families, as an institution, have spoken publicly and given support to their gay family members through organizations such as PFLAG. Also, where legal decisions in favor of the GSM community have been made, public awareness of potentially dangerous environments for GSM youth has increased.

Sampling difficulties have made it challenging to research the prevalence of substance use in the LGBTQIA community. For example, studies of alcoholism and drug use have sampled gay and lesbian individuals in bars, a location where higher alcohol and drug use might be expected [8]. Substance use rates for gay and lesbian individuals have been reported as high as 20% to 30%, compared to a rate of 10% among the general public when based on this sampling methodology [30]. However, studies using other sampling methodologies have generally disputed the high incidence of alcoholism and substance use [8]. Research suggests that sexual minority adolescents who reside in communities with a more supportive climate had lower odds of lifetime illegal drug use, marijuana use, and smoking. Specifically, in communities with more frequent LGBTQIA events, such as pride events, the odds of substance use among sexual minority adolescents was lower compared with sexual minority adolescents living in communities with fewer such supports [135].

The pressure of coming of age in a society that says that LGBTQIA individuals should not exist or act on their feelings contributes to the use of alcohol and drugs [136]. Internalized homophobia develops and creates feelings of denial, fear, anxiety, and even revulsion about being gay, socializing in the GSM community, and having gay sex. Substance use temporarily relieves these negative feelings, allowing feelings to be acted upon. The homophobic feelings return during drug withdrawal. Substance use occurs again, contributing to the self-hatred. Depression leading to a worsening self-esteem may result from the use of alcohol and many other drugs [136].

Participating in Alcoholics Anonymous and other recovery programs may be difficult for the LGBTQIA individual. Some of the programs suggest giving up old friends, especially fellow substance users, and staying away from parties and bars. These actions may be too difficult for an individual who has limited social contacts and no other available avenues of social outlet [136]. Someone who is socially withdrawn or insecure with his or her own social skills may have difficulty limiting contact with any friends they do have.

Other concerns related to recovery groups exist. Heterosexism in support groups makes coming out difficult for LGBTQIA participants. The difficulty of coming out or accepting one's own sexual orientation may become an excuse to resume alcohol or drug abuse [30]. National organizations, such as the National Gay and Lesbian Health Association and the Gay and Lesbian Medical Association, can assist with referrals to appropriate recovery groups [136].

Tobacco use among sexual minorities may be higher than in the general population, resulting in an increased rate of tobacco-related health problems [137]. Because LGBTQIA individuals may experience difficulty accessing the healthcare system, they are at an increased risk for missing health promotion activities. As a result, illness detection and treatment are delayed.

Domestic Violence

Despite the myth that intimate partner violence (IPV) is exclusively an issue in heterosexual relationships, many studies have revealed the existence of IPV among same-sex couples and found its incidence to be comparable to or higher than that among heterosexual couples. Additionally, unique features and dynamics are present in IPV among same-sex couples, such as identification and treatment of same-sex IPV in the community and the need to take into consideration the role of sexual minority stressors. The lack of studies that address same-sex couple IPV is partly attributable to the silence that has historically existed around violence in the LGBTQIA community, which has obstructed a public discussion on the phenomenon [138]. Homophobia makes accessing information and support services problematic for LGBTQIA individuals. Gay and lesbian victims may experience more maladaptive outcomes as a result of the unique components of same-sex IPV, their sexual minority status in American society, and the lack of appropriate services tailored to victims of this type of domestic violence [139]. Results from the National Longitudinal Study of Adolescent to Adult Health indicate that IPV within the context of same-sex relationships led to more depressive symptoms and greater involvement in violent delinquency, with the impact of IPV on violent delinquency being greater for victims of same-sex IPV compared with opposite-sex IPV [139].

Violence

Violence toward an LGBTQIA individual affects the entire GSM community and the general population. Each year, thousands of incidents of violence against gays and lesbians are reported. These incidents range from verbal abuse to homicide [140]. While statistics demonstrating the incidences of antigay violence are frightening, they do not adequately convey the fear and anguish experienced not only by survivors but also by their communities [141]. Violence has occurred in a variety of settings and in all ages of LGBTQIA individuals. Settings range from elementary schools to nursing homes.

