Chapter 8

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 healthcare prescriptions, and/or learn better coping strategies. Nancy Krieger's astute comment that begins the 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 healthcare 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. The disapproval may be manifest in such diverse behaviors as ignoring, invalidating, avoiding, harassing, or even violent actions. Discrimination can occur in education, housing, employment, public services, religious organizations, and health care. Stigma is based on prejudice and stereotypes that unjustly judge the other as deficient, evil, abnormal, inferior, sick, subhuman, immoral, or criminal. These attitudes and stereotypes, 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 (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.

Sources of Stigma

In the United States, stigma regarding sexual and gender identities stems primarily from one of two sources. The first is from medical discourses based on ideas of disease or biological abnormality, particularly beliefs drawn from the field of psychiatry about sickness, abnormality, or mental illness. The second is the stigma that results from religious or moral beliefs, including the idea of sin or immorality. Sin and sickness discourses coexist in much of the anti-LGBTQ rhetoric throughout the past century, and continue today in the cultural clashes about LGBTQ civil rights. 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 (Jordan-Young, 2010). In 1973, the American Psychiatric Association removed sexual orientation from their 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 (also called conversion therapy) to attempt to change the sexual orientation of LGB people (see e.g., NARTH: the National Association for Research and Therapy for Homosexuality). The presence of reparative therapy, which has considerable overlap with fundamentalist 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.

Talk About It 8.1

Most people cannot even imagine someone advising them that they need to change their sexual identity, because most people identify as heterosexual, and take for granted that this could never be challenged or changed. Read this summary of the history of so-called "therapies" to change the sexual identity of people who identify as gay, lesbian or bisexual, then discuss with friends and colleagues.

(*continued*)

Therapies to change one's sexual orientation stem from psychoanalytic theories in the late 1880s. Although Freud himself was not a supporter of such therapies, his daughter Anna reported that she had successfully changed men's sexual orientation through therapy. Psychoanalytic therapies were common in the United States in the early 1900s and well into the 1960s. The first edition of the Diagnostic and Statistical Manual of Mental Disorders, published in 1952, listed homosexuality as a mental disorder. The three types of therapy still used today include (1) long-term psychoanalysis, (2) forms of behavior modification, particularly aversion therapies, some of which resembled torture in their methods, and (3) ex-gay ministries that focus on gender issues, relationships with same-sex role models/parents, and/or prayer.

One of the first challenges to the pathologizing of homosexuality came from psychologist Evelyn Hooker in a 1957 publication that corrected the problems with older research based on mostly institutionalized or incarcerated populations. Hooker found normal psychological development in homosexual men. Psychologists who were vocal about the ability to change sexual orientation included Irving Bieber, Albert Ellis, Charles Socarides, Elizabeth Moberly, and Joseph Nicolosi. In the 1990s, the Christian right became much more involved in sponsoring reparative therapies (see Family Research Council, for example), with programs such as Love Won Out and Exodus International.

In 2001, the Surgeon General of the United States, David Satcher, issued the first government-sponsored report condemning reparative therapy. The same year, a study by Robert Spitzer claimed that highly motivated individuals could change their sexual orientation—years later in 2012, Spitzer recanted his study and apologized to the LGBT community. Nearly every professional association in health fields have issued statements against reparative therapy.

California became the first state to ban reparative therapy for minors (2012), followed by New Jersey, the District of Columbia, and Oregon. In mid 2015, several other states had such legislation in the works. These laws only protect minors from being coerced into therapy, but there are still desperate adults and youth who have suffered much rejection and trauma related to their sexual orientation or gender identity that are vulnerable to claims of therapists or religious groups that they can "cure" them.

We discussed the role of religion on attitudes about LGBTQ people briefly in Chapters 4 and 7. A recent rise in fundamentalism has resulted in renewed attacks on the civil liberties of LGBTQ people, most notably focusing on the battles around marriage equality. But there has also been an increase in the number of "ex-gay" ministries (Hedges, 2008), which are ministries devoted to changing people from LGBTQ to heterosexual through prayer, isolation, and pseudo-psychological 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, 2002).

The overwhelming lack of evidence that reparative therapy, whether based on religion or psychological theory, changes sexual orientation, and the mounting 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). California became the first state to ban reparative therapy for nonconsenting youth, making it illegal for parents or religious leaders to force youth into therapy.

