Lesbian, Gay, Bisexual, and Transgender Healthcare

A Clinical Guide to Preventive, Primary, and Specialist Care

Kristen L. Eckstrand
Jesse M. Ehrenfeld
Editors

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ISBN 978-3-319-19751-7 ISBN 978-3-319-19752-4 (eBook)
DOI 10.1007/978-3-319-19752-4

Library of Congress Control Number: 2015959790

Springer Cham Heidelberg New York Dordrecht London
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Printed on acid-free paper

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Foreword

LGBT Health in a Changing World

A decade ago, there were few options for serious study of the health needs of LGBT people. There were no texts in the United States, there was no official recognition by the federal government, and providers with interest in caring for the needs of LGBT people were most notably found practicing in a handful of health centers mainly located in large cities around the country as well as in private practice. GLMA: Health Professionals Advancing LGBT Equality, formerly the Association of Physicians for Human Rights, held an annual conference that provided some anchoring and sustenance for clinicians interested in caring for the community who there were able to feel as if they had some collegial connections from across the nation.

How things have changed! This is now the second text on LGBT health care in the United States, following the publication of the Fenway Guide to LGBT Health by the American College of Physicians in 2008. Healthy People 2020 contained a section on the health disparities experienced by LGBT people in the United States and put them on an agenda for eradication in this second decade of the twenty-first century. The National Institutes of Health commissioned the Institute of Medicine of the National Academy of Sciences to write a report on the state of LGBT health and to delineate a research agenda aimed at learning more about the etiology of and barriers to overcoming disparities in care. This publication "Lesbian, Gay, Bisexual and Transgender Healthcare: A Clinical Guide to Preventative, Primary, and Specialist Care" has become an invaluable resource for anyone wanting to read what is and is not known about the LGBT population and gather ideas for study and education. Changes in federal policies have been legion and coming in rapid sequence with the legalization of same-sex marriage. The Affordable Care Act protects LGBT against discrimination for policies purchased through the marketplace. There are new regulations prohibiting discrimination in nursing home admissions.

Perhaps the most important reason to use this readily available text is that care of LGBT people is now seen as a critical offering of many mainstream healthcare providers across the nation. It is not just happening in pockets or large cities, but across the nation and increasingly the world. Despite personal politics, most healthcare providers believe in providing equitable care for all, including LGBT people. This places great importance on the easy availability

of standards of care on just the topics covered in the chapters of this book. It is important to understand unique clinical needs, but just as important to be able to ask questions to understand one's identity, behavior, and desires and how to systemize what should be routine screenings and immunizations based on that information. It is important not only to recognize the need to learn about one's gender identity but also how to appropriately and sensitively approach those who have and may not have had any significant surgery in order to assure that necessary cancer screening is carried out correctly. These are but a few examples of why we need more resources on the healthcare needs of LGBT people. In addition, we have to create programs for care that do outreach to the very diverse people who are L, G, B, and/or T as well as others who may not readily identify as such but who engage behaviors and have desires that warrant exploration by caring and sensitive clinicians who work in inclusive and affirming care environments holistically providing medical and behavioral health needs optimally in an integrated setting.

The challenges ahead are great. Many states which chose not to extend Medicaid are in the South where there is a high incidence of HIV among young MSM, a group which may be a proxy for a larger circle of LGBT people who may still be uninsured. We need to find those who are uninsured, or simply not accessing care, engage them in discussion to help them overcome possible negative experiences with the health care system, work with them on understanding the importance of seeking care, and help them find places where they can receive appropriate care. I end this introduction with the hope that it will not only an introduction to a new resource but an introduction to a new generation of providers who will enlarge the circle of clinicians caring and teaching about caring for LGBT people in the years ahead.

Boston, MA Harvey J. Makadon

Preface

Individuals identifying as lesbian, gay, bisexual, and transgender (LGBT) experience disparities in access and receiving health care, as exemplified in foundational reports including the Institute of Medicine's *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* and the National Center for Transgender Equality's *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*.

As a result, striking advances have been made over recent years to address disparities in the quality of care and health outcomes of individuals who identify LGBT. These improvements address all aspects of personhood and across the healthcare system from the clinic environment, patient-provider interactions, and quality medical care. The result is improving access to and receipt of quality care by LGBT individuals. The breadth of information available for health care practitioners is exciting; however, synthesizing emerging research and new guidelines into the patient care encounter can be overwhelming to healthcare providers unfamiliar with the health needs of LGBT patients. Furthermore, challenges arise when defining what is core clinical knowledge for all practitioners and what is specific to different clinical specialties. For example, what information do all healthcare providers need to know to provide quality care for LGBT individuals versus what information do Pediatricians needs to know? Surgeons? Dermatologists?

The purpose of this book is to serve as a guide for LGBT preventive and specialty medicine that can be utilized within health professions education from students, residents, and healthcare practitioners. The book begins with core information on providing care to LGBT individuals relevant to all healthcare practitioners. Subsequent chapters address best practices in specialty and subspecialty care, providing depth beyond core clinical concepts. Across chapters are threads of information related to healthcare systems, patient advocacy, and sociopolitical climate as they relate to clinical care. Specific attention is paid throughout the text to how we can ensure our healthcare systems are better designed to accommodate the needs of LGBT patients. Each chapter is accompanied by learning objectives linked to the Association of American Medical Colleges' *Professional Competencies to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born With DSD*. This text is thus aligned with emerging best practices in education and training to facilitate the understanding and acquisition of key concepts.