Violent crimes based on one's sexual orientation were not recorded until after 1990, when the federal Hate Crime Statistics Act went into effect. This law requires the Department of Justice to collect and publish annual statistics on crimes that manifest prejudice based on race, religion, sexual orientation, and ethnic origin [142; 143]. Education for law enforcement personnel about evaluating a crime scene for evidence of a bias crime has taken place across the nation. However, determining the accurate incidence of antigay bias crimes remains difficult. Interviews with LGBTQIA victims have revealed their fear of disclosure and other anxieties. This has resulted in victim failure to report assaults or pursue investigations and has contributed to difficulties with data collection [141].

LGBTQIA individuals experience many of the same physical and emotional effects following violence as the general public. However, LGBTQIA individuals "are often the objects of hate-based violence because of their sexual orientation and may show signs of exacerbated internalized homophobia after victimization" [140]. Healthcare professionals working with these individuals should be informed about the physical and mental health consequences of violence associated with stigmatization based on sexual orientation [140].

OLDER ADULTS

Research challenges have made determining the size and other demographic and sociologic characteristics of the older GSM population very difficult. The LGBT Aging Center has estimated that approximately 1.5 million LGBT adults 65 years of age or older reside in the United States, with the number expected to double by 2030 [144]. Literature discussing the health and health needs of GSM elderly has also been limited. As a result, identifying problems and advocating for solutions for this population has been challenging [144; 145].

Clearly, older GSM individuals experience the same marginalization due to age and ethnic or racial heritage as the nation's general population. Older gay adults experience additional marginalization related to sexual orientation. While federal and state governments offer a wide variety of social programs and services that aim to support the lives of older people, rarely do these programs recognize or support the families that LGBTQIA people build [145]. For example, in the past, same-gender partners have not received Social Security benefits, no matter how long partners had been together. As of June 2015, this has changed. A spouse, divorced spouse, or surviving spouse of a same-sex marriage or non-marital legal same-sex relationship may not only qualify to receive Social Security benefits (including death benefits) but is required to disclose their relationship, as their partner's income will affect their benefits [146].

Although limited, research findings have shed some light on LGBTQIA elderly. For example, older gay men are more likely to be angry after years of oppression than are non-gays. While some of these men have directed the anger constructively into their occupations or political activism or toward developing strong networks of friends, others have turned the anger inward and consequently experience anxiety, depression, and self-esteem problems related to internalized homophobia [147]. Older gays may also receive less sympathy and attention in general when dealing with the loss of a long-term lover or close friend. Because of problems from family members and reactions from healthcare providers and others, the GSM individual may also experience complications with the grieving process [147].

Another area of need for older GSM individuals is that for HIV/AIDS education. The stereotype that older people are not sexually active has contributed to making this an unnoticed population for AIDS educators and others [148; 149]. As recently as the late 1990s, primary care physicians were less likely to discuss HIV or HIV risk reduction with patients older than 50 years of age than with those 30 years of age and younger [150]. Only within the GSM community itself have prevention campaigns targeted all age groups [149].

Researchers have reported striking differences between older and younger GSM people related to their attitudes toward public disclosure of their gay sexual orientation [41; 151]. One of the most trying issues related to caring for older LGBTQIA individuals is the issue of patient self-disclosure [152]. In a study involving more than 2,500 LGBT persons 65 years of age or older, more than 20% did not disclose their sexual identity to their physician [153]. In general, elderly LGBTQIA individuals come from a highly stigmatized background in which they had been considered most of their lives to be ill and deviant. Consequently, they have learned to conceal their sexual orientation as a means of survival [154].

These older LGBTQIA individuals grew into adulthood during the Pre-Stonewall Riots period. This was a very oppressive time period for the LGBTQIA community and one during which there were no hate crime laws and no research on the incidences of antigay hate crimes. LGBTQIA individuals had to learn how to manage homophobia and heterosexism over a lifetime, an effort that requires tremendous daily emotional energy. The healthcare community might never know the full effect that internalized homophobia has had on older GSM Americans [154]. Having lived through years of stigma, before the ascendance of more positive attitudes toward homosexuality, older GSM individuals may think that disclosure to a healthcare provider cannot or should not be done.

LGBTQIA individuals also disagree within their community about self-disclosure, and they do so for a variety of complex reasons. For example, older GSM individuals who do self-disclose may view it as necessary to override heterosexist assumptions about non-straight sexuality. Or, they may feel that disclosure makes discrediting them more difficult [41]. The subculture's self-examination and discussion about self-disclosure has been dynamic and across intergenerational and intragenerational lines.

