Health Disparities of the Sexual Orientation and Gender Identity Marginalized Community: Where Do We Go from Here?

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Introduction

To understand the health disparities of the Sexual Orientation and Gender Identity Marginalized (SGM) Community it is important to first understand the diverse groups of people that make up this category. While sometimes overlapping, definitions include youth and older adults in the SGM community who may be a racial minority as well as Gay, Lesbian, Bisexual or Transgendered individuals. Each subgroup within these categories have distinct health issues.

Since the 1980s', in a desire to be more inclusive, LGBT has been used to describe Lesbian, Gay, Bisexual, and Transgendered individuals rather than using the collective term "*Gay rights*". Various legislation has been passed in the past ten years to provide protections to this growing group of individuals. While most of this legislation has been enacted at the federal level, it is desirable to reflect these reforms in all health systems whether local, or statewide.

A safe, welcoming place of work that offers both cultural competency and gender affirming services should be the end goal. As there are varying lengths of the initialism LGBT, the author will refer to them as the SGM Community as the most inclusive term. However, instances where an author is quoted, their chosen initialism will be used.

Subgroups of the SGM Community

"Although it's often simpler to refer to "*the LGBT population*," providers must recognize that LGBT people are not identical. This population includes individuals of every race, ethnicity, religion, mental capacity, physical ability/disability, age, and socioeconomic group". [1] Additionally, each subgroup possesses unique social determinants. "The social determinants of health refer to the structural determinants and conditions in which people are born, grow, live, work and age".[2]

Social Determinants and Health Risks for SGM Youth

SGM youth, like all adolescents, have a somewhat challenged relationship with their parents. Family acceptance of sexual orientation and gender identity is critical in maintaining good physical and mental health in young Americans. Perceptions of acceptance from parents and other important adults seems to limit the amount of substance use among SGM young adults.[3] This is also true of the risks for depression, suicide, and risky sexual behaviors. Those who had experienced rejection from their families were much more likely to engage in these behaviors. [3]

Ryan et al. [4] found adolescents who had low family acceptance were three times more likely to commit suicide. Thirty-five percent of homeless youth are SGM. Safety is of utmost concern for those on the streets. In order to sustain themselves, they often resort to sex work in exchange for housing, food, money etc.[3]

Implications for nursing practice

Nurses should routinely ask teenagers about their sexual orientation in order to provide appropriate care, educational resources, and support for the parents as well as provide access to community resources, counseling, support groups, and other programs for the youth. [3]

Nurses can help parents understand that coming out is a normative step in their child's development. "…educating families of LGBT youth can help them understand the serious negative health impact of family rejection on the adolescent's health and mental health (including depression, suicide, illegal drug use, and risk for HIV)" [4]

Social Determinants and Health Risks of Gay Men

Likewise, Gay men experience a higher incidence of mental health problems including suicidal ideation, and attempts as well as substance abuse and mood disorders; Gay men who choose not to disclose their sexual orientation are less likely to seek mental health care. [5] Avoidance is their primary coping strategy and they are therefore less likely to report sexual encounters with men, especially risky ones, and be tested for HIV/AIDS or other STI's. The perceptions that Gay men have of the healthcare environment being heterosexist perpetuates the existing barriers to care. [5]

Indeed, providers cannot address needs they do not know exist. Therefore, a non-judgmental, welcoming, and confidential environment is the best way to address the disparities of mental health care among Gay men. They are oftentimes isolated and thus connecting them to social support, SGM friendly providers and affirming services is paramount to correcting the disparities that exist. [5]

Social Determinants and Health Risks of Lesbians

In the same way, Fidelindo et al [1] found that appropriate and affirming care for Lesbians should be a priority of training for all providers. Lesbians are more likely to have obesity and the related conditions of osteoarthritis, heart disease, stroke, and diabetes. They also have a higher risk of fatality from cancer. [1]

Lesbians are more likely than their heterosexual counterparts to use their Women's healthcare provider (WHCP) as their primary care provider. [6] As a result, many of them have had discussions about their mental health and are being prescribed psychotropic drugs by their WHCP; few of them, however, were asked about their sexual orientation, given adequate safe sex advice, or had a WHCP who seemed knowledgeable about their issues. [6]

