Chapter 7: The Effects of Stigma on Health

The study of why some people swim well and others drown when tossed into a river displaces the study of who is tossing whom into the current—and what else might be in the water.

Krieger (2001, p. 670)

In chapter 3, we reviewed the effects of stigma on the everyday lives of LGBTQ people, including lack of recognition of significant others and family, hate crimes, social rejection, and employment discrimination. This chapter addresses the effects of stigma on the health of LGBTQ people. It is easy to fall into an individual focus when discussing health problems and assign individual responsibility for overcoming these problems, such as telling LGBTQ people that they should seek out health care earlier, comply with health care proscriptions, and/or learn better coping strategies. Nancy Krieger’s astute comment that begins this chapter grounds the discussion, reminding us that stigma arises from societal-level influences that impact the individual. Not all LGBTQ people will have overt health problems related to stigma, but the overall hostile climate of society in general and health care institutions in particular creates the conditions for health disparities to develop and fester.

Social stigma refers to severe disapproval and discrimination that is directed by one group toward others based on their perceived or actual membership in a particular group. It is based on prejudice and stereotypes that unjustly judge the other as deficient, evil, abnormal, inferior, sick, subhuman, immoral, or criminal. These attitudes, reviewed in chapters 3 and 4, marginalize LGBTQ people from the mainstream of society, deny them basic and fundamental rights of citizenship, create an atmosphere of fear and hatred, and endanger their well-being. Stigma affects society as a whole, because it creates an atmosphere of hatred, hostility, and intolerance, robs the community of the benefits that could be gained by full participation and contribution of those who are stigmatized, increases the health burden of the LGBTQ community, and interferes with the development of potentially supportive relationships among people of differing sexualities and genders.

Stigma can result from visible or relatively invisible human characteristics. Some authors argue that individuals with a concealable stigma can easily hide and therefore avoid the prejudice and resultant discrimination that goes along with visible differences (e.g., Goffman, 1963). Recent research suggests, however, that the effort of hiding a stigmatized identity takes an enormous toll and may adversely impact the individual’s life. Whereas people with visible differences (such as obvious skin color differences or in a wheelchair) are constantly “out,” people with hidden forms of difference must continually make decisions about disclosure, sometimes multiple times in the course of a day. LGBTQ people must weigh “whether, when, how, and to whom to disclose their stigma” (Pachankis, 2007, p. 328), always wondering whether the reaction will be positive or negative. Some authors refer to this internal cognitive processing as “stigma management” (Meyer, 2007), and it adds a level of stress to daily life that heterosexual people may never have imagined.

In the United States, stigma regarding sexual and gender identities stems primarily from one of the following two sources:

- **Medicine**: based on ideas of disease or biological abnormality, particularly beliefs drawn from the field of psychiatry about sickness, abnormality, or mental illness, and
- **Religion**: the idea of sin or immorality.

Sin and sickness discourses coexist in much of the anti-LGBTQ rhetoric throughout the past century. Medical sciences have focused on a search for the cause of minority sexual and gender orientations, but not for the cause of heterosexuality, and for a biological basis for male–female differences rather than focusing on the similarities. By not equally studying how heterosexuality arises, and by making the assumption that men and women have different skill sets, personalities, or behaviors because of biological differences, medical sciences tend to reify sexual
and gender difference rather than highlight the myriad similarities among people with differing gender and sexuality. In 1973, the American Psychiatric Association removed sexual orientation from its diagnostic categories of mental illness from the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, but there continues to be a minority of psychiatrists and psychologists who advocate “reparative” therapies to attempt to change the sexual orientation of LGB people (see, e.g., the National Association for Research and Therapy for Homosexuality [NARTH]). The presence of reparative therapy, which has considerable overlap with religious beliefs and religious conversion experiences, perpetuates the myth that minority sexual/gender identifications are associated with mental illness and abnormality, and this contributes to the stigma of being openly LGBTQ.

We discussed the role of religion on attitudes about LGBTQ people briefly in chapter 4. A recent rise in fundamentalism has resulted in renewed attacks on the civil liberties of LGBTQ people, most notably in the areas of marriage and an increase in the number of “ex-gay” ministries (Hedges, 2006), which are ministries devoted to changing people from LGBTQ to heterosexual through prayer, isolation, and pseudopsychological techniques. Erzen (2006) studied men in one of the oldest ex-gay ministries in the United States and proposed that “ex-gay” had become yet another social identity in place of LGBTQ, and that few of the men actually converted to or considered themselves as heterosexual even after years of prayer, social isolation, and religious intervention. Rather, they learned to suppress their sexual desires by associating only with “safe” people—mostly other “ex-gays” and to deal with frequent relapses and persistent same-sex desires. Research on conversion and reparative therapies confirms Erzen’s position—few if any people engaging in these therapies are able to change their sexual attractions or desires (Shidlo, Schroeder, & Drescher, 2001). The overwhelming lack of evidence that reparative therapy, whether based in religion or in psychological theory, changes sexual orientation, and the voluminous anecdotal evidence of the harm inflicted by the attempt to change one’s sexuality have led the majority of medical and psychological associations in the United States to denounce reparative therapy as unethical (e.g., the American Medical Association, the American Psychiatric Association, the American Psychological Association, the National Association of Social Workers).

The United States is supposedly built upon a separation of church and state, meaning that public institutions that serve the needs of the population are not to inflict any particular religious viewpoint upon their clients. Whereas most health care professionals may not conduct or refer clients to reparative therapy, some of them impose their religious beliefs in other ways. Unfortunately, far too many clients are exposed to unwanted proselytizing when they attempt to access health care, as the following example illustrates.

> When J. went to the doctor’s office in her Florida town, the last thing she expected to receive was a packet of anti-gay propaganda referring to homosexuality as “sinful” and “impure” and advising lesbians and gay men to change their sexual orientation. “When I opened the sealed packet, I was shocked and outraged,” says J. “I was extremely offended and I felt like I had been violated.” J. made a formal complaint with the office manager, who informed her that their office routinely disseminates the antigay materials to patients. When she retrieved her medical records, J. was in for yet another shock. On her chart was written “Scripture references were given regarding homosexuality and lesbianism” (reported on the Web site of the Mautner Project, 2007).

If you were J, what would you have done?

The sin and sickness discourses have impacted health care institutions in other ways as well, limiting access to health care services and affecting the quality of care received once in the system. Heck, Sell, and Sheinfeld-Gorin (2006) studied a random national sample of U.S. households and compared same-sex households with other-sex households on four indicators of health care access. Women in same-sex households were less likely to have health insurance, less likely to have a primary care doctor, less likely to have seen a health care provider in the past year, and more likely to have unmet health needs because of cost considerations than women in other-sex households who had the ability to marry. Men in same-sex households were roughly equivalent to men in other-sex relationships, but there was a trend toward less access to health care as well.

Marion is a male-to-female postoperative transgender woman and is a pediatrician in a large suburban practice in the Midwest. She is concerned that being “out” would jeopardize her career in her conservative community, so she has told no one of her gender identity. She lives with her partner of 5 years, a lesbian named Shelly, who has been introduced at work as Marion’s roommate. They have a very small circle of friends in the lesbian community but restrict their public social activities with those friends for fear of being seen by patients or coworkers. Marion needs to find a primary care physician for herself and is in turmoil about finding a discrete provider who will not reveal her gender and sexual identities to colleagues. The stress of concealing her identities has affected Marion in many ways—she is paranoid and suspicious at work and coworkers think of her as “standoffish.” She occasionally has panic attacks, and the secrecy is affecting her relationship with Shelly, who wants to be out and open about their relationship, but fears rejection by the lesbian community as well as by Marion’s heterosexual...
EFFECTS OF STIGMA ON HEALTH

The stress related to minority identification can affect people from any disenfranchised or oppressed group. Minority Stress refers to the additional stresses experienced specifically because of identification with an oppressed minority group. Minority stress

1. is unique and adds more stress on top of the general life stressors that many people experience;
2. is chronic; and
3. comes from social processes, institutions, or structures rather than from individual risk factors such as biological or genetic variables. (Mayer, 2007, pp. 243–244)

Mays and Cochran (2001) found that LGB people were more likely to report discrimination in jobs, housing, education, health care, and other settings than heterosexual people (see Table 3.2 in chapter 3). Being denied health care or receiving inferior care was reported by 7% of lesbian/bisexual women, 3% of gay/bisexual men, 3% of heterosexual women, and 4% of heterosexual men (Mays & Cochran, 2001). Xavier, Honnold, and Bradford (2007) reported that 27% of transgendered Virginians had no health insurance, 38% did not have a regular physician, 36% felt uncomfortable talking to health care professionals about transgender-specific health issues, and 24% had experienced discrimination from a health care professional. Very little is known about bisexual people’s experiences with health care (Miller, Andre, Ebin, & Bessonova, 2007).