As a result, healthcare professionals can anticipate that not all GSM individuals will be able to self-disclose. At any rate, asking older patients about their sexual orientation may not always be the best approach. By not asking, trust may be more likely to develop between the healthcare professional and the patient. At the same time, it is helpful to know the sexual orientation of the patient. In bereavement work, for example, the older patient should be free to reminisce about his or her life partner within a comfortable, trusting environment without fear of critique [152]. Clearly, this is an extremely difficult issue to navigate.

Intergenerational differences related to practical concerns also exist. For example, older LGBTQIA individuals have identified legal strategies for protecting property as an important concern. A home care option that would offer protection from homophobic atmospheres in nursing homes, allowing more care from significant others and friends, has been identified as another important issue. Emotional needs, such as trust, hope, worries about loss, spirituality, family rejection, and loneliness, have also been identified. Though topics of concern are similar among the LGBTQIA generations, manifestation of these topics may vary widely at different times over the individual's life span [151].

Health and loneliness may be more intertwined in the older LGBTQIA community [134]. For example, because older gay adults often have been closeted most of their lives, they may not know how to connect with existing health support systems provided by the GSM community [155]. Many older LGBTQIA individuals must also face the impact of HIV/AIDS on aging. AIDS has left many in this population with fewer friends and support networks. Many GSM community members do not have children, who are a major source of support for the heterosexual population. The fear of developing poor health and experiencing illness may lead the GSM individual to concerns about poor quality and quantity of care by healthcare providers who are unaware and insensitive to the gay subculture's unique healthcare needs and concerns [134].

Older gays and lesbians have many strengths, among them the learned importance of personal independence in planning for their own futures [154]. Growing older brings greater maturity, wisdom, and experience, resulting in a sense of empowerment for many [134]. Because of experiencing a lifetime of managing the many social stresses related to prejudice and discrimination, older gays and lesbians may be more prepared to cope with social discrimination and losses that accompany aging than are their heterosexual peers [79].

CROSSCULTURAL COMMUNICATION

Only when the healthcare professional remains sensitive and aware can culturally competent care be provided for the LGBTQIA individual. LGBTQIA patients' concerns about sexual identity or sexual orientation may exist or be deeply denied. Healthcare professionals are seeing LGBTQIA individuals of all ages but may not know who these patients are unless the patient realizes his or her sexual identity and is comfortable enough to disclose it. In many health interactions, it is not necessary for the healthcare professional to know who is gay or questioning, but a comfortable setting should be created in which individuals may seek support and help for their concerns.

The healthcare professional can utilize a variety of strategies to promote personal sensitivity, awareness, and knowledge of the LGBTQIA population. Borrowing from the discipline of crosscultural counseling, four communication skill areas may provide a framework for strategies that the healthcare professional can use to be more culturally competent when interacting with the LGBTQIA subculture. The skill areas are [156]:

- Be able to explain a problem or issue from another person's perspective.
- Know what causes the other person to become defensive and resistant.

- Take actions to reduce defensiveness and resistance.
- Know recovery skills to use when communication errors occur.

Use of these skill areas may serve as a bridge to meeting professional and legal responsibilities when interacting with the LGBTQIA subculture [87].

APPLICATION OF SKILL AREAS AND CULTURALLY APPROPRIATE STRATEGIES

The first crosscultural communication skill is to be able to articulate and present a problem or issue as it is seen from another's perspective. To do this, the healthcare professional must learn about the culture in question. Studying the sexual identity models, reading about the history of the gay subculture, watching documentaries related to diverse human sexuality, exploring educational Internet sites, or attending professional workshops addressing gay-related topics are excellent strategies for increasing personal awareness, sensitivity, and knowledge about the LGBTQIA population. Because increased contact with minorities has been found to be a very effective strategy for promoting understanding, a healthcare professional could increase interactions with members of the GSM community to reduce negative stereotyping, prejudice, and discrimination [157]. Keep in mind that gaining access to a subculture requires sensitivity, patience, and understanding because one's interest in the community may be questioned by subculture members [158].

The second crosscultural communication skill area involves recognizing defensiveness and resistance and knowing its cause [156]. Problem behaviors arise when the healthcare professional begins to impose personal values on others. Assuming that everyone is heterosexual and demonstrating a lack of knowledge about the health-damaging effects of stigma on the LGBTQIA population are two behaviors that may create defensiveness or resistance. Other problem behaviors involve making hostile or discriminatory statements, using slang, and telling or laughing at derogatory jokes about the GSM community. Because this active form of collusion furthers stereotypes, the healthcare professional should monitor his or her own behavior so that he/she remains sensitive and culturally competent.