Read This 8.1

Read the full text of the California law banning reparative therapies for youth (https://goo.gl/4LJKFP). The Web site has tabs that provide interesting information about the bill, including the history of the bill and an analysis of the bill.

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 or constituents. This separation of church and state has eroded considerably in the past 10 years, with right to religious freedom laws in several states affecting businesses and healthcare institutions. For example, the Supreme Court's ruling on the Hobby Lobby case opened the door for states to say that individual businesses and people within agencies could refuse to serve people based on their religious beliefs. This allowed magistrates to refuse to marry same-sex couples. Indiana passed such a bill in 2014, but it was softened after national outcry against it and threats to boycott the state. North Carolina in summer of 2015 passed a similar law, in spite of the considerable backlash against the Indiana law. Civil

Think About It 8.1

Whereas most healthcare professionals may not conduct or refer clients to reparative therapy or refuse to serve LGBTQ patients (although a small number do), 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 anti-gay 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."

If you were J., what would you have done?

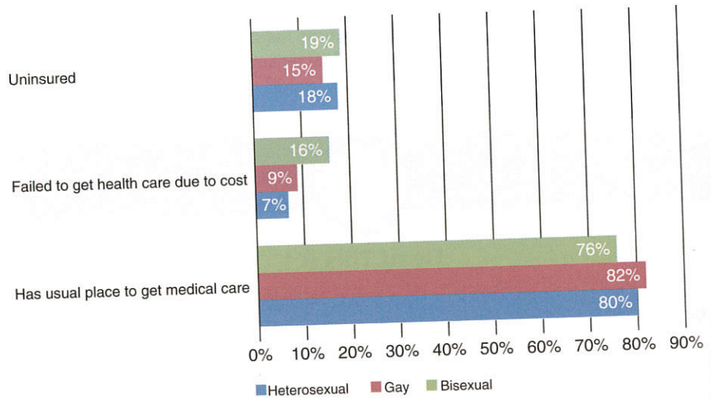

Figure 8.1 – Healthcare Access for Men in the NHIS (Based on **Ward et al., 2014**).

rights work is a constant process of progress and backlash, but as Martin Luther King said, "The arc of the moral universe is long, but it bends toward justice."

The sin and sickness discourses have impacted healthcare institutions in other ways as well, limiting access to healthcare services and affecting the quality of care received once in the system. The National Health Interview Survey (NHIS) included a sexual orientation question for the first time in their 2013 survey and reported indicators of healthcare access including insurance coverage, having a regular provider, and failing to get care because of cost (Ward, Dahlhamer, Galinsky, & Joestl, 2014). Figure 8.1 depicts data for men and Figure 8.2 for women, showing somewhat greater

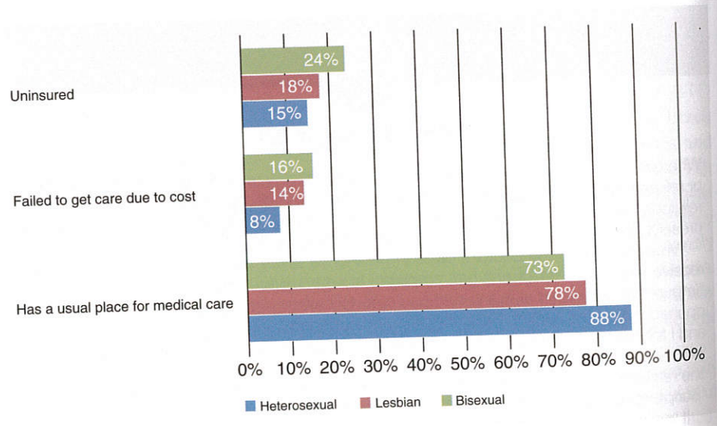

Figure 8.2 – Healthcare Access for Women in the NHIS (Based on **Ward et al., 2014**).

disparities for sexual minority women who simultaneously suffer the stigmas of sexism and heterosexism. Bisexual men and women also suffer more health access issues than do gay/lesbian or heterosexual people.

Think About It 8.2

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 "stand-offish." 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 coworkers. If Marion worked in the healthcare setting where you work or receive care, how do you think she would be treated if her gender and sexual identities were known?