Minority stress can come from internal and external sources. Some authors discuss the internalized effects of stigma, called variously in the literature internalized homophobia, internalized oppression, or internalized heterosexism. Internalization occurs when individuals believe the negative stereotypes related to their identities and, as a consequence, develop shame, guilt, and self-hatred (Mayer, 2003). They may expect poor treatment from others. However, even well-adjusted LGBTQ people who have rejected the negative stereotypes must deal with minority stress from external sources, such as discrimination, harassment, and threat of violence from others who hold the negative stereotypes. Minority stress results in a heightened sense of vigilance in situations where the person anticipates that discrimination, harassment, or violence may occur. Unfortunately, health care settings are among the places where that increased vigilance is at play (Eliason & Schope, 2001; Hitchcock & Wilson, 1992; Stevens, 1994). The increased vigilance takes its toll. It is stressful and energy-demanding to always be on one’s guard.

The high level of internal and external stress can result in new disorders or worsen existing health problems and may be compounded by lack of access to quality health care. Emotional status and reactions to the environment can have enormous impact on physical and mental health. It is important to recognize when stress is causing or contributing to illness because conventional treatments may not be as effective if the root source of stress is not addressed. People who have experienced chronic stress may no longer recognize the stress because it has become part of their daily existence, so helping them become aware of stress and finding ways to reduce the stress are important components of treatment. Recognizing that they are not to blame for the negative attitudes of other people is another critical aspect of treatment.

Stress can impact nearly any organ system, but we will focus on the areas where there is a substantial evidence base about the impact of minority stress related to sexual and gender identification. We discuss these adverse effects on health in two general categories: mental and physical health problems, although we recognize that there is considerable overlap among these categories. Mental health problems include substance abuse, depression, anxiety, suicide attempts, domestic violence, and body image and eating disorders, and physical health disorders include chronic physical ailments, cancer, and sexually transmitted infections (STIs). We end the chapter with a section on the impact of stigma on the quality of care provided in health care settings.

“...So, you know, in the lesbian community and being gay and being a person of color, being a big person, you know, it’s all those stresses. They take a toll on you. And sometimes you just don’t want to feel it. You just want to, like, be out and have fun. And sometimes you need alcohol or drugs or whatever, because then you don’t feel so self-conscious about being who you are. And that’s sad...” respondent in Gruskin, Byrne, Kools, & Altschuler, 2006, p.110).

MENTAL HEALTH PROBLEMS

Substance abuse

Alcohol use and abuse

Several studies have identified higher rates of alcohol-related problems in LGBTQ persons (Bloomfield, 1993; Crosby, Stall, Paul, & Barrett, 1998; Dibble, Roberts, Robertson, & Paul, 2002; Drabble & Trocki, 2005; Garofalo, Mustanski, McKirnan, Herrick, & Donenberg, 2007; Halkitis, Palamar, & Mukherjee, 2007; Hughes, 2003; Hughes et al., 2006; McKirnan & Peterson, 1989; Skinner & Otis, 1996), although the research on rates of current heavy or problematic drinking is less clear.
A recent study of U.S. midlife adults reported that rates of alcohol dependency in the past year were higher for gay men (9%) and lesbians (12%) than for heterosexual men (6%) or heterosexual women (3%) (Mays & Cochran, 2001).

LGBTQ people who are in young adulthood may drink at comparable rates to their peers, whereas older LGBTQ people may drink at higher rates (McKirnan & Peterson, 1989; Skinner & Otis, 1996). In the general population, most adults “mature out” of heavy drinking that occurs mostly in late adolescence and young adulthood. As people marry, have children, and get established in their careers, they go to bars less often and, in general, party less. A subset of LGBTQ people who do not (or cannot) marry, do not have children, and/or live in neighborhoods or communities where bars or parties with alcohol are readily available may continue to drink at higher rates through their midlife, especially if they have found their partners and close friends through these drinking circles. For a more detailed discussion of risk and protective factors for substance abuse, see Hughes and Eliason (2002).

**Drug abuse**

There is evidence of higher lifetime and current use of illicit drugs in LGBTQ populations (Drabble & Trocki, 2005; McKirnan & Peterson, 1989; Skinner & Otis, 1996), with different patterns of use in lesbians and gay men. Drabble and Trocki (2005) found that lesbians were almost five times more likely and bisexual women six times more likely than heterosexual women to report past-year marijuana use. Other illegal substances (e.g., cocaine, methamphetamine, heroin) are used at low frequencies among lesbians as well as among heterosexual women.

Gay men often use a constellation of substances that differs from lesbians and from heterosexual men. They are more likely to use stimulant drugs as sexual enhancers, such as “club drugs” like ecstasy, poppers, and methamphetamine (Halkitis, Green, & Mourgues, 2005; Koblin et al., 2003; Stall et al., 2001). These drugs, particularly methamphetamine, enhance both the emotional and physical pleasure of sex and prolong sexual encounters, which also increases the risk for STIs such as HIV infection and hepatitis. The drug and sexual activities may become linked so that after treatment and/or abstinence from the drug, sex itself may be a relapse trigger for drug use (Díaz, Heckert, & Sanchez, 2005; Halkitis, Fischgrund, & Parsons, 2005; Semple, Zians, Grant, & Patterson, 2006).

Transgender women, particularly those who are sex workers, have very high lifetime rates of illicit drug use. A study in San Francisco reported the following lifetime rates: marijuana, 90%; cocaine, 66%; speed, 57%; LSD, 52%; poppers, 50%; crack, 48%; and heroin, 24% (Clements-Nolle, Marx, Guzman, & Katz, 2001). For many sex workers, drugs are used to cope with the stigma, and drug use/dealing and sex work often go hand in hand. In addition, some transgender women inject silicone or other oils to give them “curves” that allow them to better pass as women and thus be safer on the street. In some urban areas, rates of injecting silicone may be as high as 25%-53% (Reback, Simon, Bemis, & Gatson, 2001). Often done under unsanitary conditions, with dirty or shared needles, and drugs obtained from the street (with unknown purity), the practice carries risk of HIV infection and hepatitis, systemic illness, disfigurement, and even death, if the oil enters the blood stream. Over time, silicone succumbs to gravity and settles around the ankles and feet. It is important for health care professionals to assist transgender individuals in identifying safe medical access to hormones and cosmetic procedures and provide accurate information about the dangers of silicone. Other hormones, such as estrogen and testosterone, can also be obtained on the street and therefore carry risks related to purity and dosage.

In general, injection drug use carries the highest physical health risks of any substance use. One third of transgender individuals in San Francisco reported lifetime use of intravenous drugs (Zevin, 2000) and 22% had a steady sex partner who injected drugs (Nemoto, Luke, Mamo, Ching, & Patria, 1999). Injection drug use among gay men and lesbians is lower than alcohol and noninjection drug use but still significantly higher than for heterosexual samples. One study of lesbian and bisexual women from low-income households found a lifetime rate of injection drug use at 22% compared with 3% for heterosexual women (Scheer et al., 2002, 2003). For gay men (or MSM in general), incidence of injection drug use varies. In one study of young MSM in New York City, nonhomeless MSM had very low rates of current injection drug use (0.3%), homeless youth had higher rates (6%), and MSM who were regular speed users had the highest rates, at 11.9% (Clatts, Goldsamt, & Yi, 2005; see also Kipke, Weiss, & Wong, 2007; Kral et al., 2005).

There are a few LGBTQ-specific treatment programs in the United States, including Pride Institute (Eden Prairie, MN; Arlington, TX; Summit, NJ), Alternatives (Minneapolis, MN; Los Angeles, CA; New York City, NY; Palm Springs, CA), New Leaf Services for Our Community (San Francisco), Van Ness Recovery House (Los Angeles), and the LGBTQ Community Centers in Los Angeles and New York City. There are more than 500 Alcoholics Anonymous or Narcotics Anonymous groups specifically for LGBTQ people. Most LGBTQ people attend treatment programs or self-help groups that are designed for heterosexual people. In these programs, LGBTQ people face the same prejudices and discrimination from staff and other clients as they do in everyday life, but at a time when they are even more vulnerable and need support (see B. N. Cochran, Peavy,
Smoking

Smoking is the number 1 cause of preventable death in the world, contributing to the morbidity and mortality statistics by underlying heart disease, cancer, stroke, and a myriad of lung diseases and other physical health consequences. Of the studies that have gathered information about smoking rates among LGBTQ people, nearly all of them report higher rates than the general population or heterosexual comparison groups (Greenwood & Gruskin, 2007; Tang et al., 2004). Theoretically, nicotine is the ideal drug for stress relief—it is highly portable, widely available, legal, and quick acting, so it is not surprising that people with high levels of stress might be more likely to smoke. High rates of smoking may be one of the primary causes of chronic physical health problems in LGBTQ people. For example, Heck and Jacobsen (2006) reported rates of lifetime diagnosis of asthma in 13.5% of men who reported male partners, 14.3% of women who reported female partners, 7.6% of heterosexual men, and 10.2% of heterosexual women. The disparity of smoking rates between people in same-sex relationships and people in other-sex relationships is illustrated in Figure 7.1 from a random household survey of people in the states of Washington and Oregon (Dilley et al., 2005).