It is our hope that this text will inform quality health care for LGBT patients, ultimately reducing the inequities in health care faced by LGBT individuals and improving the health of LGBT communities.

Nashville, TN, USA

Kristen L. Eckstrand
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Acknowledgements

This book would not have been possible without the support of our families, our colleagues, and most importantly our LGBT patients from whom we have learned so much. Special thanks to Irene Eckstrand, Steve Eckstrand, Nathan Eckstrand, and Laurel Eckstrand, Judd Taback, David Ehrenfeld, and Katharine Nicodemus. Additionally, we would like to thank our Vanderbilt Team—Drs. Andre Churchwell, Kim Lomis, Amy Fleming, and Bonnie Miller—for their encouragement in the development of this book and the Vanderbilt Program for LGBTI Health.

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Part I

The LGBT Population and Health

Understanding the LGBT Communities

1

Derek R. Blechinger

Purpose

The purpose of this chapter is to provide an overview of the lesbian, gay, bisexual, and transgender (LGBT) communities, persons affected by differences in sex development (DSD-affected), and the unique health needs of these populations.

Learning Objectives

- Define key sexuality and gender terminology used by and for LGBT patients (*KP1*)
- Discuss key differences between gender vs. sexuality, gender vs. anatomic sex, gender identity vs. gender expression, transgender vs. gender non-conforming, and the various sexual orientations (*KP1*)
- Identify frameworks for approaching the unique health needs and disparities experienced by LGBT & DSD-affected patients (*KP3*, *KP4*)
- Discuss the impact of minority stress on sexual and gender minorities' health outcomes (*KP3*, *ICS3*, *SBP4*)

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Do You Have Sex with Men, Women or Both?

Medical practitioners are often ready and willing to ask about sex to round out a solid social history. This dialogue often begins with the question, "Do you have sex with men, women, or both?" The rote expectation is that patients will report opposite sex partners. But what do you do when the patient says something less expected, such as "both"?

While medical schools across the nation are increasingly teaching future physicians to ask this important question, a 2011 study published in JAMA showed that 132 schools spent a median of 5 h of teaching lesbian, gay, bisexual and transgender (LGBT)-related content [1]. This content was broken down into 16 clinically relevant topics and, when asking what was actually taught, only 8 % of schools reported teaching all 16 topics. For most schools, topics like HIV and STDs topped the list as "LGBT-specific" while important issues such as LGBT adolescent health, transgender hormone management, suicide and coming out were left in the proverbial academic dust.

It is noteworthy that providers are being better equipped to ask the question "Do you have sex with men, women, or both?" but the art of medicine goes well beyond data gathering. It is not enough to simply elicit with whom a patient has sex; providers must use this question and others to build therapeutic alliance, reduce risk, and improve clinical outcomes. Nearly every LGBT

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K.L. Eckstrand, J.M. Ehrenfeld (eds.), *Lesbian, Gay, Bisexual, and Transgender Healthcare*,
DOI 10.1007/978-3-319-19752-4_1

patient (97 %) in the U.S. accesses health care at non-LGBT affiliated medical facilities [2], making this an important question even in spaces not specific to LGBT healthcare. The Kaiser Family Foundation recently released a report showing nearly half of all gay and bisexual men have never discussed their sexual orientation with a physician [3]. This has important consequences. All providers, regardless of specialty, must know how to identify LGBT patients, understand their unique health needs, and know how to be not just culturally competent, but culturally excellent. It is our hope that, regardless of specialty, this book will help you achieve just that—excellence.

An Introduction for the Busy Practitioner

The turn of the twenty-first century has been an auspicious time for advancing lesbian, gay, bisexual, transgender (LGBT) health. This historically stigmatized, highly hidden, diverse, underserved population has a variety of unique health needs and health disparities, many secondary to discrimination and minority stress [4–10]. In contrast, individuals affected by differences in sex development (DSD) still have not received the publicity and consideration that recent decades have afforded the LGBT community (the history of DSD-affected persons and health is discussed in detail in Chap. 23). Regardless of specialty or geographic location, we all work with LGBT and DSD-affected patients (whether they go recognized as such or not). Sexual and gender minority patients are youth, adults, elderly, rich, middle class, poor, employed, unemployed, disabled, able-bodied, citizens, immigrants and of every religious, ethnic and racial background that exists in every corner of the world. The health needs of sexual and gender minorities span the entire spectrum of medicine. Efforts are underway to better serve LGBT patients and address a variety of health disparities as highlighted by Healthy People 2020:

- LGBT individuals have the highest rates of tobacco, alcohol and other drug use [11–15].
- LGBT youth are more likely to be homeless and are two to three times more likely to attempt suicide [16–19].
- LGBT elders face barriers to health because of isolation and a lack of social services and culturally competent providers, often having to "go back into the closet" [20].
- Lesbian women are less likely to get preventive services for cancer [21, 22].
- Lesbian and bisexual women are more likely to be obese [23].
- Gay and bisexual men, while making up only 4 % of men in the U.S., account for 61 % of new HIV infections annually, 44 times that of other men [24].
- Transgender people experience high rates of victimization, HIV/STDs, mental health issues, suicide and lower rates of health insurance [25–29].