Effects of Stigma on Health

> *"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)

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 is

1. unique, and adds more stress on top of the general life stressors that many people experience;
2. chronic; and
3. comes from social processes, institutions or structures rather than from individual risk factors such as biological or genetic variables (Meyer, 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. 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 transgender Virginians had no health insurance, 38% did not have a regular physician, 36% felt uncomfortable talking to healthcare professionals about transgender-specific health issues, and 24% had experienced discrimination from a healthcare professional. Much less is known about bisexual people's experiences with health care (Miller, Andre, Ebin, & Bessonova, 2007), but there is mounting evidence that the even greater stigma of bisexuality affects healthcare access (Ward et al., 2014).

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 (Meyer, 2013). 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, healthcare 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-draining to always be on one's guard. Of all places, a healthcare setting should be one where patients feel safe and protected.

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 to 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 (Frost, Lehavot, & Meyer, 2015; Hatzenbuehler, Slopen, & McLaughlin, 2014). In the next two chapters, 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, and body image and eating disorders, and physical health disorders include chronic physical ailments such as diabetes, asthma, heart disease, cancer, and sexually transmitted infections. In this chapter, we focus on the more general effects of stigma on well-being, including intimate partner violence (IPV), effects of living in more restrictive geographic regions without LGBTQ legal protections, and the stress of interacting in healthcare settings.

The Effects of Living in Fear/Uncertainty

There has been increased study of the structural effects of stigma on LGBTQ people's health in recent years. This research has linked increased rates of sexual risk behavior to country-level stigma in an international study (Pachankis et al., 2015) and was also found for differing structural stigma in states in the United States where MSM in more stigmatized states reported less use of HIV-prevention strategies and higher sexual risks (Oldenburg et al., 2015). Among youth, living in an area with fewer protections and resources for LGBTQ people leads to higher drug use (Hatzenbuehler, Jun, Corliss, & Bryn Austin, 2015). Suicide behaviors are also higher among youth who live in neighborhoods with higher rates of hate crimes against LGBT people (Duncan & Hatzenbuehler, 2014) and for youth in schools without gay-straight alliances or protective policies (Hatzenbuehler, Birkett, Van Wagenen, & Meyer, 2014). Finally, one study linked anti-gay prejudice in heterosexual respondents to higher mortality rates. Those with anti-gay attitudes died on average 2.5 years earlier than those with low levels of anti-gay prejudice, suggesting that stigma adversely affects heterosexuals as well as LGBTQ people (Hatzenbuehler, Bellatorre, & Muennig, 2014).

Domestic Violence/Intimate Partner Violence

Much of the literature on domestic violence, or 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, Beauchaine, Mickey, & Rothblum, 2005; Greenwood et al., 2002; Tjaden, Thoennes, & Allison, 1999, 2000; Walters, Chen, & Breiding, 2013).

Gender is not the only source of power imbalance in relationships, and it is rare to find couples that are truly equal in all ways. Imbalances in finances, social support outside the relationship, drug and alcohol abuse, the degree of "neediness," fear of being outed, and the stress of stigma (minority stress), as well as sexism and heterosexism, are factors in same-sex IPV. In addition, in heterosexual couples, depression and alcohol use are associated with higher rates of abuse, particularly bidirectional partner violence, and since both depression and alcohol use are higher among LGBTQ people, they may drive the higher rates of partner abuse seen in some studies (Lewis et al., 2015).

A systematic review of the literature on lesbians and IPV (Badenes-Ribera, Bonilla-Campos, Frias-Navarro, Pons-Salvador, & Monterde-I-Bort, 2015) pointed out that the majority of studies in the past have methodological flaws, with the majority employing convenience samples of mostly White and well-educated women. The victimization rates reported in these studies ranged from 10% to 73% and the perpetration rates from 17% to 75%, probably because of the different definitions and measures of violence used across these studies. Walters et al. (2013) reported prevalence rates from a probability sample from the CDC, as shown in Figure 8.3. This data show that bisexual women have the highest rates of lifetime victimization (with 95% of that from male partners). These data are even more shocking when one considers the definition of victimization