Transgender people have not been well-studied in regards to smoking, although one study from the state of Virginia identified even higher rates of smoking than in LGB individuals, with 62% of female-to-male transgenders and 55% of male-to-female transgender reporting current smoking (Xavier et al., 2007).

It is difficult to address drinking, drug use, and smoking separately, as they so often go hand in hand. However, people who seek solutions for their alcohol and drug problems often are not counseled about tobacco use, so rates of smoking remain high even after recovery from alcohol and drug abuse (Eliason & Worthington, 2004). Substance abuse treatment facilities and LGBTQ alcohol- and drug-related support groups or self-help groups would be an ideal place for smoking cessation counseling and interventions, as this is the highest risk group for smoking.

One study examined treatment experiences of LGBTQ smokers (Bye, Gruskin, Greenwood, Albright, & Krotski, 2005). This study was a random digit dial survey of Californians, and LGBTQ people were compared with the general population. Overall, LGBTQs were similar to the general population in terms of quit attempts—that is, LGBT people were just as likely to want to quit smoking and just as likely to attempt to quit as heterosexuals (63% of LGBTQ smokers tried to quit in the past year). Of the methods used to quit smoking, 25% of the LGBT sample had used nicotine replacement therapy compared with 16% of general population who used NRT. Unfortunately, fewer LGBTQ people visiting a health care provider were advised to quit than heterosexuals. Regarding prevention issues, 37% felt that antismoking campaigns ignore LGBTQ people, and only 32% of men and 20% of women thought that smoking was a bigger problem for LGBTQs than for heterosexuals.

Summary: Substance abuse

Stigma contributes to substance abuse in many ways, through the mechanisms of internalized oppression (homo/bi/transphobia), and heterosexism. One effect of external sources of minority stress is that gay bars became one of the central institutions for social support, and one of the few safe spaces where LGBTQ people can congregate and be themselves (Warwick, Douglas, Aggleton, & Boyce, 2003). Smoking and drinking are the primary activities in a bar, and if one meets friends and partners in bars, they are more likely to develop social networks of smokers and drinkers (Weinberg, 1994). Some LGBTQ people, particularly those from racial/ethnic or religious backgrounds that are more negative about same-sex behaviors and those who engage in same-sex behaviors but do not label themselves as LGBTQ, may use substances to overcome shame and guilt about sexual activities (Amadio, 2006; Semple, Patterson, & Grant, 2002) or to offer an excuse for same-sex behaviors (“I was drunk and didn’t know what I was doing”).

Tobacco and alcohol companies have recognized the niche market in LGBTQ communities and target advertisements to these groups (Smith, Offen, & Malone, 2007).
Oppressed minority populations are ripe for targeted advertising, because they do not often see themselves reflected in the media. Advertising that addresses them specifically may be appealing and validating and thus more influential than it is for mainstream audiences. Many LGBTQ-oriented publications receive money from tobacco and alcohol advertising and may promote images of smoking as glamorous in photo shots on covers and stories about celebrities. For example, in 2006, a cover of the newsmagazine, *The Advocate*, drew fire from public health advocates. The cover depicted an actress from the popular lesbian soap opera, *The L Word*. The caption read “Smokin’ Kristanna Loken” and showed the actress scantily clad, holding a cigarette and exhaling smoke over text at the top of the page that ironically read “health matters.”

There are a few LGBTQ-specific smoking prevention and intervention campaigns. In California and spreading to some other locations is a curriculum called, *The Last Drag*, which is a group intervention for LGBTQ smokers. The Gay American Smoke-Out Web site contains posters and information about smoking cessation. The Mautner Project sponsored a media campaign called “Delicious Lesbian Kisses” to counter the smoking advertisements in lesbian communities. See the Appendix for some of these resources.

Axis I mental health disorders: Depression and anxiety

Mental health disorders are biopsychosocial entities, and some are more influenced by genetics and biological factors whereas others have a firmer foundation in environmental circumstances. It is likely that LGBTQ people have about the same rate of the more biologically based disorders such as schizophrenia and bipolar disorder, but higher rates of disorders that are more directly affected by stress and stigma. LGBTQ individuals report higher rates of depression and anxiety disorders than does the general population (Cochran & Mays, 2000a, 2000b; Gilman et al., 2001; Mills et al., 2004; Warner et al., 2004). LGBTQ people of color have even higher rates of depression and anxiety than white LGBTQ people (Cochran, Sullivan, & Mays, 2003, Cochran & Mays, 1994; Gilman et al., 2001; Greene, 1997), supporting the idea that multiple sources of stigma add more minority stress to life. Jorm, Korten, Rodgers, Jacob, and Christensen (2002) reported that bisexual people had the poorest mental health of any of the sexual identity groups in their study, reflecting the even greater stigma attached to bisexual identity than to gay or lesbian identity.

A study of midlife adults found that 26% of LGB respondents reported current high levels of psychological distress, compared with 17% of heterosexuals (Mays & Cochran, 2001). Table 7.1 shows data from the midlife adult sample regarding mental health problems and treatment seeking in the past year.

Notice that more LGB people attended self-help groups than heterosexual individuals—this may represent a cost- and time-effective mode of treatment that is acceptable to LGB persons. Tjepkema (2008) also found higher use of self-help groups among LGBs in Canada. Some LGBTQ people, especially White lesbians, value therapy as a means of improving the quality of life, but finding mental health providers with a good understanding of the impact of stigma based on sexual and gender identifications can be a challenge (Jones & Gabriel, 1999; Page, 2004). Focusing only on individual-level factors in therapy, and ignoring the sociopolitical basis of stigma, can be victim-blaming and counterproductive to improvements in mental health (Kitzinger & Perkins, 1993). Page (2004) surveyed bisexual individuals about their experiences with mental health providers and found that 10% reported having a provider who was moderately or extremely unaccepting of their bisexuality and felt that these providers invalidated or pathologized their identities. Similarly, a survey of lesbians and gay men found that 25% had experienced a therapist who was “unreceptive . . . judgmental, discouraging, or dismissive” of their sexuality issues (Jones & Gabriel, 1999, p. 214).

**Table 7.1.** Rates of Depression, Anxiety, and Mental Health Treatment Seeking in LGB Versus Heterosexual Respondents

<table>
<thead>
<tr>
<th>Past 12 Months</th>
<th>Gay/Bisexual Men</th>
<th>Heterosexual Men</th>
<th>Lesbian/Bisexual Women</th>
<th>Heterosexual Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depression</td>
<td>31%</td>
<td>10%</td>
<td>34%</td>
<td>17%</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>5%</td>
<td>2%</td>
<td>15%</td>
<td>4%</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>18%</td>
<td>4%</td>
<td>17%</td>
<td>9%</td>
</tr>
<tr>
<td>Saw a mental health care provider</td>
<td>19%</td>
<td>8%</td>
<td>33%</td>
<td>11%</td>
</tr>
<tr>
<td>Attended a self-help group</td>
<td>15%</td>
<td>4%</td>
<td>28%</td>
<td>8%</td>
</tr>
<tr>
<td>Took a psychiatric medication</td>
<td>25%</td>
<td>6%</td>
<td>19%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Transgender individuals fight an additional battle along with the mental health effects of enormous societal stigma—their very identities are still pathologized by the inclusion of Gender Identity Disorder in the DSM-IV. In addition, the amount of discrimination, harassment, and threatened or actual violence that they experience is a source of constant stress. Many clinics and hospitals that provide hormone therapy and/or perform gender reassignment surgeries require that transgender individuals undergo extensive counseling and receive clearance from a mental health care professional before they can have surgery. Finding mental health providers with an expertise in transgender counseling is difficult at best, and putting the mental health care provider in a “gate-keeper” role may be a barrier to a productive, therapeutic relationship (Hale, 2007). The need to get clearance from a mental health care provider also puts an additional financial burden on transgender individuals. Few insurance plans cover any of the costs of transition.