These and many other disparities have also been outlined by the 2011 Institute of Medicine's Report "The Health of LGBT People" funded by the NIH. Numerous professional associations including the American Medical Association, American Nurses Association, American Academy of Family Physicians, American Academy of Pediatrics, American Psychiatric Association, American Cancer Society, GLMA: Health Professionals Advancing LGBT Equality, and others have written position statements in support of a variety of LGBT issues (see Appendix C). Our nation and leading medical associations have heard the call to better serve LGBT people, and providers across all medical fields are being called to respond.

Terminology for the Busy Practitioner

Sexuality and gender are at the core of our experience as human beings. They are complex and multidimensional, and do not conform to traditional binaries (ex. masculine versus feminine, straight versus gay). It is the aim of this chapter to make the material approachable for all practitioners. Like many things in medicine, broadening your differential for "gender" and "sexuality" will help you better understand your patients and

Table 1.1 LGBT and DSD-affected medical terminology in the clinical encounter

Acronym	Possible associated identities[a]	Examples of usage
MSM	• Gay man • Queer • Homosexual • Can include bisexual men	• Pt is a 41 year old MSM presenting w/… • Pt is a gay man w/hx of… • Pt identifies as a queer man w/…
MSMW	• Bisexual man • Queer • Can include straight-identified men	• Pt is a 32 year old MSMW in a primary relationship w/… • Pt identifies as a queer man, reports sex with men and women
WSW	• Lesbian • Gay woman • Queer • Can include bisexual women	• Pt is a 89 year old WSW presenting w/… • Pt identifies as lesbian • Pt self-identifies as a queer woman who only has sex with women
WSWM	• Bisexual woman • Queer • Can include straight-identified women	• Pt is a 20 year old WSWM in a primary relationship w/… • Pt identifies as a queer woman, reports sex with women and transmen
MTF	• Transgender woman • Transwoman • Genderqueer • May be pre- or post-op	• Pt is a 52 year old MTF transgender woman presenting w/history of… • Pt identifies as an MTF woman w/intermittent hx of estrogen use. • Pt identifies as genderqueer, assigned male at birth, preferred pronouns "they/them"
FTM	• Transgender man • Transman • Transsexual man • May be pre- or post-op	• Pt is a 24 year old FTM transman • Pt identifies as man now s/p top surgery, continuing gender-affirming hormones now presenting w/… • Pt identifies as trans (FTM, pre-op), interested in pursuing GRS in July
GRS	• SRS (sex reassignment surgery) • Gender reassignment surgery (less accurate description) • Post-op	• Pt is a 29 year old transman s/p GRS 4 years ago continuing on gender-affirming hormone therapy • Pt identifies as an MTF woman, now s/p SRS × 1 year continuing on estrogen therapy
DSD-affected	• Intersex	• Pt is a 35 year old woman assigned female at birth s/p genital surgery 2/2 congenital adrenal hyperplasia • Pt identifies as DSD-affected s/p corrective surgery at birth w/hx of… • Pt is a 19 year old woman w/hx of infertility 2/2 androgen insensitivity syndrome presenting with…

[a]These identities may be associated with a preferred sexual or gender identity, but these are not universal associations. Rather than make assumptions, always let patients self-identify their preferred terminology

improve your clinical acumen (see Table 1.1 for examples of how to incorporate terminology into clinical practice).

Helpful Hint

Gender identity, gender expression, and sexuality are not binary concepts—thinking of them as having two ends on a linear spectrum artificially limits understanding of their complexities.

Beginner Level

Many practitioners without much experience with sexual and gender minorities have likely already heard the terms "lesbian", "gay", "bisexual", and "transgender". These four terms are often combined into the acronym "LGBT". While this acronym contains both identifiers of sexuality *and* gender, they are not the same. In order to understand the complexities of LGBT healthcare, an understanding of basic terminology is required:

"*Gender*"—a highly complex biopsychosocial concept often reduced to a binary set of identities and behaviors that are either masculine or feminine, male or female. Gender is multifaceted and can be quite fluid throughout the lifetime, including concepts such as identity and expression. Gender is often confused for biologic sex, however gender is independent of anatomy.

"*Gender identity*"—an internalized concept of self as a particular gender, regardless of external appearance. Because gender identity is internally defined, it is separate from a person's physical anatomy—male genitalia does not mean one's gender identity is that of a man, nor does female genitalia or breasts identify someone as a woman.

"*Gender expression*"—describes a set of behaviors that have been socially assigned as masculine or feminine. Remember that the simple binary of "male" vs. "female" behavior belies the myriad, complex, often overlapping nature of these behaviors independent of actual gender identity. A person may express a particular gender at any given time without changing their gender identity.

"*Sex*"—a descriptor of a person's anatomical state, most often reduced to two phenotypes of male (e.g., penis, scrotum, testicles) vs. female (e.g., breasts, vagina, uterus, ovaries). Medically, we know that there are a multitude of natural variations on anatomical sex not just limited to different shapes and sizes but also presence, absence and extent of differentiation of various structures. Regardless of function, phenotypes incongruent with the male vs. female binary are often identified by medical practitioners as differences of sex development (DSD).