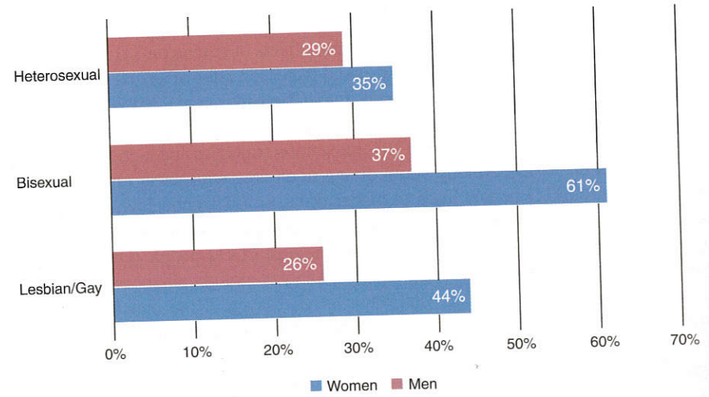

Figure 8.3 – Prevalence of Intimate Partner Victimization in a Lifetime by Sexual Orientation and Gender (Based on **Walters et al., 2013**).

here: lifetime experience of rape, physical violence, or stalking. Emotional abuse and verbal abuse are not included in this data, yet we know they are even more common occurrences.

One study found higher rates of IPV among transgender people (52%) compared to cis gender people (34%) (Langenderfer-Magruder, Whitfield, Walls, Kattari, & Ramos, 2014). HIV positive and younger men were more vulnerable to violence than HIV negative and older men. In addition, LGBTQ people are more likely to experience psychological and physical violence within their intimate relationships, presumably because the stresses of same-sex relationships are greater (Badenes-Ribera et al., 2015; 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 & Dolan-Soto, 2001). Additionally, 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 (such as power, finances, fears of abandonment), but the resources for intervention/treatment are much more limited (Calton, Cattaneo, & Gebhard, 2015). 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, and one study found that 62% of LGBTQ victims of abuse who sought assistance in a domestic violence shelter were refused services (National Coalition of Anti-Violence Programs [NCAVP], 2013). 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, courts, hospital staff, social workers, and other healthcare professionals (National Coalition of Anti-Violence Programs [NCAVP], 2013).

Transgender individuals who are sex workers, much like cisgender 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 had experienced intimate relationship violence (Xavier et al., 2007), but many more experience verbal abuse and harassment from parents (22%), siblings (17%), and other relatives (14%) as well as police officers (37%) (Reback, Simon, Bemis, & Gatson, 2001). The National Gay & Lesbian Task Force commissioned a report on issues of transgender individuals in homeless shelters that addresses some of the same problems that transgender people would encounter in domestic violence shelters—this may serve as a useful starting point for those healthcare professionals who work in any kind of residential setting (Mottet & Ohle, 2003). An unexplored potential source of domestic violence among transgender individuals may be their significant others at the time that they "come out" as transgender. As one partner of a trans person put it,

> *"I don't always think staying together is the most positive outcome for a couple. Some SOs [significant others] are much happier when they leave, and it's right for them to do so. Often the transperson is happier too, especially vis-à-vis transition … especially those who had wives who denigrated them for the cross-dressing for a long time. There's a huge potential for (mostly verbal) abuse of transpeople by partners that no one is really talking about much yet."* (Erhardt, 2006, p. 5)

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 a study of physical health symptoms and disorders (Cochran & 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 (2009) 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 to 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 in the past 5 years—these same factors predicted suicide risk. These studies and more suggest that minority stress or stigma is the primary culprit in LGBTQ health disparities of all sorts, from mental health to chronic physical problems.