Along with the higher rates of depression are higher rates of suicidal ideation and attempts (Safren & Heinberg, 1999). Among transgender individuals, rates of suicidal ideation are as high as 64%, with the rate of suicide attempts at 16%–37% (Grossman & D’Augelli, 2006; National Coalition on LGBT Health, 2004). Cochran and Mays (2000) reported that among MSM, 19.3% had a lifetime suicide attempt, compared with 3.6% of heterosexual men. Lhomond and Saurel-Cubizolles (2006) examined French women and found that 10.4% of WSW reported a lifetime suicide attempt compared with 3.9% of exclusively heterosexual women. Nearly every study conducted on suicide attempts and suicide ideation has reported higher rates among LGBTQ people (Ferguson, Horwood, Ridder, & Beautrais, 2005).

**Body image and eating disorders**

This section will review two types of problems: obesity and overweight, and body image issues. Obesity is a serious problem in the United States, with some experts projecting that it will soon surpass tobacco use as the leading cause of preventable death and disability. Rates of obesity tend to be higher in medically underserved and stigmatized populations, although the impact of stigma on weight appears to differ substantially by gender in LGBTQ communities. Lesbians tend to have greater body image concerns than heterosexual men (14%), lesbians (4%), and heterosexual men (3%) (Siever, 1994).

As heterosexual men’s bodies are increasingly objectified in the media, as women’s bodies have been for years, men’s body images have been suffering. Gay male culture has a long history of objectifying men’s bodies in print and in videos and tends to place strong emphasis on physical attractiveness and youthfulness, particularly in a hypermasculine body (Brand, Rothblum, & Solomon, 1992)—a concept that one commentator called “body fascism.” This cultural critic, Michael Signorile noted, “I think it’s because we were all insecure, we all feel inferior...gay men are made to feel effeminate, and that’s seen as being bad. One way to feel superior is to overcompensate in being macho” (quoted in Mann, 1998, p. 348).

### Table 7.2. Percentage of Lesbian and Bisexual Women Who Were Overweight or Obese by Racial/Ethnic Group

<table>
<thead>
<tr>
<th>Racial/Ethnic Group</th>
<th>% Overweight</th>
<th>% Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>25</td>
<td>36</td>
</tr>
<tr>
<td>African American</td>
<td>32</td>
<td>41</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>29</td>
<td>8</td>
</tr>
<tr>
<td>White</td>
<td>28</td>
<td>23</td>
</tr>
</tbody>
</table>


in Los Angeles county by racial/ethnic group, demonstrating again the additive effect of racism, sexism, and heterosexism on health risks.

Lesbians appear to be less affected by cultural imperatives for women to be thin and have higher body self-esteem than heterosexual women (French, Story, Remafedi, Resnick, & Blum, 1996; Share & Mintz, 2002). Some authors suggest that relating to other women sexually can lead lesbian and bisexual women to appreciate and know their own bodies more thoroughly and become more confident about their sexual attractiveness, and thus the cultural standards about women’s bodies lose some of their power (Beren, Hayden, Wiffley, & Grilo, 1996). Being freed from unrealistic standards of physical size and shape may allow stress from stigma to trigger dysfunctional overeating or binge eating, increasing the risk for obesity.

Gay and bisexual men have different pressures—to be lean and muscular (a desire shared by many heterosexual men as well). They are more likely to experience body dissatisfaction than heterosexual men and may be more prone to eating disorders such as anorexia and bulimia (Carlat, Camargo, & Herzog, 1997; Martins, Tiggeman, & Kirkbride, 2007). One study that compared groups by gender and sexuality found the rates of eating disorders to be the highest in gay men (17%), followed by heterosexual women (14%), lesbians (4%), and heterosexual men (3%) (Siever, 1994).
Body image problems are a major component of the transition process for transgender individuals, although the extent to which any individual experiences body dissatisfaction will vary widely. On one extreme, a few transgender individuals are so dissatisfied with their bodies that they mutilate their genitals, perhaps as many as 1 in 18 has thought about self-mutilation (Israel & Tarver, 1997). Others inject silicone or other oils to appear more feminized or take excessive amounts of testosterone to masculinize their appearance. Some transgender individuals are happy with their bodies, but change their names, clothing, hairstyles, or other outward trappings to match their image of themselves. The common theme is aligning outward appearance with an internal image of oneself.

For those who need to align their physical bodies, genital reconstructions, mastectomies, facial reconstructions, and other cosmetic surgical interventions may be necessary. The vast majority of those who have surgical interventions are satisfied with the results—one study of 218 postoperative transgender individuals 4–24 years after surgery found that only 3.8% regretted their decision later (Landen, Walinder, Hambert, & Lundstrom, 1998). Another study reported high levels of body satisfaction and self-confidence in postoperative transgender men and women (Kraemer, Delisignore, Schyder, & Hepp, 2008). Hormone therapies are also effective in creating some of the changes that align the physical body with the psychological image, and speech training, gender coaching, and fashion advice may also help (see Kirk & Kulkarni, 2006, and Lawrence, 2007, for specific health care issues related to transition).

Reflection: Many people in the press and on talk shows have questioned the “sanity” of genital reconstructions because they are permanent. However, rarely do we question the sanity of a person having a face lift, nose job, or Botox injection, procedures that are also relatively permanent and carry risk. Why do we put genitals in a different category than other body parts?

**Domestic violence/intimate partner violence**

Much of the literature on domestic violence, or intimate partner violence (IPV) in heterosexual relationships, particularly by feminist researchers, has focused on power imbalances based on gender and explores why men are overwhelmingly the perpetrators of violence and women the victims. This focus on power imbalance based on sexism rendered the possibility of same-sex IPV invisible for years. As more research examined IPV, it has been noted that the incidence of IPV in same-sex couples is about equal to or higher than in other-sex couples (Balsam, Rothblum, & Beauchaine, 2005; Greenwood et al., 2002; Tjaden, Thoennes, & Allison, 1999). Gender is not the only source of power imbalance in relationships, and it is rare to find couples who are truly equal in all ways. Imbalances in finances, social support outside the relationship, drug and alcohol abuse, the degree of “neediness,” fear of beingouted, and the stress of stigma (minority stress), as well as sexism and heterosexism, are factors in same-sex IPV.

A probability-based study of MSM living in four large cities identified a very high rate of interpersonal violence, with 34% reporting psychological battering, 22% physical violence, and 5% sexual violence within a relationship in the past 5 years (Greenwood et al., 2002). HIV-infected and younger men were more vulnerable to violence than HIV-negative and older men. In a population study of 8,000 women, 11% of lesbians reported violence from a female intimate partner and 30% reported violence from a former male intimate partner, compared with 20% of heterosexual women who experienced physical violence from a male intimate partner. Therefore, lesbians may be at greater risk from violence from former male partners than heterosexual women. In addition, LGBTQ people are equally likely to experience psychological and physical violence within their intimate relationships, presumably because the stresses of same-sex relationships are greater (Balsam et al., 2005). One way that domestic violence might differ in same-sex relationships is that the abusive partner may use the threat of outing the individual to their boss, parents, or other people, and use that threat to isolate the partner from potential social support (Pitt & Alpert, 2007). In addition, the abusing partner might use the threat of stigma to deter the victim from seeking help (“the police never believe queers”) or state that no one would believe the victims story (“no one is going to believe that a woman could be the perpetrator” or “no one would believe that men can be victims”).

The underlying reasons for violence are often the same as in other-sex relationships (power, finances, fears of abandonment, etc.), but the resources for intervention/treatment are much more limited. Battered women’s shelters often do not know how to deal with female same-sex relationship issues, where the line between perpetrator and victim is sometimes more blurred. Women’s shelters usually do not accept men or transgender individuals at all. Men who are battered have very few or no community resources and may face ridicule or denial that a man could be a victim of abuse. Men who are victimized are seen as “sissies” and stereotyped as inferior men. They often experience secondary victimization from police, hospital staff, social workers, and other health care professionals.