"*Sexual orientation*"—a set of sexual attractions, behaviors and/or romantic feelings for men, women or both. Sexual orientation is often reduced to specific terms like homosexual vs. bisexual vs. heterosexual, however there is a broad spectrum of sexual orientations that can vary depending on the gender identity of the person and that person's various attractions, which may include attractions to certain sexes, gender identities, gender expressions and combinations thereof. The first attempts to quantify sexual orientation were made in the Kinsey scale, ranking people as 0 (exclusively heterosexual) to 6 (exclusively homosexual), or "X" for asexual. More sophisticated, contemporary models of sexuality have since been developed, recognizing it's breadth of natural variation and fluidity throughout a lifetime.

Helpful Hint

At the risk of over-simplification: Gender is between the ears. Sex is between the legs. Sexual orientation refers to attraction to either of these things (see Fig. 1.1).

Fig. 1.1 The modified gender gingerbread person model, which can be used as an aid to explain gender (image courtesy, J. Ehrenfeld)

"*Lesbian*"—used to describe women who are primarily attracted to women. This identifier of sexual orientation notably describes attraction vs. behavior. Identifying as lesbian implies sexual activity with women but does not exclude them from having attractions or sexual experiences with men, and it is important to clarify with your

patient not only who they are primarily attracted to, but also whether or not they have sex with men. "Homosexual woman" is antiquated and can be depersonalizing for your patient.

"*Gay*"—used to describe both men and women who have same-sex attractions. Historically, this has been used to refer to men who are primarily attracted to and sexual with men but can also refer to women who are primarily attracted to and sexual with women. If you are unsure of whether a woman identifies as "gay" or "lesbian", ask how they self-identify. "Homosexual" is antiquated and can be depersonalizing for your patient.

"*Bisexual*"—used to describe a person who is attracted to both men and women. This can encompass a wide spectrum of individuals who may have leanings toward a particular gender, or equal attraction to all genders, or attraction to specific aspects of various genders. Being in a relationship with a same-sex partner does not make a bisexual person gay. Being in relationship with an opposite-sex partner does not make a bisexual person straight. Bisexual people sometimes experience a unique type of disownment from both the straight and gay communities, rejected for not being "straight enough" or "gay enough." Others can experience a sense of invisibility (e.g. "bi-invisibility"), feeling lost or ignored within the LG(B)T communities.

"*Differences of sex development*"—refers to a group of phenotypes where there is a variation of sex, either chromosomal, hormonal, or anatomical, such that one's sex is not congruent with society's male versus female anatomical binary. This term does not define a person's identity, rather someone is affected by differences in sex development (DSD-affected). Prior terms for this group have, and still, include "differences of sex development" or "intersex", and their usage depends on the patient or medical society using them. The latter term is considered antiquated by some, but still in use by many, including the addition of the "I" to LGBT to form LGBTI. For further detail, see Chap. 23.

"*LGBTI*"—aforementioned acronym "LGBT" with the addition of "intersex". While the intention of this acronym is to be inclusive of all sexual and gender minorities and the often overlooked "I", not all DSD-affected individuals identify as intersex, and not all intersex individuals identify themselves as part of the "LGBTI" community. The experiences and needs of DSD-affected individuals are unique and may not fit under the wide umbrella cast by "LGBTI".

Intermediate Level

"*MSM*"—men who have sex with men, an epidemiologic term describing a man who has sex with men regardless of how he self-identifies. MSM includes not only men who identify as gay or bisexual, but also men who self-identify as straight but are sexual with men. This term is helpful when trying to categorize health risks and behaviors at a population level, though MSM would be unlikely to refer to themselves as MSM, but more likely as gay, straight or bisexual.

"*MSMW*"—men who have sex with men and women, an epidemiologic term exclusively describing a man who has sex with both men and women. A person does not need to identify as bisexual to be categorized as MSMW.

"*WSW*"—women who have sex with women, an epidemiologic term described a woman who has sex with women, regardless of how she self-identities. WSW includes not only women who identify as lesbian, gay or bisexual, but also those who self-identify as straight but are sexual with women. This is a useful epidemiologic term, especially when trying to categorize health risks and behaviors at a population level, though WSW would be unlikely to refer to themselves as WSW, but more likely as lesbian, gay, straight or bisexual.

"*WSWM*"—women who have sex with women and men, an epidemiologic term exclusively describing a woman who has sex with both men and women. A person does not need to identify as bisexual to be categorized as WSWM.

"*Cis-gender*"—a person whose anatomical birth sex is congruent with their gender identity. The majority of humans would be considered cis-gendered, though many may not have given much thought to this identification given society's designation of cis-gender as default, or "normal".

"*Transgender*"—a person whose anatomical birth sex is incongruent with their gender identity. Transgender people often exhibit cross-gender behavior at an early age. If their designated sex is female, their gender identity is male (often shorted to "trans man" or "female to male" or "FTM"). Conversely, if their birth sex is designated male, their gender identity is female (often shorted to "trans woman" or "male to female" or "MTF"). Note that using the word "trans-" prior to a patient's identifier as a man or a woman can be perceived as belittling and should only be used if the patient identifies that way. For more detail, see Part V.