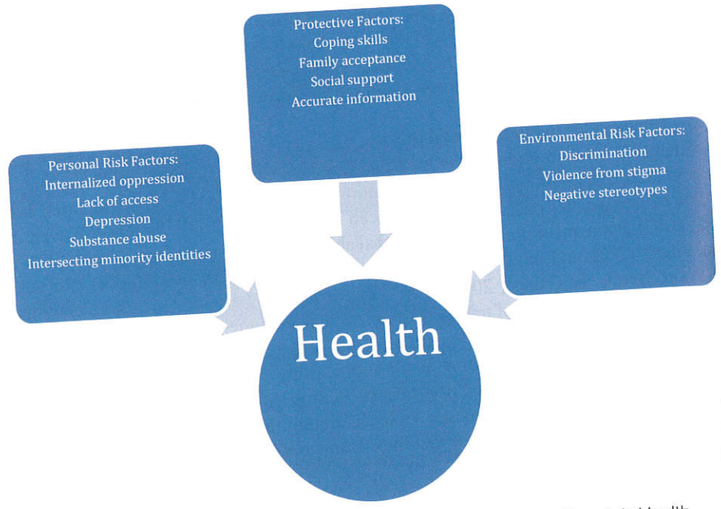

Figure 8.4 – Risk and Protective Factors that Impact LGBTQ People's Health.

Stress can be buffered by the protective factors such as accurate information, family acceptance, social support, and healthy coping strategies. Figure 8.4 depicts the possible relationships among these protective and risk factors—living in the cultural soup of negative stereotypes which create stigma, the LGBTQ individual can have external environmental risk factors such as stigma and negative stereotypes, and personal risk factors such as internalized oppression and stigma consciousness (a heightened sensitivity to stigma), that facilitate the development of physical and mental health problems. Theoretically, if the protective factors outnumber the risk factors, the individual may have strong boundaries to defend against stigma and stay healthy. It is important to keep in mind that many LGBTQ people have strong layers of protection and inner strength that keep them healthy. We do not want to imply that all or even most suffer from physical or mental health problems related to stigma. It is equally important to keep in mind that minority stress and stigma might have impact on the health of family members such as parents, who worry about their LGBTQ children or fear negative repercussions from their communities if their children's identities are known. Minority stress models might also apply to the heterosexual children of LGBTQ parents, or to siblings and other family members of LGBTQ individuals, although little research has focused on these groups.

LGBTQ People's Experiences with Healthcare

This section deals with four main issues that are created by minority stress: disclosure of one's sexual orientation and/or gender identity to a healthcare professional, the reaction that healthcare provider has to the disclosure, treatment received in healthcare settings, and treatment of partners/family in healthcare settings. All of these factors make accessing health care challenging and stressful for LGBTQ people.

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"* (Beehler, 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"* (Boehmer & Case, 2004, p. 1886).

A recent study of the likelihood of disclosing one's sexuality to a healthcare provider showed that gay (90%) and lesbian (87%) individuals were more likely to disclose than bisexual men (61%) or women (67%) (Durso & Meyer, 2013), reflecting the greater levels of biphobia and lack of knowledge of bisexual health issues among healthcare professionals. Decisions to disclose one's sexuality to a healthcare professional are rather complex, and may vary according to generation, educational levels, immigration status, race/ethnicity, couple status, gender, degree of connectedness to LGBT community, location (rural/urban), and reason for seeking care (Austin, 2013; Bernstein et al., 2008; Durso & Meyer, 2013). Some people have greater mistrust of healthcare 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. They proposed that disclosure was not a simple yes or no situation, and instead, identified four types of disclosure to healthcare providers:

- Active disclosure: The patients directly told a healthcare professional that they were LGB.
- Passive disclosure: Patients indirectly informed the professional via naming a same-sex partner, wearing a t-shirt or button that proclaims one's sexuality and assumed that the provider would pick up the clue.
- Active nondisclosure: A few patients actively lied about their sexuality to avoid negative consequences.
- Passive nondisclosure: The majority experienced a "don't ask, don't tell" situation, where 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 to men 29%). Women used more protective strategies while in healthcare settings, such as bringing someone along for support, closely monitoring the healthcare provider's behavior, scanning the environment for clues of acceptance, and controlling

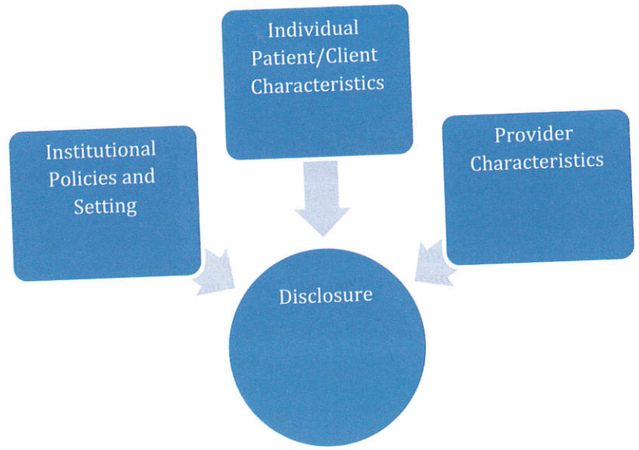

Figure 8.5 – Factors that Influence Disclosure Decisions.