In addition, Barefoot, et al. showed many Lesbians display avoidance of seeking health care due to discrimination and past negative experiences. There is a critical need for WHCP's of all lesbians to adequately screen them for HPV since they are at increased risk of cervical cancer. [6]

Social Determinants and Health Risks of Transgender Men and Women

There is also a critical need for protections of Transgender individuals. Transgender individuals are less likely than Gays and Lesbians to have health insurance. [1] Discrimination is a large deterrent to seeking out medical care especially if they are a person of color. Mental health issues, suicide, victimization, and AIDS are problems faced at much greater rates than the general population. [1]

Transgender individuals are more likely to be homeless than Lesbians, and Gays. [3] They are excluded from most shelters that are gender specific, and when they are accepted, they are required to generally express themselves as their birth gender. This makes them vulnerable to attacks, aggression from other clients, and discrimination by staff. [3]

Due to lack of education, training, social and family support, Transgender adults have high rates of unemployment. They also experience greater barriers to legal and social services, fair and decent housing, and primary care; this results in greater levels of homelessness than non-trans people. [3]

Diagnosis and treatment.

"Currently, the DSM-IV-TR diagnosis of Gender Identity Disorder (GID) is often used by clinicians to describe the Transgender experience". [3] Some activists argue that it is not correct to describe Transgender as an illness, however, most gender affirming care in this country is only eligible for provider reimbursement after this diagnosis is confirmed. Without it, the Transgender people who have managed to find insurance coverage would not be able to pursue or continue their care. Gender confirming surgeries and the risks, challenges and positive outcomes, as well as the role of the mental health provider in this process should all be discussed.[3]

Spicer [3] continued that a lack of access and poor communication of health history contribute to illegal and risky activities. Injection of hormones and silicone by untrained individuals using shared needles can cause disfiguration of the body, and increased risk of HIV/AIDS and other diseases. Other medical issues such as cancer screenings are often neglected as are STI screenings. Eating disorders and negative body images are common in Transwomen. In addition, smoking and alcohol can have dangerous side effects with the hormonal drugs commonly prescribed for transitioning. [3]

To break the cycle of barriers to care, providers need to demonstate on all levels that they are gender affirming: have non-discrimination policies displayed in a conspicuous place, have intake forms with non-gender options that accurately capture someone's medical history, listing someone's preferred name and using their pronouns. Understanding the individual and systemic concerns of Transgender individuals will help to protect and advocate for this vulnerable population. [3]

Social Determinants and Health Risks of Bisexuals

Bisexuals are a subgroup for which there is a dearth of information. However, Fidelindo et al. [1] discovered that Bisexuals have higher rates of depression, suicidal thoughts, domestic violence, asthma, obesity and lack of quality of life. Steele[7] found that "BI/PAN women were 1.8 times more likely to have unmet needs for mental health". These higher rates among Bisexual women were in part explained by social factors and systemic exclusion from healthcare. [7] In other words, if you are a Bisexual woman with a low socioeconomic status, and lack of social support, you will be at the highest risk.

In most studies reviewed, Bisexuals were lumped together with their cisgendered Lesbian and Gay counterparts. The author found no studies that looked exclusively at Bisexuals as a distinct subgroup. Bisexuals need to self-advocate for their own unique needs. This will increase their safety and wellbeing by making their providers aware of what they need to remain healthy.

Social Determinants and Health Risks of SGM Older Adults

Another subgroup rarely seen as distinct is SGM older adults. Fidelindo [1] noted that ageism and the stigma of being SGM will make treatment of comorbidity common in old age more difficult with drug interaction concerns and the necessity for follow up care.

Fredriksen-Goldsen et al. [8] wrote that SGM individuals that are currently over 50 grew up in an era where their identity was not only highly stigmatized but also criminalized. They faced day-to-day marginalization, discrimination, victimization, and microaggressions. "…[T]ailored interventions promoting identity affirmation and strategic identity management as well as psychological, social, and behavioral resources need to be developed to promote optimal health of LGBT older adults." [8]

Social Determinants and Health Risks of SGM Racial Minority

Trinh et al. [9] investigated the intersectionality of being in the SGM community and being a racial minority. Black SGM women had a three-fold risk of stroke as compared to heterosexual women; while Hispanic SGM men were more likely to have hypertension and functional limitations than Hispanic heterosexual men, Black SGM men were more likely to be uninsured than Black heterosexual men. [9] The additive and multiplicative effect of being an SGM person of racial or ethnic descent is clear in these results.