Failure to have wording on patient history and intake documents that is inclusive of sexual minorities and partners could be problematic, as well. For example, do documents include space for a partner notation, or do they ask only for marital status (i.e., single, married, widowed, or divorced)? None of these words may be an honest answer in a gay patient's mind. The Gay and Lesbian Medical Association offers guidelines for creating a safe and comfortable clinical environment (see ***Resources***). Intake information should also include an explanation about how confidentiality will be managed.

Disclosing a patient's sexual orientation without the patient's permission should be avoided. Not only might "outing" the patient lead to patient defensiveness, but information about a patient's sexual orientation is protected by the Health Insurance Portability and Accountability Act (HIPAA) [159]. In situations when a patient's disclosure may not remain confidential, some reassurance of respect could be provided if disclosure was always accompanied by the patient's consent.

Healthcare professionals should also be knowledgeable about the visitation policies of their healthcare agency. Policies and practices that are inclusive of partners and co-parents are valuable measures that demonstrate cultural competence.

The third crosscultural communication skill area requires taking actions to reduce feelings of defensiveness and resistance in oneself and others. One of the most important activities for the culturally competent healthcare professional is to examine one's own feelings, values, and stereotypes regarding culture and, in this case, regarding human sexuality [34]. Examining one's attitudes does not mean that the professional is approving or condoning a specific orientation or behaviors. The healthcare professional need not necessarily change personal beliefs to provide culturally competent care.

The healthcare professional must ask: "Can I recognize behaviors in others that may indicate feelings of defensiveness and resistance?" Related to youth, the school nurse should observe for individuals who may be trying to make themselves invisible by isolating themselves from others. For example, are there students who are avoiding settings that may place them in a position to be questioned [87]? Adults and the elderly may isolate themselves as well. It seems unlikely that a sexual orientation that has been concealed for a lifetime will be easily or quickly revealed to anyone, even a well-intentioned healthcare professional. Anger, illness, and other manifestations of stress may be evident. Fortunately, many strategies can be suggested to help reduce defensive and resistant feelings.

Promoting an atmosphere of openness and calm may be helpful. Displaying posters, educational materials, and other materials of interest that are positive about the LGBTQIA community may signal the existence of a safe environment. For example, a sign in the waiting area that says, "We do not discriminate on the basis of age, race, sex, sexual orientation, gender identity, religion, language, or disability," would be noticed by a GSM person. Showing equal respect for friends, partners, spouses, and relatives may also be helpful [160].

Being familiar with at least one of the sexual identity models discussed would assist the healthcare professional to assess at what point in the coming-out process an individual may be. For LGBTQIA youth, having this awareness could strengthen the planning related to their overwhelming need for anticipatory guidance [87].

Practicing nonjudgmental caring, by developing interviewing skills that employ inclusive terminologies, may also help reduce defensiveness. Speaking up when ridiculing remarks are made is vital. "That kind of joke has no place here" should be sufficient to send the message to a gay observer that the professional is sensitive to LGBTQIA concerns [161].

Demonstrating awareness that elderly LGBTQIA individuals may have fewer support systems is important. The American Association of Retired People provides Internet resources designed for elderly GSM persons. Individuals unable to use Internet services will need assistance with referral sources. Becoming familiar with appropriate LGBTQIA community referral sites is important as well. Contact local LGBTQIA support agencies for information about their services. Referring GSM individuals to a GSM-related referral site is like referring a diabetic to the American Diabetes Association [159].

The fourth crosscultural communication skill area requires acknowledging that mistakes will be made [156]. Heterosexual bias is not the fault of the individual healthcare professional, so expect to make honest mistakes. Some GSM individuals have children, so assuming, during conversation, that someone with children is not gay could lead to a communication mistake [87]. Communication with adolescents should focus on developing rapport. When discussing the subject of sexual orientation, teens feel more comfortable if the healthcare professional uses a non-confrontational, casual approach [65].

When communicating with older GSM individuals, remember that diverse views exist related to disclosure of their sexual orientation. Providing a comfortable clinical environment, one that visually demonstrates awareness of the LGBTQIA community, will assist with the decision to self-disclose. As a result, the opportunity for more complete health data collection is possible so that unique health and safety needs may be identified and addressed.