Helpful Hint
When considering cis- vs. trans-gender, think back to organic chemistry and recall cis- vs. trans-isomerism (on the same side vs. on the other side!).

"*Genital reassignment surgery*"—often shortened GRS, an intervention that surgically changes the genital anatomy of an individual to better fit their gender identity with society's corresponding anatomic expectations. "Sex reassignment surgery" (SRS) refers to surgeries affecting genitals as well as secondary sex characteristics. For more detail, see Chap. 20.

"*Transsexual*"—in the past, this term referred to a transgender person after sexual reassignment surgery. Notably, this is an adjective and not a noun. For example, a MTF transwoman who is now post-op would be medically described as a transsexual woman, as opposed to a transsexual. When used as a noun, the word "transsexual" is often perceived as a highly medical term and is considered pejorative by patients who would otherwise identify as their gender.

Advanced Level

"*Queer*"—an umbrella term that encompasses a wide range of sexualities and genders that are outside the societal "norm". This may include lesbian, gay, bisexual, transgender individuals and allies who don't ascribe to being "normal". Historically a term used to denigrate LGBT individuals, this term has been reclaimed in the twenty-first century as a term of empowerment. Some LGBT individuals, especially those of older generations, find this word to be hate speech and too painful or disturbing to use. Self-identifying as queer has become more common in younger generations of sexual and gender minorities.

"*Pansexual*"—an individual who has a diverse set of attractions to a variety of anatomies, gender expressions and gender identities. While at first glance similar to bisexuality, the self-designation as pansexual is an intentional rejection of the gender binary and encompasses the whole spectrum of sexuality and genders.

Helpful Hint
During the clinical encounter, reflect the terminology used by your patient. If you are uncertain about terms or preferred pronouns, ask.

"*Drag*"—a type of cross-gender expression, often done as performance art. The art of drag has received national attention via the television show "RuPaul's Drag Race". Men who perform as women are called drag queens and women who perform as men are called drag kings. A transman is not a drag king and similarly a transwoman is not a drag queen. Drag is a performative act of gender expression, not a gender identity.

"*Genderqueer*"—an umbrella term that encompasses a wide range of genders. This term can include those who feel like they fit outside of a gender binary of male vs. female, as well as individuals who consider themselves to have multiple genders or no gender at all. Genderqueer subverts the simple distinction between cisgender vs. transgender people, as well as blurring the distinctions between gender identity and gender expression. A person who identifies as genderqueer may use gender neutral pronouns such as "they", "them", "their" or fluidly change between "she/her" or "he/him".

"*Trans**"—the addition of the asterisk (*) to trans (ex. trans*) is meant to be inclusive of gender queer and gender non-conforming individuals that don't think of themselves as on a cis- or transgender binary (ex. FTM transman versus MTF transwoman). Trans* can be used to describe any person not identifying as a cis-man or cis-woman, encompassing the entirety of non-cis gender identities and expressions.

"*Gender dysphoria*"—the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM-5) [30] designation for individuals who experience clinically significant distress associated with their gender associated with their gender identity for 6 months or greater. Gender dysphoria replaces "gender identity disorder" as an attempt to better characterize the experiences of gender non-conforming individuals. Notably, the DSM-5 has an additional diagnostic code for individuals who have already transitioned and are continuing medical treatment (e.g. ongoing hormone therapy, supportive counseling, surgeries) to ensure treatment access (and insurance coverage) without terming their gender or anatomic sex status as "disordered". Gender dysphoria has been intentionally separated from chapters including paraphilic and sexual dysfunction disorders to help address the stigma produced by our previous attempts at medically coding transgender, intersex and genderqueer individuals. For more detail, see Chap. 13.

"*Heteronormativity*"—a subjective world view that heterosexuality is normal and measuring any variations in human sexuality from the heterosexual "norm". Heteronormativity is similar in concept to "ethnocentric", as pertaining to sexuality. It is a term that addresses the concept of heterosexual privilege, or the advantages in social, political, and economic arenas granted to heterosexuals that are acquired by default given their status as a valued, preferred sexual orientation in society. Exclusive recognition of heterosexuality and constant depictions of heterosexual acts in public, media and graduate medical education are mainstays of heteronormativity, contributing to LGBT discrimination and stigma. See Fig. 1.2.

Helpful Hint

Try to avoid gendered or heteronormative language during the clinical encounter. For example, try using "partner" instead of boyfriend, girlfriend, husband, wife, or spouse. Remember that your clinic forms can make this mistake before the patient even meets you.

"*Coming out*"—an act by which a sexual or gender minority discloses their identity to another person. Coming out to family and other loved ones are often particularly formative experiences for LGBT people ranging from profoundly affirming to violent rejection. When asking a LGBT patient when they came out, you are asking them the first time they disclosed their identity as a sexual or gender minority. However, all LGBT people are constantly having to come out in large and small ways throughout their life time—every time they meet a new person, start a new job, join a new church, and even when deciding to hold hands with their loved one while walking in a park. As a result of heteronormativity, LGBT people are often in a constant state of vigilance around the words they use, their body language and the gender pronouns they use about themselves or their loved ones lest they come out unintentionally. This hypervigilance can be a significant source of stress and likely contributes to a number of LGBT health disparities. For more detail, see Chap. 4.