Minority stresses can be internalized. "…individuals in this group could experience 'double (or triple, in the case of SM women of color) jeopardy': racism from the white LGB community, sexism, and heterosexism from their racial/ethnic communities". [9] It is clear that the more social determinants and minority characteristics a person is defined by, the more affects they suffer from. [2] Racial minority SGM as well as all other subgroups of SGM deserve representation and protections from discrimination and victimization on the local, state and federal levels.

History of Legislation and Reforms Pertaining to SGM Individuals

To understand what needs to happen in order to protect and provide for this vulnerable population, first it is essential to understand the history of their struggle and what legislative measures have happened recently to de-pathologize their identities.

In 1973, homosexuality was removed from the DSM as a mental illness. Spicer encapsulated the marginalization that has continued to this day for the SGM population. [3] "Often, when individuals in a minority group are stigmatized and viewed as "*sick*" or "*deviant*," a cycle of oppression ensues wherein the individuals are unable to obtain or maintain jobs and lose social supports. This, in turn, can lead to low self-confidence and self-worth due to chronic trauma and loss. Ultimately, they become further marginalized with increased risk of being homeless and needing to rely on illegal behaviors to survive. These behaviors may then reinforce the view of being "*deviant*" and perpetuate the cycle of oppression" [3]

Legislation and Reforms Passed in 2010

In 2010, The Patient Protection and Affordable Care Act expanded insurance coverage, established the collection of Sexual Orientation and Gender Identity (SOGI) data, established nondiscrimination protections, and provided support for public health initiatives and outreach to SGM individuals. [10]

Also in 2010, the Joint Commission published a field guide with core principles on cultural competence that covered healthcare leadership, treatment and services, data collection and use, patient family and community engagement, the workforce, and provisions for care. [1]

Cultural competency can be defined as having the skills, knowledge, and attitudes to work with diverse populations. [11] The United States Armed Forces repealed "Don't Ask, Don't Tell" in 2010 allowing members of the SGM community to serve openly in all branches of the U.S. Military. [11] These three things established that members of the SGM community were rightly protected and supported as a *priority population.* [11]

Legislation and Reforms Passed in 2011

In 2011, the Institute of Medicine (IOM) released a report detailing an ethical obligation to recognize the health care disparities of the SGM community and work to improve prevention and intervention of their unique needs. [12]

Additionally, "In 2011, the Department of Health and Human Services announced that all hospitals participating in Medicare and Medicaid were now required to 'protect hospital patients' right to choose their own visitors during a hospital stay, including a visitor who is a same-sex domestic partner". [1] These were both important steps in increasing the visibility of SGM individuals and the disparities that had largely gone unaddressed before.

Other Legislations

In 2015, Gay Marriage was made legal in all 50 states by the U.S. Supreme Court. [11] Further protections for SGM individuals were established in 2019 with the passage of the Equality Act in the U.S. House of Representatives. [13] This Act prohibits the discrimination of people based on gender identity and sexual orientation in "… employment, housing, public education, and public accommodations (e.g., health care facilities, nursing homes, youth service providers, transportation systems, and retail and hospitality industries)". [13] The aim of this legislation was to ensure that all Americans, regardless of their identity, can be guaranteed respect, and dignity in every area of their lives. [13]All the legislations that have passed in the last ten years have made great strides in protecting patient rights of those in the SGM community. Federal laws, however, are only as good as their enforcement on the local level. In conservative states like Oklahoma, a largely hostile environment exists toward Gay and Bisexual men. [5]

Anti-LGBT legislation passed in Oklahoma and other conservative states can have a direct impact on SGM individuals. "…[S]tates that specifically banned same-sex marriage demonstrated a 37% increase in mood disorders, 42% increase in alcohol use, and a 248% increase in generalized anxiety disorder compared to LGBT individuals living in states with no bans". [5]

Where Do We Go from Here?

This brings us to how we can move forward to end the stigma and health care disparities in the SGM community. It requires a global approach. We need to make broad changes in the education of clinicians, and in the workforce itself.
Teaching students how to be comfortable collecting sexual histories will allow them to be both culturally competent and gender affirming. They can then create a workplace that is safe and welcoming for both employees and patients by utilizing inclusive intake forms and brochures and documenting SOGI data in Electronic Health Records (EHR'S).