Transgender individuals who are sex workers, much like biological women sex workers, face much higher risks for abuse from strangers/clients, but little is known about their risk for violence within their intimate relationships. One study reported that 10% of transgender people...
Table 7.3. Selected Physical Health Disorders in Women by Sexual Orientation/Behavior Categories

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Heterosexual</th>
<th>Lesbian</th>
<th>Bisexual</th>
<th>Homosexually Experienced Heterosexual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>6.9%</td>
<td>2.2%</td>
<td>1.3%</td>
<td>0</td>
</tr>
<tr>
<td>Liver disease</td>
<td>1.0%</td>
<td>1.8%</td>
<td>1.0%</td>
<td>0</td>
</tr>
<tr>
<td>Digestive problems</td>
<td>7.9%</td>
<td>6.1%</td>
<td>15.4%</td>
<td>8.8%</td>
</tr>
<tr>
<td>Urinary problems</td>
<td>4.3%</td>
<td>0.5%</td>
<td>7.2%</td>
<td>0</td>
</tr>
<tr>
<td>Migraines/headaches</td>
<td>19.1%</td>
<td>18.4%</td>
<td>26.4%</td>
<td>32.0%</td>
</tr>
<tr>
<td>Asthma</td>
<td>8.6%</td>
<td>13.1%</td>
<td>19.2%</td>
<td>24.5%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>21.4%</td>
<td>33.5%</td>
<td>17.7%</td>
<td>19.7%</td>
</tr>
<tr>
<td>Back problems</td>
<td>14.4%</td>
<td>23.3%</td>
<td>26.5%</td>
<td>37.0%</td>
</tr>
<tr>
<td>HIV infection</td>
<td>0</td>
<td>0</td>
<td>2.9%</td>
<td>0</td>
</tr>
<tr>
<td>Functional health limitation</td>
<td>21%</td>
<td>30.5%</td>
<td>37.6%</td>
<td>21.1%</td>
</tr>
<tr>
<td>Receives disability income</td>
<td>5.1%</td>
<td>12.6%</td>
<td>12.4%</td>
<td>5.0%</td>
</tr>
</tbody>
</table>


PHYSICAL HEALTH DISORDERS

Chronic health disorders

A few large population studies in recent years have examined self-reported physical health disorders in LGBTQ populations, and these studies support and extend the findings of earlier studies that relied on convenience samples (e.g., Bakker, Sandfort, Wanwesenbeeck, van Lindert, & Westert, 2006; King & Nazareth, 2006; Tjepkema, 2008; Wang, Hausermann, Vounatsov, Agglet, & Weiss, 2007). One recent study (Cochran & Mays, 2007) reviewed data from the California Quality of Life Survey with more than 2,000 individuals, oversampling for LGB people. Four groups were formed: heterosexual (n = 1999), lesbian or gay (n = 158), bisexual (n = 67), and “homosexually experienced heterosexuals” (n = 51). The later were people who said that their identity was heterosexual, but they had recent same-sex experiences. Respondents were asked if they had heart disease, hypertension, cancer diagnosed within the past 3 years, diabetes, liver disease, digestive problems (ulcer, enteritis, colitis), urinary problems, migraines or headaches, asthma, arthritis, back problems, chronic pain, chronic fatigue syndrome or fibromyalgia, HIV infection, and AIDS/HIV disease. Because of the complexity of having two genders and four sexuality groups, the findings are not so straightforward. Tables 7.3 (data for women) and 7.4 (data for men) summarize some of the key findings.

Heterosexual women had higher rates of diabetes, but the other three groups reported higher rates of most of the other physical health problems assessed. Those who were bisexual or heterosexual with same-sex behavior reported very high rates of some stress-related disorders such as migraines/headaches, asthma, and back problems. The patterns were similar for men. Heterosexual men had the lowest rates of most health problems, and heterosexual men with same-sex experiences had among the highest rates of physical ailments. HIV infection rates were highest among the gay men. Unfortunately, this study did not report rates of smoking, drinking, weight, or other factors that could explain some of the health problems. Tjepkema (2008) reported data from a Canadian national probability sample and found that bisexual men and women reported the poorest overall health, followed by gay men and lesbians, and heterosexual...
Table 7.4. Selected Physical Health Disorders in Men by Sexual Orientation/Behavior Categories

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Heterosexual</th>
<th>Gay</th>
<th>Bisexual</th>
<th>Homosexually Experienced Heterosexual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart disease</td>
<td>3.3%</td>
<td>4.2%</td>
<td>3.1%</td>
<td>9.4%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>16.1%</td>
<td>21.9%</td>
<td>14.0%</td>
<td>20.1%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>8.3%</td>
<td>6.7%</td>
<td>5.2%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Liver disease</td>
<td>0.9%</td>
<td>3.7%</td>
<td>4.3%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Digestive problems</td>
<td>2.6%</td>
<td>7.9%</td>
<td>5.6%</td>
<td>19.4%</td>
</tr>
<tr>
<td>Urinary problems</td>
<td>2.2%</td>
<td>6.5%</td>
<td>6.5%</td>
<td>0</td>
</tr>
<tr>
<td>Migraines/headaches</td>
<td>7.2%</td>
<td>15.5%</td>
<td>6.5%</td>
<td>32.4%</td>
</tr>
<tr>
<td>Asthma</td>
<td>6.5%</td>
<td>4.2%</td>
<td>9.0%</td>
<td>21.1%</td>
</tr>
<tr>
<td>Chronic fatigue</td>
<td>2.8%</td>
<td>8.0%</td>
<td>3.7%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Back problems</td>
<td>14.4%</td>
<td>11.6%</td>
<td>19.7%</td>
<td>32.7%</td>
</tr>
<tr>
<td>HIV infection</td>
<td>0</td>
<td>22.5%</td>
<td>6.8%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Functional health limitation</td>
<td>18.9%</td>
<td>23.5%</td>
<td>30.5%</td>
<td>30.6%</td>
</tr>
<tr>
<td>Receives disability income</td>
<td>6.4%</td>
<td>.2%</td>
<td>1.2%</td>
<td>9.0%</td>
</tr>
</tbody>
</table>


respondents with the highest levels of health. LGB people had higher rates of unmet health care needs in the past 12 months, even in Canada, where everyone has access to health care. There appear to be complex relationships between health and sexuality, which differ depending on whether an individual adopts an LGBTQ identity, which might imply that they have some level of community and sense of unity around the label, versus those who engage in same-sex behavior without adopting an identity label.

Cancer

Cancer risks have been discussed in some studies. Cancer burden is not distributed equally in the population, and most racial/ethnic minority groups have lower survival rates from cancer (American Cancer Society, 2004), suggesting that stigma creates health disparities around cancer treatment. Only a few studies have examined cancer risk and cancer incidence among LGBTQ people. In a study of 324 sister pairs, where one sister was a lesbian, the lesbian sisters were found to have higher risk factors for breast cancer than their heterosexual sisters (Dibble, Roberts, & Nussey, 2004). Among the few studies to look at cancer diagnosis, Cochran and Mays (2007) asked respondents from a random sample of Californians about new cancer diagnoses in the past year. There were no differences among women by sexual identity or behavior, but among men, those who called themselves heterosexual but had same-sex experiences had higher rates of cancer diagnoses (4.3%) than heterosexual (1.1%), gay (0.8%), or bisexual men (0). A Danish study found no difference between women registered in same-sex relationships compared with women in heterosexual marriages on cancer rates (Frisch, Smith, Grulich, & Johansen, 2003). One small-scale study found higher rates of breast cancer among lesbians than among heterosexual women (Roberts, Dibble, Scanlon, Paul, Davids, 1998).

Among women, most of the research has focused on breast cancer risk factors and proposes that the risks may be higher for lesbians/bisexual women than for heterosexual women because lesbian/bisexual women are less likely to bear children, more likely to be overweight, and more likely to be current or past smokers (Cochran et al., 2001; Dibble et al., 2002, 2004; Roberts & Sorensen, 1999). In addition, some studies have reported that lesbians are less likely to get Pap tests and mammograms (Cochran et al., 2001; Diamant, Schuster, & Lever, 2000; Koh, 2000; Rankow & Tessaro, 1998; Valanis et al., 2000; White & Dull, 1997); therefore, cancers may not be identified as early.

Literature on cancer among gay and bisexual men has focused primarily on anal cancer and cancers related to HIV status. Men who engage in anal sex should have annual anal Pap tests to screen for cancer (Goldstone, 1999) as some data suggest MSM are at higher risk. There are high rates of human papillomavirus infection among MSM, which may be associated with higher rates of anal cancer (Frisch et al., 2003). Rates of anal cancer in the general population are about 1 case per 100,000 people, but one study suggested rates in MSM might be closer to 35 per 100,000 (Darragh & Winkler, 2004). LGBTQ people who are HIV positive must be monitored closely for a wide variety of cancers that are associated with HIV, such as Kaposi’s sarcoma and lymphoma (Engels, 2007; Martro et al., 2007). Little is known about cancer
Table 7.5. HIV Infection by Exposure Category

<table>
<thead>
<tr>
<th>Transmission Category</th>
<th>Adult and Adolescent Male</th>
<th>Adult and Adolescent Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male-to-male sexual contact</td>
<td>465,965</td>
<td>—</td>
<td>465,965</td>
</tr>
<tr>
<td>Injection drug use</td>
<td>170,171</td>
<td>74,718</td>
<td>244,889</td>
</tr>
<tr>
<td>Male-to-male sexual contact and injection drug use</td>
<td>68,516</td>
<td>—</td>
<td>68,516</td>
</tr>
<tr>
<td>High-risk heterosexual contacta</td>
<td>65,241</td>
<td>108,252</td>
<td>173,493</td>
</tr>
<tr>
<td>Otherb</td>
<td>13,893</td>
<td>6,596</td>
<td>20,489</td>
</tr>
</tbody>
</table>

aHeterosexual contact with a person known to have, or to be at high risk for, HIV infection.
bIncludes hemophilia, blood transfusion, perinatal, and risk not reported or not identified.