Exercise: Reflections on LGBT Terminology

Now that you understand some of the basic differences between sexuality and gender, let's dive deeper. Take the term "lesbian", for example. Notice that this word describes not only sexual orientation but also gender identity. For someone

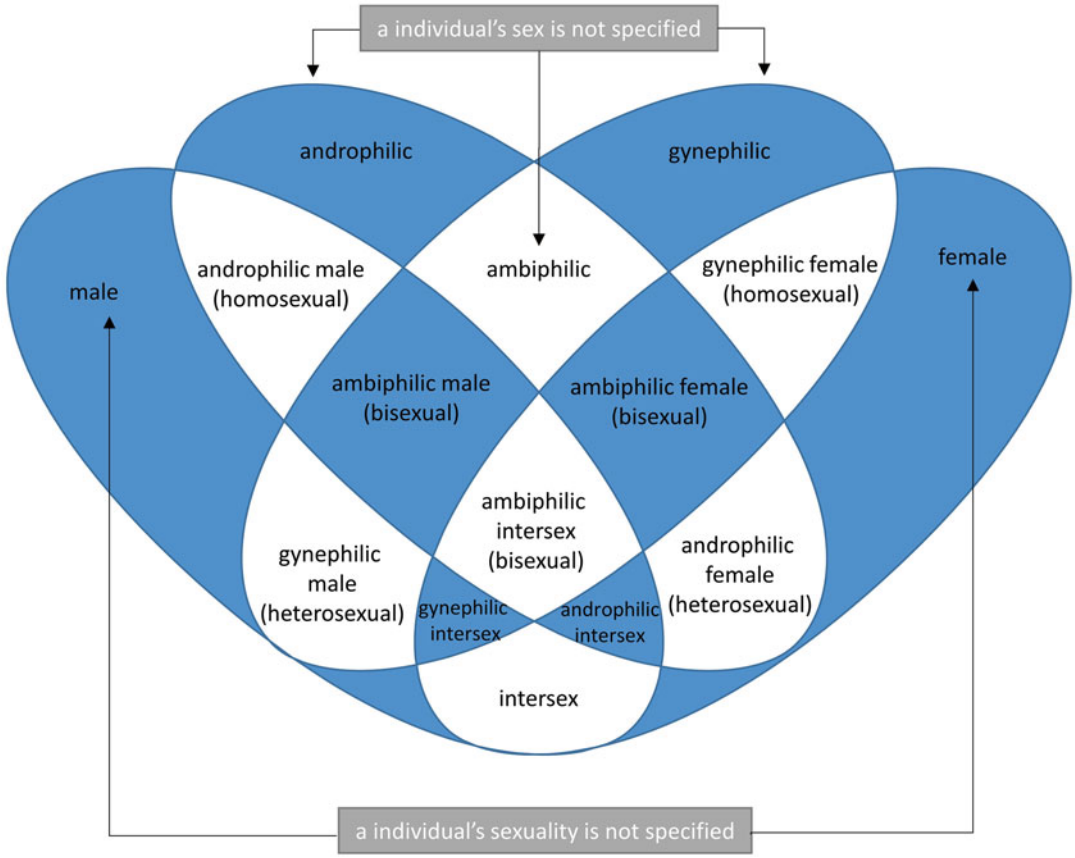

Fig. 1.2 A diagram showing the relationships between sexual orientation and assigned sex. Some prefer to use the terms androphilia and gynephilia, because homosexual and heterosexual assign a sex to the individual (image courtesy J. Ehrenfeld)

to identify as a lesbian, they most likely have a gender identity that is female and a sexual attraction to women. This distinction is subtle but important. For example, a transgender woman whose gender identity is female and their attraction is to other women makes them perceived as "straight" by some if only their birth sex is being considered. This, however, would not be honoring the person's autonomy in self-determining their gender and their sexuality. Remember that anatomy does not equal gender identity, making anatomic sex irrelevant. A transwoman attracted to other women would most likely self-identify as a lesbian. A transman attracted to other men would most likely self-identify as gay. Ultimately, every patient has the right to self-identify and it is up to us as medical professionals to learn to ask questions that help us understand the unique health needs and stratify risks for each and every patient we serve.

Deconstructing LGBT terminology can be difficult even for experienced LGBT health care providers. Continuing to struggle with the content and asking questions is a sign of a healthy, curious, well-intentioned practitioner. When approaching this material at an advanced level, it is also helpful to recognize your own place of privilege, whatever it may be, regarding sexuality and gender. Privilege, as mentioned above in the definition of "heteronormativity", is a set of unearned social, political and economic advantages obtained by virtue of a person's identity being valued by society. While the focus of this chapter is on sexuality and gender, certainly race, age, religious affiliations, economic status, mental health, class, profession and other factors

come with their own set of privileges and interact with sexual and gender identity in a variety of ways. Below are some starting places accompanied by a hypothetical reflection to help consider sexuality and gender privilege:

- Perhaps you are straight, and you've never had to decide whether or not to tell your family, friends, employer, or government officials your sexual orientation for fear of rejection, discrimination or violence.
- Perhaps you are a gay man who has never had to grapple with the idea of being attracted to both sexes and not fully belonging to either the gay community or the straight community.
- Perhaps you are a cis-gendered lesbian who has never considered what it would be like to have a penis instead of a vagina.
- Perhaps you are a transwoman who, while feeling you have body parts incongruent with your gender, have never had your genitals surgically altered without your consent as a child.
- Perhaps you are bisexual, and have not considered your increased potential to marry in every state in America and improved possibility of having children without reproductive assistance if paired with an opposite sex partner.