Educational changes

Most disparities are a direct result of medical staff not having enough training to feel confident treating SGM patients. [14] Curricula in medical schools has only increased from 3h 26m in 4 years in 1992 to 5h in 4 years in 2011. "…72% of nursing educators from accredited colleges reported being unprepared to teach LGBT content" [14]

Curricula in Undergraduate, Graduate, and Postgraduate (including continuing education) must include simulated patient scenarios that integrate and normalize comfortable discussions of documenting SOGI as well as awareness and reduction of microaggressions (inappropriate jokes and exclusionary verbiage). [12] "…[O]nly in a safe environment can a trainee from a sexual minority population function optimally, share his or her rich perspectives, and possibly enhance colleagues' LGBTIQQ care competence". [12]

Having a comfort level with something is not the same as having competency with it. [15] "It is interesting to note that despite professed level of comfort, residents fare poorly overall in performing basic tasks of taking sexual history by their own report" [15]. There is no way to know how much harm these incidents have on SGM populations especially given that in many instances Emergency Medical residents are their option of last and sometimes only resort. Indeed, lack of contact with experts is one of the leading barriers to access and positive outcomes.[15]

One way to promote cultural competence is using online learning modules as Donaldson et al. [11] did. Their study utilized a Talent Management System at the Veteran's Administration to deliver content to educate and test competency before and after completing the learning module. "This project also shows how a brief, easily deployable, low-cost intervention can be used to improve staff knowledge in this area of cultural competency". [11]

Workforce Changes

In addition to being culturally competent, today's workforce needs to be gender affirming to end health disparities of the SGM community. This effort needs to be implemented at all levels. The coordination of care from all team members is important to creating a welcoming environment. From the moment the patient encounters the security guard at the entrance, the front desk staff, the medical technologist, the physician, and the billing department, SGM populations are looking for signs they are welcome and understood. [14]

The use of EHR's can lessen the disparities faced by SGM individuals in the U.S. health care system. [12] Health professionals must ensure the safety of patients and staff members. With these safeguards in place, the collection of data will provide common understanding of the health risks for SGM individuals. [12] At this point, interventions and preventions are possible. Systematic collection of SOGI data at all levels of care from ER to primary, and specialist visits can help reduce the *invisibility* of SGM individuals. Constant and consistent use of EHR's can work around nationwide disparities as state guidelines vary widely. [12]

In light of the global pandemic caused by SARS-COV-2 and COVID-19, collecting SOGI data is crucial to reducing health care disparities in the SGM community. [16] SGM individuals are more likely to work jobs that put them at greater risk. Over 25% of this population works in retail, hospitals, and food service. [16] For this reason, they have lower incomes; many of them lost their jobs and their employee sponsored health insurance in the Spring of 2020. [16]

They are also more likely to live in areas of dense population where social distancing is more difficult to achieve. In addition, they are likely to be vulnerable to complications from COVID-19 as they are more likely to have chronic diseases, smoke cigarettes, and have higher rates of disability than heterosexuals. Deployment of resources, care, and treatment based on these factors cannot occur unless appropriate patient data is collected. Without appropriate data, adequate treatment is not possible for this population. [16] More than ever, health departments across the nation need to be collecting SOGI.

Conclusion

The SGM community is not one entity but many smaller, sometimes overlapping subgroups. SGM individuals are a vulnerable population with unique health care needs. Understanding the distinct challenges inherent in each subgroup is the first key to understanding how to properly care for and treat them.

SGM individuals have been designated in various legislation and reforms as a *priority population* [1,10-11] and provided with nondiscrimination protections after decades of being criminalized, victimized, and marginalized.

Teaching documentation of sexual histories in medical education, encouraging patients to self-disclose by providing inclusive intake forms and patient education brochures, and using EHR's to track SOGI information to create actionable insights are steps that can provide for safe spaces at institutions, not only for the patients, their visitors and families, but also for the faculty and staff that work there. [11-12,14]

Our Society has a long way to go to end the stigma and disparities of SGM individuals, but the ideas outlined in this paper present meaningful opportunities to bring us a great deal closer to the realization of social and treatment parity.

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