The higher smoking rate among LGBTQ people warrants more attention to rates of lung cancer as well. Thus far, there have not been focused studies on the health effects of smoking among LGBTQ people, but it is likely that there are higher rates of COPD and lung cancer among older LGBTQ individuals. The lack of findings of increased cancer rates in the studies cited above may have to do with the age of the respondents, as cancer rates increase with age.

Another area of concern is the appropriate screening and preventive care for transgender individuals. Some providers consider male-to-female transgender individuals to be biologically male and thus do not consider gynecologic screening. Female-to-male transgender individuals who have a cervix need to have regular Pap tests. Thus far, no studies have examined cancer risks in transgender individuals.

Sexually transmitted disease (STD) or sexually transmitted infection (STI)? What’s in a word? Many specialists are using the more accurate term STI to describe acute illnesses that are transmitted sexually. We do not refer to a cold or the flu as diseases, but as acute illness. Most of the STIs are also acute, thus the less stigmatizing term is warranted.

Sexually transmitted infections and HIV/AIDS

Sexual orientation and gender identity are not risk factors for HIV/AIDS or STIs. Instead, specific sexual behaviors that can be performed by any person, or combination of persons, carry risk only if one of the partners is infected. Sexual activities are often stigmatized in our society, and in spite of the proliferation of sexual images in the media, most of the culture is rather sex phobic. Therefore, we have judgments about whether women should express that they like sex, about how many partners, and what kind of partners are appropriate, and what behaviors are acceptable forms of sex and which are not. The number of sexual partners and the types of sexual activities are not in and of themselves risk factors—they are only risky if the partner has HIV infection or an STI. Some activities are more likely to transmit an STI than others, if one partner is infected. Where stigma increases the risks for LGBTQ people to contract STIs is the lack of adequate sex education about how to have sex safely. One could argue that heterosexuals are equally lacking in adequate sex education as youth, but there are many sources of accurate information available once heterosexuals become late adolescents or young adults. Some LGBTQ communities have focused safer sex education campaigns, but on the whole, LGBTQ people do not get comprehensive, LGBTQ focused sexuality education from school, home, or health care professionals. Table 7.5 shows the exposure categories recorded by the Centers for Disease Control and Prevention (CDC) for AIDS through 2006. Male-to-male contact still leads the list for men.

Because the risks for HIV infection and STIs vary by sexual identity group and gender, we will explore these risk factors separately by gender, starting with discussion of women. A large British probability sample of nearly 6,400 women aged 16–44 years offers some useful information about sexual risk factors (Mercer et al., 2007). The sexuality measures in this study included both same-sex behavior and attraction. About 5% of the women reported that they had ever had a female partner, and 2.8% had a same-sex partner in the past 5 years. Eleven percent of the women reported that they had ever felt sexually attracted to a woman, but only 0.2% of the women were exclusively and only attracted to women in their lifetimes. The sample was divided into three groups to examine their
risk factors for STIs. Table 7.6 shows these data, indicating that women who have sex with men and women have the greatest sexual risk behaviors and are also the most sexually active of the three groups.

Exclusive lesbians had the lowest number of male partners in their lifetimes as expected and were as likely as heterosexual women to be currently partnered. Interestingly, “unsafe sex” was not even reported for lesbians in this study, yet there is evidence that HIV infection and other STIs can be transmitted from woman to woman and that lesbians need to have education about safer sex (Dolan, 2005). The CDC does not have a category for female-to-female transmission of HIV, so an HIV-positive lesbian would be queried about her other risk factors, and if none is found, her risk exposure would be listed as “other.” This exclusion of female-to-female transmission means that we do not know the extent of the risk of transmitting HIV from one woman to another.

For men, studies regarding STIs have focused more on sexual behavior than identity, so this section will use the term **MSM**—men who have sex with men (regardless of whether they have sex with women as well). Some sexual activities that are common to MSM carry greater risk for spread of HIV and other STIs than others. For example, anal sex carries more risk than oral sex. Among urban men, the rate of HIV infection at the end of the 1990s was reported to be 17% overall, but 25% for African American MSM, and 40% for MSM who inject drugs (Catania et al., 2001). Figure 7.2 shows the data from the CDC about the racial/ethnic distribution of HIV/AIDS cases for MSM (CDC, 2007). MSM are also at higher risk for viral hepatitis; thus, the CDC has recommended vaccination for all MSM since 1991. For more information on STIs and HIV/AIDS, see the CDC Web site for extensive information. Transmission of many STIs and HIV can be reduced dramatically by consistent use of condoms, and by also using ample lubrication for anal sex.

**Figure 7.2.** Race/ethnicity of men who have sex with men (MSM) living with HIV/AIDS, 2005. From “HIV/AIDS Among Men Who Have Sex With Men,” by Centers for Disease Control and Prevention, 2007, http://www.cdc.gov/hiv/topics/msm/resources/factsheets/msm.htm

Transgender individuals, particularly MTF, have among the highest rates of HIV infection of any group, ranging from 14% in San Juan (Rodriguez-Madera & Toro-Alfonso, 2005), 21% in Chicago (Kenagy & Bostwick, 2001), 22% in Los Angeles (Reback et al., 2001), 32% in Washington, DC (Xavier, 2000), and 47% in San Francisco (Nemoto, Operario, Keatley, Han, & Soma, 2004). The elevated rates are related to the very high number of transgender women who cannot find safe employment and must engage in sex work to survive. Transgender women of color are at particular risk (Nemoto, Operario, & Keatley, 2005; Sausa, Keatley, Operario, 2007). Recently, one study addressed the potential risks to men who have sex with transgender women—they, too, might represent a specific group at higher risk for HIV and are not currently

---

**Table 7.6. Sexual Risk Factors for Women by Behavioral Categories**

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Women Who Have Sex With Men Exclusively</th>
<th>Women Who Have Sex With Women and Men</th>
<th>Women Who Have Sex Exclusively With Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean # of male partners in their lifetimes (SD)</td>
<td>6.5 (8.7)</td>
<td>21.2 (26.8)</td>
<td>3.2 (5.6)</td>
</tr>
<tr>
<td>Median: male partners</td>
<td>4</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>“Unsafe” sex</td>
<td>1.5%</td>
<td>9.8%</td>
<td>NA</td>
</tr>
<tr>
<td>Sex with most recent partner occurred within 24 hr of meeting for the first time</td>
<td>4.8%</td>
<td>12%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Masturbation in past month</td>
<td>37%</td>
<td>69%</td>
<td>60%</td>
</tr>
<tr>
<td>Married/cohabitating or partnered</td>
<td>67%</td>
<td>16%</td>
<td>64%</td>
</tr>
<tr>
<td>College degree</td>
<td>18%</td>
<td>21%</td>
<td>38%</td>
</tr>
</tbody>
</table>

Table 7.7. Risks for Acquiring HIV

<table>
<thead>
<tr>
<th>Risk Exposure Behavior</th>
<th>Risk per 10,000 Exposures to an Infected Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood transfusion</td>
<td>9,000</td>
</tr>
<tr>
<td>Needle-sharing drug use</td>
<td>67</td>
</tr>
<tr>
<td>Receptive anal sex</td>
<td>50</td>
</tr>
<tr>
<td>Receptive penile–vaginal sex</td>
<td>10</td>
</tr>
<tr>
<td>Insertive anal sex</td>
<td>6.5</td>
</tr>
<tr>
<td>Insertive penile–vaginal sex</td>
<td>5</td>
</tr>
<tr>
<td>Receptive oral sex with a man</td>
<td>1</td>
</tr>
<tr>
<td>Insertive oral sex with a man</td>
<td>0.5</td>
</tr>
</tbody>
</table>


reflected in the CDC risk-exposure categories (Operario, Burton, Underhill, & Sevelius, 2008).

Table 7.7 shows the risk of acquiring HIV infection by the different risk exposure categories, suggesting that blood-sharing activities are much more potent transmitters of HIV than are sexual activities, yet same-sex sexual behaviors are even more stigmatized in society than injection drug use.