These reflections are by no means meant to shame or discourage practitioners of various walks of life, but rather begin the exploration of how one fits (or does not fit) in various communities and gain greater insight into the experiences of those different from you. Being a gay man does not automatically provide insight into the experiences of a transwoman. Nor does being a transgender person provide someone with special knowledge of the bisexual community. Regardless of our sexuality, gender or sex, we all should objectively assess our own privileges and limitations without guilt and continue to be curious about ourselves and others.

LGBT Demographics (Table 1.2)

Sexual and gender minorities are a unique demographic as they cut across all other demographics. LGBT & DSD-affected people can be very rich or very poor. Lesbian women can be African American. Bisexual men can be Muslim. Transwomen can be found in rural communities. Gay men can be elderly. DSD-affected people can be Southeast Asian immigrants. Bisexual women can be disabled. Notably, the vast majority of LGBT children are born and raised by cis-gendered, heterosexual parents. This limits the vertical transmission of culture and histories from older to newer generations enjoyed by other cultures. The shared experiences of stigma, discrimination and having to come out as a sexual or gender minority is what ties this complex, sometimes highly hidden demographic together. Same-sex couples are found in 99 % of counties across America [31]. Regardless of specialty or practice location, all providers care for sexual and gender minority patients. See Fig. 1.3.

Table 1.2 LGBT demographics

	U.S. population estimate (%)
LGBT	3.8
LGB	3.5
LG	1.7
B	1.8
T	0.3
Lesbian women	1.1 (of women)
Gay men	2.2 (of men)
Bisexual women	2.2 (of women)
Bisexual men	1.4 (of men)
Have engaged in same-sex sexual behavior	8.2
Acknowledge some same-sex sexual attraction	11

Helpful Hint
Same-sex couples are found in 99 % of U.S. counties. You have sexual and gender minority patients.

There have been many attempts over the decades to estimate the number of LGBT people in the U.S. Alfred Kinsey, famed for his work in sexuality and the development of the "Kinsey Scale", noted in his research that 10 % of men

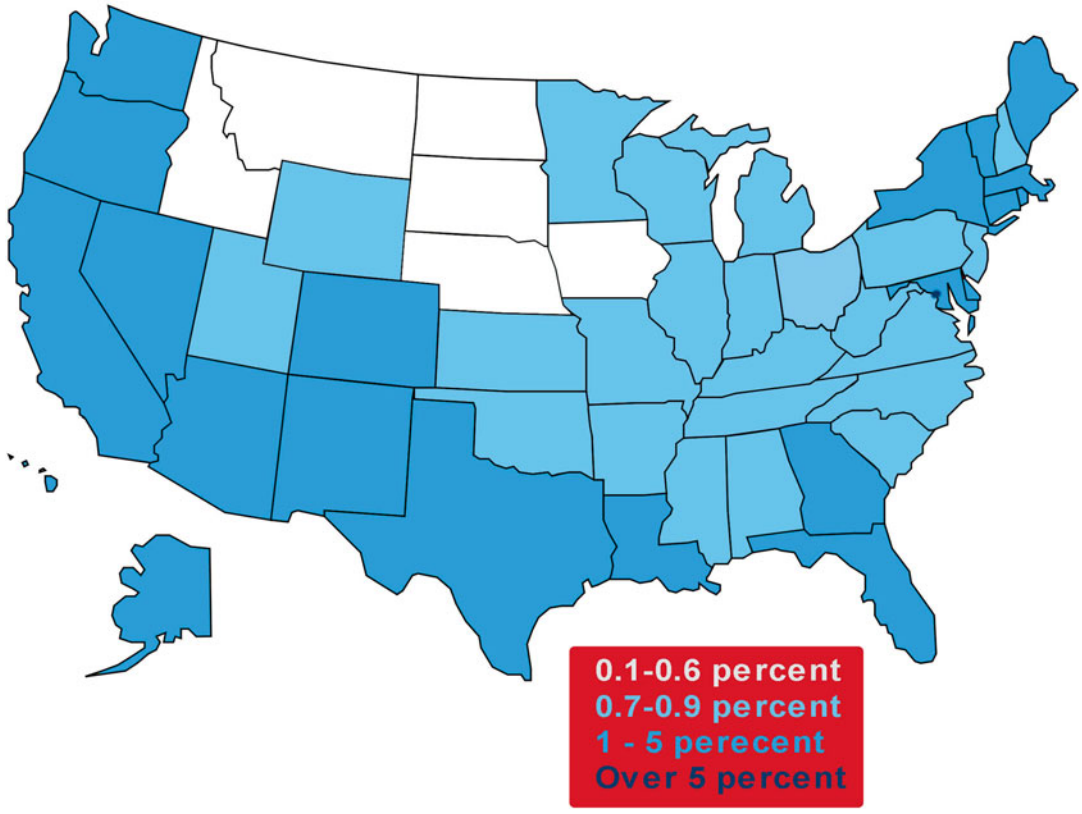

Fig. 1.3 Percentage of households with same-sex couples 2010 (adapted from the U.S. Census Bureau)