Learning communication recovery skills will help the healthcare professional accomplish more positive outcomes when providing healthcare or health consultation [156]. Recovery skills include apologizing for an error, focusing on another health need until rapport is re-established, or reversing roles and asking the patient to help you with a problem or information need [156]. For example, if a patient seems offended by something you have asked or said, simply apologize and offer a brief explanation about why the information is necessary to provide good

care. Explain, if you can, why the mistake was made. Perhaps you did not have the awareness you needed. Later, if appropriate, you can ask about another health need (e.g., immunizations) and work toward re-establishing rapport. Learn from the mistake. Remember, it may take time for the LGBTQIA person to trust. Most errors will be forgiven if recovery efforts are made with sincerity.

Like all cultures, the gay subculture is dynamic. Many changes have and are taking place within the subculture and within the general population's attitudes toward the subculture. Ongoing education is necessary to remain culturally competent.

CONCLUSION

The GSM population is a diverse subculture, representing men and women of all ages and all socioeconomic, ethnic, educational, and religious backgrounds. The population has been described as "hidden and invisible," "marginalized," and "stigmatized." As a result, the unique health and safety needs of the population have often been overlooked or ignored. Healthcare professionals have been seeking more information about this population's health promotion and care needs. More research about the subculture's characteristics, physical and mental health promotion needs, and strategies to address these needs has been requested.

It has been suggested that the available sexual identity models are "fast becoming antiquated" and that they lack explanation for the multifactorial nature of human development [162]. There must be continued effort toward identifying "normal" developmental issues and tasks for the GSM individual. Unique issues related to identity development and maintenance, career development, race/ethnicity/social class, coping with antigay violence, AIDS, same-sex coupling, and parenting also require further clarification and validation [147]. Both nurses and physicians have indicated that they need more knowledge and skills to meet the needs of LGBTQIA adolescents [65]. For example, a survey of pediatricians indicated a need and desire for further training related to the health of sexual minority youth [163].

The American Psychological Association and the National Association of School Psychologists have advocated funding and support efforts for applied research and scientific evaluations of interventions and programs that are designed to address the issues of lesbian, gay, and bisexual youth in the schools [164]. In 2012, the National Institutes of Health announced a funding opportunity for extensive research into LGBTQIA health, including research related to cancer risk, depression, suicide, obesity, long-term hormone use, substance use/abuse, and HIV/AIDS and STIs [165]. Together, the National Institute of Child Health and Human Development, the National Institute of Mental Health, and the National Institute of Child Abuse have called for grant applications for the study of behavioral, social, mental health, and substance abuse research in the sexual minority communities [164]. The American Public Health Association has identified the need for public health research on gender identity and sexual orientation [12]. AMA Policy H-160.991 indicates that more research is needed to provide improved care to the GSM population [13]. The Department of Health and Human Services has worked to include subpopulations of women, including lesbian women, in research trials [30]. Other examples exist, but few studies have examined the experiences of older lesbian, gay, and bisexual adults [166].

There are serious challenges to designing research that results in accurate data. From the discipline of counseling, use of the four crosscultural communication skill areas provides a framework for identifying strategies that a healthcare provider may use to promote culturally competent care for the GSM community. Just as learning about other cultures requires ongoing education as the cultures change over time, learning about the gay subculture also requires continuous education as more information becomes available.

RESOURCES

Parents, Families, and Friends of Lesbians and Gays (PFLAG)
https://pflag.org
202-467-8180

Lambda Legal
https://www.lambdalegal.org
212-809-8585

Sexuality Information and Education Council of the United States (SIECUS)
https://siecus.org
202-265-2405

Gay and Lesbian Medical Association
http://www.glma.org
202-600-8037

Children of Lesbians and Gays Everywhere (COLAGE)
https://www.colage.org
828-782-1938

Gays and Lesbians in Alcoholics Anonymous
https://gal-aa.org

Gay, Lesbian, and Straight Education Network
https://www.glsen.org
212-727-0135

Human Rights Campaign
https://www.hrc.org
800-777-4723

National LGBTQ Task Force
https://www.thetaskforce.org
202-393-5177

American Association of Retired People (AARP)
https://www.aarp.org/home-family/voices/lgbt-pride
1-888-OUR-AARP (1-888-687-2277)

Services and Advocacy for LGBT Elders (SAGE)
https://www.sageusa.org
212-741-2247

American Society on Aging On Aging Institute
https://asaging.org/education-topic/lgbtq-aging
1-800-537-9728

LGBT National Youth Talkline
https://www.glbthotline.org/talkline.html
1-800-246-PRIDE (1-800-246-7743)

Transgender Law Center
https://transgenderlawcenter.org
510-587-9696

National Runaway Safeline
https://www.1800runaway.org
1-800-RUNAWAY (1-800-786-2929)

Trans Lifeline
1-877-565-8860

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

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