THE ROLE OF STRESS/DISTRESS ON HEALTH

It appears that minority stress is one of the major factors that influence the health of LGBTQ people. In the study by Cochran and Mays (2007) when the analysis controlled for psychological distress, most of the differences by sexual orientation on physical health for women nearly disappeared, suggesting that stress was the major underlying factor. For men, physical health problem differences remained even after controlling for psychological distress. Sandfort, Bakker, Schellevis, and Vanwesenbeeck (2007) found that the type of coping strategies for stress in gay men accounted for a considerable portion of their excess mental and physical health problem when compared with heterosexual men. Amadio (2006) found internalized heterosexism to be associated with greater number of adverse consequences from drinking (see also McKirnan & Peterson, 1989). Reilly and Rudd (2007) found an association between internalized oppression and body image in gay men. Warner et al. (2004) found that mental health disorders were associated with demographic factors but also conflict between religion and sexuality and being insulted in school and in the past 5 years—these same factors predicted suicide risk. There are too few studies to say conclusively that minority stress or stigma is the primary culprit, but there is growing evidence to support that statement.

Stress can be buffered by the protective factors such as accurate information, family acceptance, social support, and healthy coping strategies. Figure 7.3 depicts the possible relationships among these protective and risk factors—living in the cultural soup of negative stereotypes that create stigma, the LGBTQ individual can have external environmental risk factors (stigma, negative stereotypes) and personal risk factors (internalized oppression, stigma consciousness (a heightened sensitivity to stigma) that facilitate the development of physical and mental health problems. Theoretically, if the

Figure 7.3. Risk and protective factors that impact LGBTQ people’s health.
THE IMPACT OF STIGMA ON HEALTH CARE PROFESSIONALS' KNOWLEDGE, ATTITUDES, AND SKILLS

It would be very damaging if you got into interactions with health care providers in which you were considered deviant. . . . It is like putting your life in someone's hands who really hates you. (respondent in Stevens & Hall, 1988, p. 71)

Health care systems are a microcosm of society, where institutionalized heteronormativity and gender normativity affect policies and procedures and maintain the negative stereotypes that influence the behavior of individual health care professionals. There is little or no formal education about LGBTQ issues in health care training programs to counter the stigma (Corliss, Shankle, & Moyer, 2007; Tesar & Rovi, 1998; Wallick, Cambre, & Townsend, 1992). This means that an LGBTQ person entering the health care system already wounded by the stress of stigma must face additional minority stress while trying to heal from minority stress. People are at their most vulnerable when they are facing serious illness, and fear of negative treatment compounds the stress of the illness. Chapter 8 addresses the policies and procedures that impact LGBTQ people seeking care, so this section will focus on individual health care professional attitudes and behaviors.

Accessing health care means running a gauntlet of strangers, each one potentially negative or ambivalent about LGBTQ people, from the receptionist in admitting to the floor nurses and dieticians to the physicians, physician assistants, and social workers, just to name a few. Patients in hospital settings often have to repeat their histories and current symptoms multiple times as they are quizzed by medical students, nursing students, residents, attending physicians, and staff nurses. This means multiple “coming-out” stories, each accompanied with the pang of anxiety about the reaction that might be evoked. A survey of about 1,000 LGB Canadians revealed that 87% had been discriminated against and 70% had been insulted in a health care setting because of their sexual orientation (Project Affirmation, 1995; reported in Robinson & Cohen, 1996). A survey of more than 2,000 LGB individuals in New Zealand showed that 83% of women and 66% of men reported that their health care provider assumed that they were heterosexual; 72% of the women and 65% of the men disclosed their sexuality (Neville & Henrickson, 2006). Why do all LGBTQ people not disclose their sexuality in a health care setting? The following sections review what we know about health care provider knowledge, attitudes, and skills. These issues are discussed in more detail in chapter 9 from the perspective of health care professionals who identify as LGBTQ.

Physicians and medical schools

Smith and Mathews (2007) reported on a follow-up survey of Southern California physicians’ attitudes—the first survey was conducted in 1982 (Mathews, Booth, Turner, & Kessler, 1986), and it was repeated in 1999. While there was considerable improvement in attitudes over that time, with the percent of respondents who were strongly homophobic dropping from 58% in 1982 to 19% in 1999, some of the findings continued to indicate negative attitudes in a substantial number (one in five still being strongly homophobic, e.g.). Lena, Wiebe, Ingram, and Jabour (2002) found that 70% of pediatricians said they do not address sexual orientation in their patients for fear of offending them and for lack of knowledge, and 59% were unfamiliar with local resources for gay youth.

There have been a few studies of medical students. Klamen, Grossman, and Kopacz (1999) surveyed 2nd-year medical students at one institution and found that one fourth of them believed that homosexuality is immoral and dangerous to the institution of family and 9% thought homosexuality was a mental disorder. Sanchez, Rabatin, Sanchez, Hubbard, and Kalet (2006) conducted an online survey of 3rd- and 4th-year medical students in one school in New York City and found that the majority did not ask about same-sex activity when they took histories, and 28% said they were uncomfortable addressing the health needs of LGBT patients. They found that most (over 90%) had dealt with at least one LGBT patient during medical school, and those with more frequent clinical exposure to LGBT patients were more accepting, more likely to take sexual histories, and more knowledgeable about LGBT health concerns.

Nurses and nursing schools

In the 1990s, a few studies of nurses and nursing students began to emerge. These studies often focused on attitudes about lesbians, because of the historical lesbian-phobia of nursing, a discipline plagued by “lesbian witch hunts.” A study of nurse educators in the mid-1980s found
that the majority had negative attitudes about lesbians, with 58% stating that lesbians are “unnatural,” 35% stating that lesbians are “disgusting,” and 17% stating that they are “immoral.” Half of them had never discussed lesbian issues in the classroom, and 28% said they would be very uncomfortable talking about lesbian issues. Ten percent thought that lesbians should not be allowed to teach in schools of nursing (Randall, 1989). A substantial proportion of nursing students were also “lesbian phobic” during this time period. One study found that 26% thought that lesbians were “unacceptable” and would endeavor to avoid all contact with a lesbian (Eliason & Randall, 1991), and a follow-up study found that 38% of female nursing students were afraid of “being hit on” by a lesbian. Thirteen percent objected to lesbians on moral or religious grounds (Eliason, Donelan, & Randall, 1992).

A series of recent studies by Swedish nurse researchers has identified a number of issues related to the nursing care of LGBT patients. A study of nursing staff members from one infectious disease clinic found that 36% of the staff nurses surveyed would not care for LGBT patients if given the option, although only 9% of nursing students said they would refuse care (Röndahl, Innala, & Carlsson, 2004a). Nurses who believed that homosexuality is congenital (58%) had more positive attitudes than nurses who thought it is acquired (35%) (Röndahl, Innala, & Carlsson, 2004b). Finally, in a qualitative study of 27 gay men and lesbians about their experiences with nursing, nearly all the informants reported that nursing situations were heteronormative. “They take for granted that I’m heterosexual until I say that I’m not, and then everything comes to a halt” (p. 376). Partners were rendered invisible “I wasn’t told anything, nothing . . . they only spoke to X, didn’t even look at me. I didn’t exist” (Röndahl, Innala, & Carlsson, 2006, p. 378).

Other health care professionals

There is a small body of research on health care professionals other than physicians and nurses. Harris, Nightengale, and Owen (1995) compared nurses, social workers, and psychologists, and found that nurses were more homophobic and less knowledgeable about LGBT issues than the other professions. It may be useful to explore why nurses differ from the other professions. More, Whitehead, and Gonthier (2004) studied dental school programs and found little support for LGBTQ students or patients, and little in the curriculum to inform dental students of LGBTQ health issues. In fact, 33% of the administrators did not know if they treated any LGBTQ patients—a sure sign of the heterosexism found in many health care settings. Willging, Salvador, and Kano (2006a) interviewed providers of mental health services in a rural state and found that most providers declared that there were no differences between LGBTQ and heterosexual patients. The authors felt that this attitude stifled discussion of sexuality and gender and led to further isolation and alienation of LGBTQ clients.