between 16 and 55 engaged in same-sex behavior exclusively for 3+ years. This led to the popularization of the "10 %" estimate for LGB prevalence. Since then, lower estimates have been made by the National Epidemiological Survey on Alcohol and Related Conditions (2004–2005), the National Survey of Family Growth (2006–2008), the General Social Survey (2008), the California Health Interview Survey (2009), and the National Survey of Sexual Health and Behavior (2009). Challenges in successfully integrating the data can be found in differing survey methodology, consistent ways of asking about sexual orientation vs. attraction vs. behavior, and changes in who is included as a sexual or gender minority. More contemporary data analysis utilizing population-based data by the Williams Institute at the UCLA School of Law has become the current standard, estimating 3.5 % of adults in the U.S. identify as LGB (over 8 million people) and 0.3 % Americans identify as transgender (700,000 people) [32]. Gates' review of state and national surveys also delineated identity from behavior and attraction, finding 8.2 % of Americans have same-sex sexual behavior and 11 % of Americans have same-sex sexual attraction.

Demographics by Sexual Orientation

In 2014, the CDC released its first National Health Interview Survey on sexual orientation and health. The study which interviewed more than 33,500 people ages 18–64 found that approximately 96 % of Americans described themselves as straight, 1.6 % gay, or lesbian, 0.7 % said they were bisexual, and just over 1 % identified as "something else." This equates to approximately 1.4 million lesbian women and 2.5 million gay men. Interestingly, gay men make up a greater percent of MSM than bisexual men (2.2 % vs. 1.4 %), in contrast to the trend noted in WSW. Notably,

bisexual people make up the majority subgroup within the LGBT community but are often subject to "bi-invisibility" given their perception as either gay when with a same-sex partner or straight when with an opposite-sex partner.

Demographics by Gender Identity

Population estimates for transgender individuals remains elusive, largely because population surveys such as the Decennial Census or American Community Survey do not directly ask about gender identity. Attempts at estimating the prevalence of transgender have instead focused on transsexualism, given at least the raw prevalence data from sex reassignment surgery (SRS) clinics throughout Europe from decades ago. A reanalysis by Olyslager and Conway [33] using mathematical modeling from those earlier reports found a most likely prevalence to be between 1:1000 and 1:2000. Using more recent incidence data and alternative estimation methods, they found that the rate is at least 1:500 (0.2 %), and possibly even higher. Their results were presented at the WPATH 20th International Symposium in Chicago, but not adopted by the APA. Incidentally, more contemporary researchers working with population data have found similar rates. By averaging the data from the Massachusetts and California surveys, Gates [34] estimates the number of Americans who identify as transgender to be 0.3 %—nearly 700,000 transgender U.S. citizens.

Transgender people can be found throughout America, from places both urban and rural and participating in society in every way imaginable. Increased trans visibility in the media include remarkable individuals such as Isis King (*America's Next Top Model*), Thomas Beatie (transman who publically came out as pregnant in 2008), Laverne Cox (*Orange is the New Black*), Chaz Bono (*Becoming Chaz*), Dr. Marci Bowers (pioneer and first transwoman GRS surgeon) and the brilliant and inspiring Janet Mock (author and staff editor at *People Magazine*). Kristin Beck, the first openly transgender Navy SEAL, told her story in her autobiography *Warrior Princess* in 2013. Notably, she retired from the military prior to coming out as transgender, as the repeal of "Don't Ask, Don't Tell" in 2011 only applied to the LGB portion of the LGBT communities, leaving the "T" unaddressed. The military still officially forbids openly transgender people from serving, but the results of the National Transgender Discrimination Survey showed us that 20 % of trans people had served in the military—two times that of the general population [35]. This discriminatory policy continues to be under pressure for change by civil rights advocates, and may hopefully see change even by the time of publishing this text.

Differences of Sex Development/ Intersex

There is a remarkable lack of epidemiologic data when it comes to DSD-affected people. While sometimes lumped with transgender people, DSD-affected experiences and health care needs as detailed by the clinical guidelines published by the Intersex Society of North America that are different from those of transgender people [36]. Most often, DSD-affected individuals have intersected with the medical field at birth, perhaps experiencing unnecessary procedures, diagnostic testing or unwanted surgeries. The Intersex Society of North America has endorsed the review of medical literature ranging from 1955 to 1998 by Anne Fausto-Sterling et al. [37] that found the total number of people with bodies different from standard male or female anatomy was 1:100 births and people receiving corrective genital surgery was 1–2 per 1000 births. Complete gonadal dysgenesis is estimated to happen in 1:150,000 and hypospadias in 1:770. Klinefelter (XXY) was found to be 1:1000, androgen insensitivity syndrome 1:130,000, and congenital adrenal hyperplasia in 1:13,000 births. For more detail, see Chap. 23.

Youth

While it is probably true that rates of sexual and gender minorities are very similar in youth as in adult LGBT populations, efforts are underway to better describe this highly vulnerable population. Estimates from the CDC's Youth Risk Behavior