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 White and male privilege, if not heterosexual privilege.

Figure 8.5 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, educational level, sexual orientation identity label, comfort with own sexuality, comfort with own gender, degree of internalized homophobia, past 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 healthcare 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/healthcare professionals because women tend to be more accepting of diverse sexual identities; some perceive younger healthcare 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 healthcare 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 healthcare professionals ranges widely, because the overall numbers do not reflect the complexity of the question. Most of the recent research suggests that

more than 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 healthcare experiences, but are probably less likely to disclose because of the enormous stigma attached to their behavior. They would not be identified unless a healthcare 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 healthcare professional. However, some reported anger, hostility, discomfort, disgust, embarrassment, fear, and shock on the part of the provider. Some note that when healthcare providers are merely silent after their disclosure, they leave the visit uncertain and concerned that the reaction may have been negative. It is important for care providers to acknowledge the disclosure. A simple statement such as "Thank you for sharing that information" or "Is it ok if I record that information in your medical record?" are neutral ways of acknowledging the disclosure. Those who are comfortable can ask follow-up questions, such as "Do you have a partner?" or "How long have you been out?"

Several studies have gathered the stories of negative experiences. Some of these are recounted below. This first quote indicates an experience with a microaggression rather than any overt discrimination.

> *"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 healthcare providers (lesbian, age 43)"* (Eliason & Schope, 2001, p. 130).

A respondent in another study experienced judgments about sexual behavior, and the care provider infantilized the patient, and the second one had a care provider who also focused on the stereotype that being a gay man was all about HIV/AIDS:

> *"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).

Finally, one respondent in another study of LGBTQ people in rural areas encountered a referral for reparative therapy based on religion when the patient sought grief therapy:

"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, 2006).

LGBTQ People's Treatment in Healthcare Settings

A national LGBTQ advocacy group, Lambda Legal, surveyed LGBTQ people in 2010 about healthcare experiences (Lambda Legal, 2010). Overall, far too many LGBTQ people had experienced poor treatment such as being blamed for their own illnesses (11% LGB and 20% trans people), receiving rough treatment (5% LGB and 8% trans), hearing harsh language from care providers (11% LGB and 21% trans), and even in 2010, 8% of LGB and 26% of trans people had been refused care in a healthcare setting. When the sample was examined by race/ethnicity, the disparities were even more pronounced, with LGBTQ people of color about twice as likely to experience physically rough or abusive treatment from healthcare providers as White LGBTQ people. These are overt acts of discrimination and unconscionable, however, LGBTQ people face even more challenges than these overt acts. Microaggressions are also common in healthcare settings and they increase the level of stress. For example, most healthcare settings are heterosexist—they do not recognize LGBTQ people at all, or if they do, they have no framework for dealing with LGBTQ patients (Röndahl, Bruhner, & Lindhe, 2009; Röndahl, Innala, & Carlsson, 2006).

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 areas with no recognition of same-sex relationships, partners without power of attorney (see Chapter 13) 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)" (Röndahl et al., 2009, 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).

Accessing Healthcare 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 healthcare 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 professional. Lesbians were 2.06 times more likely to see a mental health 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 healthcare. Matthews, Hughes, Osterman, and Kodl (2005) found that 42% of lesbians had experienced discrimination in health care compared to 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. Chapter 10 deals more with accessing routine care and recommended health screening tests.

There is some inconsistency in this literature on accessing health care. Lewis, Derlega, Clarke, and Kuang (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 healthcare professionals. More research is needed to address whether those individuals who accessed services more often actually disclosed their sexual or gender identities to the healthcare 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 healthcare. 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 healthcare 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 healthcare professionals), healthcare agency policy change, and broader societal change. Chapter 13 addresses institutional factors such as agency climate and policies and procedures.