LGBTQ people’s experiences with health care

Disclosure decisions

. . . I told him that I was gay because if there was a problem I’d rather know right away than build a relationship with a physician and then find out that it was going to be a problem. (Bechler, 2001, p. 140)

. . . in kind of the introductory notetaking that the doctor does when they ask you about your medical history, pregnancies, are you on birth control, anything kind of hormonally related. And there’s usually some question that I just, you know, around pregnancies and stuff and the use of birth control that I usually say I’m in a lesbian relationship so that’s not applicable. And I do that proactively, to put them on notice that I’m out about my sexuality and we can deal with this like adults. So I usually make a kind of proactive move somewhere in that interview process, work it into the conversation. (Bechler & Case, 2004, p. 1886)

Decisions to disclose one’s sexuality to a health care professional are rather complex and may vary according to generation, race/ethnicity, couple status, gender, and reason for seeking care. Some people have greater mistrust of health care professionals than others and withhold information about sexuality until they feel comfortable, and others disclose on the first visit. Eliason and Schope (2001) studied disclosure experiences of highly educated lesbian, gay, and bisexual individuals from one Midwestern city. Disclosure was defined as:

- active disclosure: directly told a health care professional;
- passive disclosure: indirectly informed the professional via naming a same-sex partner, wearing a T-shirt or button that proclaims one’s sexuality;
- active nondisclosure: lied about their sexuality; and
- passive nondisclosure: don’t ask, don’t tell (the provider did not ask, so the patient did not tell).

There were differences in both the types of disclosure and other experiences with health care by gender, with women being more likely to actively disclose (43% compared with men 29%). Women used more protective strategies while in health care settings, such as bringing someone along for support, closely monitoring the health care provider’s behavior, scanning the environment for clues of acceptance, and controlling information until feeling safe, than did men. It was suggested that women are more vigilant for two reasons—they are operating under at least two oppressive systems, sexism and heterosexism. The White gay men in this study at least had male privilege, if not heterosexual privilege.
Figure 7.4 depicts a model for understanding the factors related to disclosure. On the level of the individual client or patient, age, gender, racial/ethnic identity, religion, comfort with own sexuality, comfort with own gender, degree of internalized homophobia, experience with health care, type of presenting problem (one might be less likely to disclose for an acute problem and more likely for a problem that involves ongoing care), and whether the individual has a partner (whether there is someone who needs to be involved in health care decision making or not). At the provider level, personal characteristics such as age and gender might be important. Some studies suggest that LGBTQ people are more likely to choose female physicians/health care professionals because women tend to be more accepting of diverse sexual identities; some perceive younger health care professionals to be more likely to be accepting than older ones. Other considerations are body language, verbal language, reputation in the community, and whether the health care professional provides an opportunity for patients/clients to disclose. At the institutional level are the policies and procedures such as nondiscrimination policies, staff training, whether benefits are extended to domestic partners of same-sex couples, the written language on the forms, the atmosphere of the waiting room/reception areas, and so on. Which of these factors could you modify in your own work settings?

The research on the percent of LGBTQ people who disclose their sexual and gender identities to health care professionals ranges widely, and the overall numbers do not reflect the complexity of the question. Most of the recent research suggests that about three fourths of LGB people disclose (less is known about transgender individuals), but this figure may be quite misleading. The LGBTQ people who volunteer to complete surveys about health are probably more “out” in many realms than people who refuse to participate or are never reached through the sampling procedures. People who label themselves as heterosexual but have significant same-sex experiences have not been studied in terms of health care experiences but are probably less likely to disclose because of the enormous stigma attached to their behavior. They would not be identified unless a health care professional asked directly about both sexual identity and same-sex behaviors.

Reactions/responses from health care providers

In the study by Eliason and Schope (2001), most respondents reported that they had a positive (over 50%) or neutral response from their disclosure to a health care professional. However, some reported anger, hostility, discomfort, disgust, embarrassment, fear, and shock on the part of the provider. Several studies have gathered the stories of negative experiences. Some of these are recounted below:

When one doctor asked me if I was sexually active (yes) and about what kind of birth control I used, I responded that I didn’t use any since I was a lesbian. The attending nurse burst into giggles and flew from the room and the doctor and I finished the exam in silence. This wasn’t malicious of course, but did little for my sense of comfort with being open with my health care providers (lesbian, age 45). (Eliason & Schope, 2001, p. 130)

What I got from him was this judgmental statement like, well, if you should wind up HIV-positive... And he started going into all this stuff like scare tactics, you know. I felt like a thirteen-year-old being lectured about smoking... it took me aback. (Beehler, 2001, p. 138)

One doctor I just transferred from interpreted every illness in terms of my being gay. Not overtly anti-gay but came not to trust him or feel comfortable discussing my health with me (gay man, age 52). (Eliason & Schope, 2001, p. 130)

“Following an episode of... ‘weird’ behavior, his family took him to an American Indian charismatic healer who identified ‘devil possession’... told Leroy that ‘homosexuality is wrong... and set up a time for an exorcism.” This gay man had sought help for his grief over losing a family member. (Willging, Salvador, & Kano, 2006b)

Treatment of partners and family

Another stressor related to health care is how and when the partner or family will be involved in care, and how they will be treated. In states with no recognition of same-sex relationships, partners without power of attorney (see chapter 8) may have no legal recourse and may be denied access to their loved ones and have difficulty receiving information about their progress.

In my experience as both patient and close relative, it’s been worse to be the relative—as a patient, they pretty much have to take care of me, but as a relative they can ignore me—like my being there makes the patient homosexual—if I weren’t there, she
would just be another patient in the lot. But since she had me with her—she suddenly became something else—and it’s probably easier to just close your eyes and pretend I’m not there—but I can really only interpret it as if they didn’t accept that we had a homosexual relationship—they would much rather talk to our parents, even though we are adults (woman, 30 years). (Rondahl et al., 2006, p. 378)

Dr. X, on the other hand, had a problem and he asked [my partner] to wait outside. I said you know what? I’m not talking to you without her here. He said, well, we can only talk to a spouse or you know, a family member. I said well, she’s both. She’s my wife and she’s my family. She’s my next of kin. I said you know, my mind is not clear and I’m not hearing half the things that are being said. I want her present. I want her here. So he called her in. But when we were talking... He would only look at me and he would only talk to me. (Boehmer & Case, 2004, p. 1887)

As soon as I said I was a lesbian, the nurses started giving me disgusting looks. They were nasty to my partner. (Stevens & Hall, 1988, p. 72)

USE OF HEALTH CARE SERVICES

In spite of the stresses of disclosure and the actual negative experiences of many LGBTQ people, some recent research shows that LGBTQ people use health care services at an equivalent or even higher rate than the general population. For example, Bakker et al. (2006) found that gay men were 2.17 times more likely to see a medical specialist than heterosexual men, and 1.6 times more likely to see a mental health care provider. Lesbians were 2.06 times more likely to see a mental health care professional. Lesbians were 2.06 times more likely to see a mental health care provider, but equivalent to heterosexual women in seeing medical specialists (see also Tjepkema, 2008). On the other hand, some research suggests that LGBTQ people might be more likely to use alternative and complementary therapies because of discrimination or mistrust of mainstream health care. Matthews, Hughes, Osterman, and Kold (2005) found that 42% of lesbians had experienced discrimination in health care compared with 35% of heterosexual women, and the lesbians were more likely to use meditation/visualization, chiropractic services, massage, and mental health support groups than were heterosexual women. Similarly, Tjepkema (2008) found that LGB people in Canada were more likely to use alternative care providers than heterosexual people.

There is some inconsistency in this literature on accessing health care. Lewis, Derlega, and Clarke (2006) noted that sexual minority individuals often expect to encounter discrimination and prejudice when they access services and as a result, may delay, not access services, or not disclose or feel reluctant to talk about their experiences as LGBTQ to health care professionals. More research is needed to address whether those individuals who accessed services more often actually disclosed their sexual or gender identities to the health care professional.

CONCLUSIONS

Stigma, operating through minority stress, is the major contributor to the elevated risk for physical and mental health disorders in LGBTQ people, working in complex and interactive ways to increase health problems and to decrease access to quality health care. The stress of stigma also exacerbates underlying health problems stemming from other causes, making them more debilitating. The burden of stigma-related health disorders can be reduced somewhat by welcoming and inclusive health care environments, but interventions are needed at all levels of society to truly improve the health of LGBTQ individuals. Minority stress related to heterosexism, gender normativity, racism, classism, and other forms of oppression need to be reduced via education (such as individual empowerment for clients and culturally appropriate care training for health care professionals), health care agency policy change, and broader societal change. The next chapter addresses institutional factors such as agency climate and policies and procedures.

REFLECTION QUESTIONS

Awareness
1. Were you surprised by any of the elevated health risks for LGBTQ individuals?

Sensitivity
1. How has stress impacted your own life?
2. Have you experienced minority stress related to any of your social identities? How did that feel?

Knowledge
1. What are some of the potential solutions for reducing the effects of minority stress?
2. What obligations, if any, do health care systems have in reducing health disparities?